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Health Status and Use of Health Care Services by the Older Population

A Residential Comparison

Carolyn C. Rogers

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**Health Status and Use of Health Care Services by the Older Population:
A Residential Comparison.** By Carolyn C. Rogers, Agriculture and Rural Economy
Division, Economic Research Service, U.S. Department of Agriculture. Rural
Development Research Report No. 86.

Abstract

Although the majority of elderly persons are, and perceive themselves to be, in good health, health status differs by residential location, with a higher proportion of nonmetro elders reporting their health as fair or poor (35 percent) than metro elders (29 percent). The nonmetro elderly are also more likely to have certain chronic conditions, such as arthritis, that are clearly associated with poorer physical functioning. Differences in elders' self-assessments of health and physical functioning remain evident when other factors, such as age, race, social support networks, income, and education are accounted for. The nonmetro elderly use less health care (compared with metro residents) than is commensurate with their health status. This suggests that there is a gap between the nonmetro elderly's need for care, based on their poorer health status and lower socioeconomic standing, and the availability of services to meet this need. This report uses data from the 1984 Supplement on Aging to the National Health Interview Survey to describe the nature and magnitude of differences in health status and use of health care services by the older population, by place of residence.

Keywords: Elderly, older population, health status, health care services, metro-nonmetro residence

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Summary

The majority of persons aged 60 years and older are, and perceive themselves to be, in good health. But, health status differs by place of residence, with a higher proportion of nonmetro elders reporting their health as fair or poor (35 percent) than metro elders (29 percent). The nonmetro elderly are also more likely to have certain chronic conditions, such as arthritis, that are clearly associated with poorer physical functioning. Differences in elders' self-assessments of health and physical functioning remain evident by residence when other factors, such as age, race, social support networks, income, and education are held constant.

This report uses data from the 1984 Supplement on Aging to the National Health Interview Survey conducted by the National Center for Health Statistics. This data set is the latest available and the most appropriate because it provides a large enough sample size to study differences in the elderly's health and other characteristics separately by residence. The report describes the nature and magnitude of differences in health status and use of health care services by the older population, by place of residence.

Socioeconomic status, as measured by education and income, is important to the health status of the elderly, with higher socioeconomic status associated with better health. This effect is magnified in nonmetro areas, where elderly persons are generally less educated and have lower incomes than the metro elderly. Social support networks are strong in nonmetro areas, but not enough to overcome the effects of the nonmetro elderly's lower socioeconomic status.

The nonmetro elderly are less likely to use formal health care services, defined as physician visits, hospital stays, and nursing home care, than are their metro counterparts. The nonmetro elderly's poorer health and lower socioeconomic status, combined with lower use of services, suggests that a gap exists between the nonmetro elderly's need for care and the availability of services to meet this need.

Other findings of this study are as follows:

- 71 percent of metro elders reported their health as good to excellent in 1984, compared with 65 percent of nonmetro elders.
- 53 percent of nonmetro elders had arthritis, compared with 47 percent of metro elders.
- Metro-nonmetro differences in physical functioning diminish with age.
- Among the nonmetro elderly, 40 percent with incomes of less than \$20,000 reported their health as fair or poor in 1984, compared with 19 percent with incomes of \$20,000 or more.
- 82 percent of metro elderly persons used formal health care services, while 79 percent of the nonmetro elderly reported such use.

Health Status and Use of Health Care Services by the Older Population: A Residential Comparison

Carolyn C. Rogers*

Introduction

The U.S. population is aging, with concomitant changes in the structure of the family and in health and social services. In 1990, 42 million Americans were elderly, or aged 60 and older, with 26 percent residing in nonmetropolitan (nonmetro) areas. The population aged 60 and older increased 17 percent between 1980 and 1990, 19 percent in metropolitan (metro) areas and 12 percent in nonmetro areas.¹ The most rapidly growing segment of the older population is the oldest old, or those aged 75 and older. Between 1980 and 1990, the oldest old in metro areas increased 33 percent, and their nonmetro counterparts increased 30 percent. Older persons are at greater risk of disability, and are more substantial users of health, medical, and other services than the general population. With an aging population, the number of persons aged 60 and older with disabilities is increasing, creating a greater need for medical, rehabilitative, and social services.

Awareness of the special needs of the rural elderly has increased, along with the increase in size and visibility of the older population. The level and determinants of the health status of the older population by residential location have not received as much attention as have variations in the health status of the elderly by demographic and socioeconomic characteristics. This study focuses on the health status and use of health care services by the nonmetro elderly living in the community, compared with their counterparts in metro areas. The survey data used in this report exclude the institutionalized elderly, who represent 5 percent of the older population. Thirty-two percent of current nursing home residents are nonmetro elderly, and 39 percent of

nursing homes are located in nonmetro areas (National Center for Health Statistics, 1989).²

The availability and accessibility of health care services is critical for the quality of life for many older Americans. The nonmetro elderly use health care services less than the metro elderly, as recognized in a 1988 report by the National Research Council. The availability of health care services often poses problems in low-density, sparsely populated nonmetro communities. Many of these communities are both far from sophisticated medical care, which is concentrated in metro centers, and restricted in their ability to provide comprehensive services in their own jurisdictions. An understanding of the nature of the relationship between residential location and health status is essential to the allocation of health care and community resources and the planning of appropriate health care services in rural areas.

Rural residence may have both positive and negative effects on health. Because rural areas generally have cleaner air, are less congested, and have a slower pace than urban areas, one might expect better health for the rural aged. On the other hand, one can argue that the lower incomes of the rural elderly, less adequate medical services, and less adequate housing and transportation would contribute to poorer health for the rural elderly. The importance of research on residential differences in health status and health service use is evident.

The increasing number of older persons, their greater risk of disability, and their greater use of health care services have increased the need for a more complete understanding of the nature and magnitude of differences in health status and use of health care services by the older population by place of residence. The aim of this study is to better understand older Americans and how their demographic and socioeconomic characteristics, as well as their social support networks, affect their health

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¹Metro-nonmetro is used interchangeably with urban-rural in this report. Metro is defined as a county or counties consisting of a large population nucleus of 50,000 or more inhabitants, together with adjacent communities that have a high degree of economic and social integration with that nucleus. Nonmetro refers to counties outside a metro area.

²Nonmetro areas have a larger share of nursing home beds (6,599 beds per 100,000 elderly residents) than metro areas (5,257 beds per 100,000).

and use of health care services. The study focuses on factors that differentiate the nonmetro elderly from the elderly in central cities and suburban areas in terms of health status, family structure and living arrangements, social and community support, economic well-being, and the use of health care services.

This report addresses the following issues:

- Do elderly persons residing in nonmetro areas differ from their counterparts in central cities and suburban areas with respect to health status? And, if so, what is the magnitude of the difference?
- How do place of residence and demographic and socioeconomic characteristics affect the health status of the elderly?
- Do elderly persons residing in nonmetro areas use health care services to a greater or lesser extent than their counterparts in central cities and suburban areas?
- How do health status, demographic and socioeconomic characteristics, and social support networks within nonmetro areas, central cities, and suburban areas affect use of health care services?

Previous Research

Several research studies have described residential differences in the health status and use of health care services by the older population. Other studies have examined the effects of the elderly's social support networks on their health status and subsequent use of health care services. This section will highlight previous research work that is relevant to the present analysis.

Health Status

The majority of research on the health status of the rural or nonmetro elderly indicates that they have poorer health and higher incidences of health problems than their urban or metro counterparts (Coward and Lee, 1985; Krout, 1989; National Center for Health Statistics, 1984). Several research studies have found that the rural elderly have a greater number of health problems and more severe disabilities than their urban counterparts, and that more rural elderly persons retire for health reasons (Coward and Lee, 1985; Davenport and Davenport, 1977; Lassey, Lassey, Lee, and Lee, 1980; McCoy and Brown, 1978; and Palmore, 1983). Among the low-income elderly, chronic disorders and impairments were found to be more prevalent among rural than urban residents, even when sex, age, and race were statistically controlled (McCoy and Brown, 1978).

Some studies, however, have not found significant rural-urban differences in the health status of the elderly. A detailed examination of national health statistics by the Urban Institute found some differences based on residence, although these differences were usually neither large nor consistent. Place of residence (rural-urban) is not associated in general with significant differences in health status (Paringer, Bluck, Feder, and Holahan, 1979). Looking at residential differences in self-assessed health, Krout (1989) found no significant differences for residence, but did find differences for race, household income, education, and length of residence in the community. More positive health assessments were found for elderly persons who are white, better educated, wealthier, and longer term residents of their communities.

The Urban Institute study is a useful starting point for the present analysis. It is the most recent full-scale study that examines the relationship between place of residence and health status, although the study, published in 1979, is dated. A major problem with the study is that the authors presented their results without evaluating the relative merits of the various measures used. Mortality rates showed slight differences, but without a consistent pattern by residence. Incidence of acute illness was found not to vary significantly by place of residence. However, among the low-income elderly in rural areas, the prevalence of chronic conditions and activity limitations was greater than among their counterparts in urban areas. Based on bed disability days, the data suggested that the elderly in rural areas may have had somewhat poorer health status than those living in other parts of the country. The relationship between health status and place of residence varied, depending on the health status measure being used in the analysis, and the authors offered no interpretation of the different findings.

The Urban Institute study also found significant differences based on self-assessments of health by place of residence. Elderly persons in nonmetro areas were 25-30 percent more likely to rate their health as fair or poor than were their counterparts in metro areas, which confirms residential variations found in other health status measures. This finding appears to negate the authors' conclusions of no significant residential differences, in that self-assessed health status is one of the best indicators of health. Self-reporting of health status by the elderly correlates well with ratings by physicians and survival rates, and is a useful survey instrument (Ouslander and Beck, 1982).

Not all previous studies have clearly demonstrated that residential location has an independent effect on health. In light of these inconsistent findings, more systematic research is needed to assess the nature of health status differences by place of residence and to determine

whether rural residence in itself is a disadvantage. Rural-urban differences in health status may result from intervening factors, such as lower income, exposure to health risks, and poorer health care services. For example, a nonmetro disadvantage in health status may be associated with lower socioeconomic status (lower income and educational levels) in nonmetro areas.

Use of Health Care Services

Significant differences exist in health care services for the elderly by residence. Substantial evidence has indicated that the range of services for elders living in small towns and rural communities is narrower, that fewer service alternatives are available, that rural health and human services are less accessible and more costly to deliver than in urban areas, and that fewer health care providers exist in rural areas to offer particular services (Coward and Rathbone-McCuan, 1985; Coward and Cutler, 1989; Coward and Lee, 1985; Krout, 1986; Rathbone-McCuan, 1981; and Taietz and Milton, 1979).

The continuing inadequacies in the number and types of facilities and services available in many rural communities have been well documented (Coward and Lee, 1985). In a study of rural and urban counties in upstate New York, for example, urban counties had significantly more services available than did rural counties (Taietz and Milton, 1979). From a national sample of area agencies on aging (AAA's), Nelson (1980) found that rural AAA's were particularly weak in fiscal and professional staff resources necessary to develop a broad range of care. Rural service networks also tended to have the greatest deficiencies in the services most apt to be needed by the severely disabled living in the community. A large and significant rural disadvantage existed in the availability of adult day-care services, homemaker services, and foster care (Nelson, 1980). In addition, Krout (1989) found a rural disadvantage in health service availability and accessibility.

Rural areas have fewer health resources and services and a lower ratio of doctors, nurses, pharmacists, and other health care personnel to elderly residents than metro areas have (Krout, 1986; Lassey and Lassey, 1985). The health care facilities most needed by the elderly are hospitals, nursing homes, and residential care homes. Although the nursing home component of the long-term care network serves only a small proportion of elders at any one point in time (about 5 percent of the elderly population), it consumes the largest proportion of public dollars spent on the elderly (Coward and Cutler, 1989). The lower physician-to-population ratio in rural areas suggests that rural residents may visit doctors less frequently because

physicians are less accessible. Distance is also a major factor in accessibility of services; rural residents face longer travel and waiting times when they visit physicians (Paringer, Bluck, Feder, and Holahan, 1979).

Social Support Networks

Social support (familial and nonfamilial) is usually thought to be beneficial to health and longevity, and may have a moderating effect on health status and the use of formal health care services by the elderly. Married persons use health care services less frequently, either because they can substitute home health care (informal care) for formal health care or because marriage confers other benefits, such as improved health status, that also might be characteristic of nonmarried people who live with others (Cafferata, 1987). A spouse is the most important source of help in times of illness, especially for men; adult children living inside the house, and to a lesser extent siblings, are also important sources of help during illness (Shanas, 1979). Proximity and contact with friends and relatives are also important in assisting elderly persons in a wide variety of personal care activities and basic tasks of everyday living (Palmore, 1976; Stoller and Earl, 1983).

Formal social support may be more important in the absence of sources of informal support, such as a spouse, children, other relatives, friends, and neighbors. Measures of formal social support include participation in formal organizations, religious participation, and nonfamilial social relations. Living with others may reduce the need for the use of formal health care services (such as physician visits), independently of marital status, because of the substitution of home care (family members) for formal health care and/or the enhancement of physical and mental health.

Several studies have supported the substitution effect, where informal or family resources (presence of a spouse or adult child who can care for an elderly person) are substituted for formal health care resources. Using data from the National Medical Care Expenditure Survey, Cafferata (1987) found that elderly persons living with others were more likely to stay in bed, but less likely to see a doctor, than were persons who lived alone. Less use of formal health care services was also found among both married persons and nonmarried persons living with others (Greene, 1983). Another study confirmed the importance of living arrangements, finding that elderly nonmarried individuals who lived with others had a lower volume of physician visits than did married individuals (Stoller and Earl, 1983).

Current Study Design

This study examines the importance of residential location on the health status and use of health care services by the older population. The analysis is based on the 1984 Supplement on Aging (SOA), a special supplement to the National Health Interview Survey (NHIS). The 1984 SOA is the most appropriate data set for this analysis because it provides a large enough sample size to study differences in the elderly's health and other characteristics separately by residence--central city, suburban, and nonmetro--and is the latest and richest source of data.

Source of Data

The NHIS is an annual household interview survey of the civilian noninstitutional population of the United States conducted by the National Center for Health Statistics (NCHS). All interviews are conducted in person by trained Bureau of the Census interviewers with a family member most knowledgeable about the family's health.

The 1984 SOA obtained more detailed information about the health status, social characteristics, and living arrangements of persons 55 years of age and older who were living in the community, with a total sample of 16,148 respondents. The interviews were conducted with 14,783 of the sample persons themselves, or 91.5 percent of the entire SOA sample. The remaining 1,365 interviews were proxy respondents for people unable to respond for themselves because of physical or mental impairments, hospitalization, or other extended absence from the household. Proxy respondents were almost always a relative living in the same household and knowledgeable about the sample person, usually a spouse, sometimes a sibling or child.

The SOA produced an extensive cross-sectional data file about persons 55 years of age and older. A broad spectrum of topics related to health, social functioning, and living arrangements of older persons living in the community was covered. Information was included on family structure, relationships, and living arrangements; community and social support and use of community services; occupation and retirement and sources of retirement income; health conditions and impairments; activities of daily living (ADL's), instrumental activities of daily living (IADL's), and functional limitations; prevalence of chronic conditions; nursing home stays; and opinions about one's own health.

Because the SOA was a survey of the noninstitutional population, some selection bias was present from excluding the institutionalized elderly, especially those aged 85 and older. To the extent that the institutionalized

elderly have more functional limitations than their noninstitutionalized counterparts, the prevalence of limitations for the total elderly population are underestimated in this report.

Definitions and Methods

The older population, or the elderly, in this report are persons 60 years old and older. The older population is commonly referred to as persons aged 65 and older; however, 60 years and older is often used and is preferred in this study due to sample size considerations. Data are presented for the young old, ages 60 to 74 years, and the oldest old, ages 75 and older, because the aging process itself leads to a number of changes in an individual's social and economic conditions, and because many health problems and functional limitations do not become evident until late in life. The older population is a diverse group, and many differences among the elderly are age related. In many cases, data are presented for the entire age group, 60 years old and older, because either the subgroup of the population is very small (such as minority elders) or the event is relatively rare (such as the percentage who had ever been a patient in a nursing home). The SOA is the most appropriate data source for this study because it provides a large enough sample size to make numerous subgroup comparisons, such as differences in health status by income level.

Place of residence is one of many factors that can affect the health of the elderly. Research that focuses exclusively on the rural elderly, and thereby fails to treat residence as a variable, cannot go beyond the descriptive level and is limited in terms of promoting an understanding of the implications of residence for the lives of the elderly. The dichotomy metro-nonmetro conceals important differences within the residential areas. This study expands the residential classification into nonmetro, suburban, and central city.³

The social and economic diversity that exists in small towns and rural communities has been well documented (Coward and Cutler, 1988; Dillman and Hobbs, 1982). Consequently, dichotomous residential comparisons (rural-urban or metro-nonmetro) are limited, and an analytical framework that reflects greater residential variation would be preferable. Both size of place and proximity (adjacency) to a metro area are important variables to consider; however, such geographic detail is available only from the decennial census of population.

³The metro-nonmetro designation in the 1984 SOA is based on the 1970 decennial census area definition. This artificially inflates the nonmetro population, as many nonmetro areas became metro in the 1980 decennial census.

Health status is traditionally conceptualized as the presence or absence of disease. Defining health in terms of disease ignores a critical concept of the health of the elderly--functional status (Ouslander and Beck, 1982). The impairment of functioning, in terms of basic activities of daily living (ADL's) and instrumental activities of daily living (IADL's), has important consequences for elderly individuals' abilities to cope with disease and illness, as well as their need for health care services. Hence, including some measure of functional status in defining the health of the elderly is critical. For a more complete assessment of health status, this study examines several measures: self-reported health assessments, functional limitations, and limitations in abilities to perform basic ADL's and IADL's.

Self-reporting of health among the elderly correlates well with both ratings by physicians and survival rates, especially among those under age 85, and is therefore a useful survey technique (Ouslander and Beck, 1982). This report presents data on self-assessments of health and reports on certain chronic conditions. Self-reporting in personal interviews can provide useful estimates of the prevalence of medical conditions and functional disabilities in the elderly (Ford and others, 1988).

Activities of daily living, or ADL's, are the basic tasks of everyday life, including bathing or showering, dressing, eating, transferring (getting in or out of a chair or bed), walking, getting outside, and using or getting to a toilet. When people are unable to perform these activities, they need help either from other persons or via mechanical aids or devices. With advancing age, the prevalence of functional limitations tends to increase; a higher proportion of persons have difficulty performing personal care or home management activities as they age (Dawson, Hendershot, and Fulton, 1987). ADL's, especially measures of mobility such as walking and getting outside, are key indicators of one's ability to live independently in the community and are also significant predictors of admission to nursing homes (Branch and Jette, 1982), use of paid home care (Soldo and Manton, 1985), and use of hospital and physician services (Wan and Odell, 1981).

ADL's do not measure the full range of activities necessary for independent living in the community, and instrumental activities of daily living (IADL's) were developed to partially fill this gap. IADL's include meal preparation, shopping for personal items, managing money, using the telephone, doing heavy housework, and doing light housework. IADL disabilities capture those activities that are more complex and less severe than ADL difficulties.

A third measure of functional ability includes walking a quarter of a mile, walking up 10 steps, standing for 2

hours, sitting for 2 hours, stooping, crouching, or kneeling, reaching up overhead, reaching out as if to shake hands, using fingers to grasp, lifting or carrying 25 pounds, and lifting or carrying 10 pounds. The prevalence of functional limitations is an important indicator of quality of life and of the need for health and social services in an aging population.

Estimates of functional limitations in this report are conservative estimates. Persons who did not perform certain activities for reasons unrelated to health, such as men who did not cook because their wives did so, and those who did not respond were included in the base populations (but not the numerators) of the proportions of persons having difficulty with each activity. The proportions of persons experiencing difficulty would have been higher had the analysis been restricted to individuals who routinely performed each activity (that is, to individuals at risk of health-related problems in performing ADL's and IADL's). Because some of the individuals in these two categories may have had unreported problems performing ADL's or IADL's, the extent of functional disability is thus slightly understated.

Krout (1989) developed an index of health dependency that included the following measures: 12 or more physician contacts over the last 12 months, 31 or more days of hospitalization, being restricted at home for 1 month or more, overnight or longer admission to a nursing home, having received nursing services at home, having received homemaker services, having meals delivered at home, use of a walker, and use of a wheelchair. Elderly respondents identified as having used none of the services were categorized as self-sufficient, those using only one as slightly dependent, and those who had used two or more as care dependent. Krout attributed the lower health dependency found in nonmetro areas to the lesser availability of health and medical services in nonmetro areas. Although his measure can be criticized for confounding health status with health service availability and use, it is instructive for constructing a measure of the use of health services.

This study incorporates Krout's health dependency measure into an index of health care service use. Health care services can be meaningfully divided into informal and formal health care services. Informal care consists of care provided by family, friends, and neighbors. Formal care consists of physician visits, hospital stays, and nursing home stays. The elderly were characterized as either using no formal care services or by the extent of their use of these services. Those categorized as having some or moderate use of formal care are persons who either had 1-11 doctor visits in the past year, hospital stays of 1-30 days in the past year, or no nursing home stays. High use was defined as 12 or more doctor visits

within the past year, 31 or more days of hospitalization, or nursing home stays for one or more nights.

Contingency table analysis is used to uncover the bivariate relationship between residential location and health status and use of health services, taking into account the effects of demographic and socioeconomic factors.⁴ Controls are introduced to determine whether the relationship between residence and health conditions of the elderly is affected by demographic and socioeconomic characteristics. Many previous studies of health differences by residence are based on small surveys of local areas or bivariate analyses of national data, without tests for statistical significance or controls for the effects of socioeconomic status. Advantages of this study are its use of a national data set (SOA), tests for statistical significance, more than one measure of health status, and controls to determine the effects of residential location on health status and the use of health care services.

Results by Residence and Selected Characteristics

The following sections of the report show residential differences among older persons in terms of their socioeconomic characteristics, social support networks, health status, and use of health care services.

Socioeconomic Characteristics of Persons Aged 60 Years and Older

Socioeconomic status differs by residential location. The nonmetro elderly tend to be less educated and financially worse off than their metro counterparts. The lower socioeconomic status of the nonmetro elderly has important implications for their health and use of health care services.

Although different from the younger population in many social, economic, and health characteristics, the elderly are not a homogeneous group. There are considerable differences among persons aged 60 and older in marital status and living arrangements, social support networks, educational and income levels, residential location, and geographical region (table 1). One usually expects these factors to be related to health status and the need for medical care. While the elderly differ in many demographic and social characteristics, this study focuses on socioeconomic differentials, because such differences have a large impact on the health of the elderly.

⁴All differences in the text are significant at the 95-percent level of confidence.

The nonmetro elderly are more likely to own their own home; however, their overall socioeconomic status, as measured by income and education, is lower than that of the metro elderly. Nonmetro elders tend to be less educated and to have lower incomes and fewer sources of retirement income (table 1). Fifty-three percent of nonmetro elders had less than a high school education, compared with 49 percent in central cities and 42 percent in the suburbs (fig. 1). In addition, nonmetro elders were worse off financially than their metro counterparts, especially those in suburban areas. Seventy-five percent of nonmetro elders aged 60 and older had incomes less than \$20,000, compared with 69 percent of those in central cities and 56 percent in the suburbs (fig. 2). Not unexpectedly, more elderly persons were below the poverty level in nonmetro areas than in metro areas.

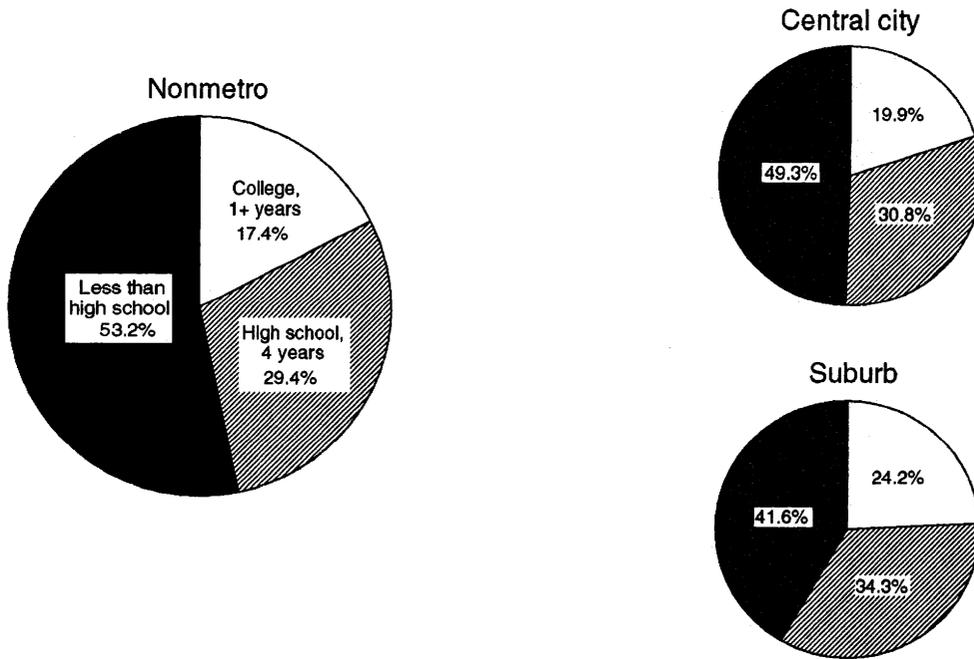
Social Support Networks

The social support networks of the nonmetro elderly are about as strong as those of their suburban counterparts. Suburban and nonmetro elders are more likely to have someone who could provide needed care; they are also less likely to live alone than their central city counterparts. Social support is usually beneficial to health and may also have a moderating effect on the elderly's use of formal health care services.

Social support comes from a variety of sources. Living arrangements, availability of potential caregivers, contacts with friends, neighbors, and relatives, involvement in social activities, and use of community services are all measures of social support networks. By most measures, nonmetro and suburban elders fare better than central city elders. Nearly two-thirds of both nonmetro and suburban elders lived with their spouses in 1984, compared with only 52 percent of central city elders (table 2). Elderly persons living with their spouses are expected to be healthier than those who live alone or with other relatives or nonrelatives. A higher proportion of central city elders lived alone (32 percent) in 1984, compared with those in nonmetro areas (27 percent) and the suburbs (24 percent). Elderly persons living alone are more likely to experience health problems and greater poverty (Commonwealth Fund Commission on Elderly People Living Alone, 1987). Suburban elders have more frequent contact with friends and neighbors than either nonmetro or central city elders, and about the same amount of contact with relatives as nonmetro elders (table 2).

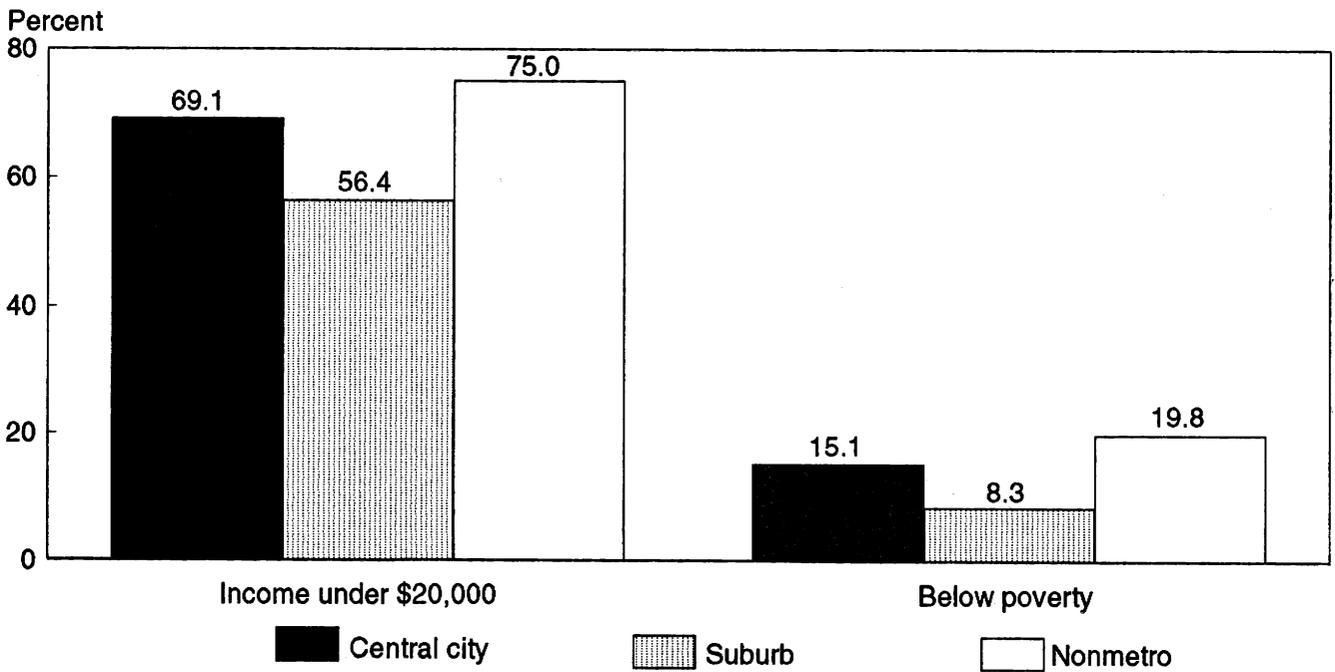
The presence of someone who could provide unpaid care for an older person indicates the possibility of social support. Spouses and children are potential sources of such support for elderly persons. Both nonmetro and suburban elders are more likely to have living adult children who could provide care than are central city

Figure 1
Educational attainment of the elderly, by residence¹



¹Elderly defined as aged 60 years and older.

Figure 2
Income and poverty status of the elderly, by residence¹



¹Elderly defined as aged 60 years and older.

elders (table 1). Residential differences are found for elderly persons having someone available to care for them for a period of a week (table 2). In 1984, suburban elders aged 60 years and older were more likely to have a household relative available to care for them (60 percent) than were nonmetro elders (56 percent) or central city elders (51 percent). When age is taken into account, a smaller proportion of the oldest old have a household relative who could provide care. In 1984, 46 percent of suburban elders aged 75 and older had a household relative who could care for them, as did 42 percent of nonmetro elders and 40 percent of central city elders (app. table 1). The elderly aged 60 and older in central cities were more likely to have no one to care for them (12 percent) than either suburban or nonmetro elders (9 percent) (table 2).

The presence or absence of family caregivers may affect an individual's use of a variety of social services in the community. These services include eating meals in a senior center and using a senior center, special transportation for the elderly, homemaker services, adult day care, and visiting nurse services. Regardless of residence, 81 percent of the elderly aged 60 and older never used community services in 1984 (table 2). Nonmetro elders were somewhat more likely to use two or more services (10 percent) than were their metro counterparts (nearly 8 percent).

The most frequently used services were senior centers (13 percent) and eating meals in a senior center (7 percent). Nonmetro and suburban elders were both slightly more likely to use a senior center (13 to 14 percent) than were the elderly in central cities (11 percent). More nonmetro elders aged 60 and older took their meals in senior centers (10 percent) than did either suburban (5 percent) or central city (6 percent) elders. The data showed that there is a greater need for community meals in nonmetro areas, as reflected by lower socioeconomic status, and that nonmetro residents seem to have this need better met than their metro counterparts.

The basic difference in social support networks by age is that the younger group (ages 60-74) is more likely to have a household relative who could provide care if needed, and that the oldest old, as expected, participate to a greater extent in community services. For example, 29 percent of nonmetro elderly aged 75 and older used one or more community services in 1984, compared with 15 percent of persons aged 60-74 (app. table 1). Among the oldest old, nearly 14 percent of nonmetro elders ate meals in a senior center, compared with 8 percent of suburbanites and 7 percent of city elders.

Health Status of Persons Aged 60 and Older, by Residence

Do elderly persons residing in nonmetro areas have better or worse health than elders in central cities and suburban areas? Differences in self-assessed health and various measures of physical functioning show that suburban elders are in better health than either nonmetro or central city elders. A larger share of the nonmetro elderly have functional limitations and certain chronic conditions (such as arthritis) than do their metro counterparts. Residential differences in health status remain evident even when other factors--age, race, social support networks, income, and education--are held constant. Nonmetro elders tend to be less educated and financially worse off than metro elders, and their lower socioeconomic status is clearly associated with poorer health.

Measures of Health Status

There are various aspects to health, and many measures can be used to assess the health of the elderly (table 3). Self-reported health status is one of the best measures of health, and corresponds closely with objective measures of health, such as physical exams and physician ratings. Difficulty in performing ADL's and IADL's is also an informative measure of health and is associated with living independently in the community. The various other measures of health in table 3 support the finding that suburban elders are in better health than their nonmetro and central city counterparts.

Self-reported health status for persons aged 60 and older is lower for nonmetro elders than for their metro counterparts. Thirty-five percent of nonmetro elders reported their health as fair or poor in 1984, compared with 32 percent for elders in central cities and 27 percent in suburban areas (table 3 and app. table 2). Although residential differences in self-assessments of health are less pronounced among the elderly aged 75 and older, the same residential pattern is evident: a larger share of nonmetro elders reported their health as fair or poor than did their metro counterparts.

One measure of functional ability is performance of ADL's. Most elderly persons aged 60 and older living in the community have no difficulties performing personal care activities, also known as ADL's. Seventy-eight percent of both nonmetro and central city elders reported no difficulty with activities of daily living in 1984, compared with 82 percent of the suburban elderly (table 4). Suburban elders tended to report a lower number of ADL difficulties than did their counterparts in other areas.

Ten percent of suburban elders reported two or more ADL difficulties, compared with about 12 percent each of nonmetro elders and central city elders. Elderly persons are more likely to have problems with walking than with any other personal care activity; 18 percent of nonmetro elders had difficulty walking, compared with 15 percent in metro areas.

A second measure of physical functioning, instrumental activities of daily living, also shows that suburban elders aged 60 and older reported fewer IADL difficulties than their counterparts in central cities or nonmetro areas reported (table 4). Twenty-six percent of nonmetro elders had one or more IADL difficulties, compared with 23 percent of metro elders. Elderly persons most frequently have difficulty performing heavy housework; 22 percent of nonmetro elders had difficulty performing this IADL.

Combining both ADL and IADL measures shows that nonmetro elders are less likely to be free of difficulties in performing these activities. Thirty-two percent of nonmetro elders reported difficulty with both ADL's or IADL's, compared with 30 percent of central city elders and 26 percent of suburban elders (table 3).

A third measure of physical functioning, which includes activities such as walking a quarter of a mile and lifting or carrying 10 pounds, also shows that the nonmetro elderly were more likely to report having limitations than were their metro counterparts, with 58 percent of nonmetro elders reporting one or more functional limitations (table 4). This compares with 53 percent of central city elders and 48 percent of suburban elders who had one or more functional limitations (tables 3 and 4). The activities most frequently reported as difficult are walking a quarter of a mile (26 percent), walking up 10 steps without rest (22 percent), standing for 2 hours (31 percent), stooping, crouching, or kneeling (36 percent), and lifting or carrying 10 pounds (36 percent). With the exception of lifting and carrying activities, nonmetro elders were more likely to report difficulty with these functional activities than were metro elders. For example, 29 percent of nonmetro elders had difficulty walking a quarter of a mile, compared with 27 percent in cities and 23 percent in the suburbs.⁵

Common chronic conditions of the elderly include arthritis, hypertension (high blood pressure), cataracts, heart disease, varicose veins, diabetes, cancer, osteoporosis (especially hip fracture), and stroke (Guralnick and others, 1989). Forty-nine percent of persons aged 60 and older reported having arthritis, with

nonmetro elders being more likely to report having arthritis or rheumatism (53 percent) than were metro elders (47 percent) (table 3). Nonmetro elders were also more likely to have hypertension (44 percent) than their counterparts in central cities (42 percent) and suburban areas (39 percent). Higher proportions of the oldest old have arthritis and hypertension than do their younger counterparts (table 3).

Arthritis and hypertension are prevalent among the elderly and affect their self-assessments of health. Persons with arthritis are more likely to report their health as fair or poor. For example, 44 percent of nonmetro elders with arthritis reported fair or poor health in 1984, compared with 24 percent of their counterparts without arthritis (app. table 4). Among suburban elders, 35 percent of those with arthritis and 20 percent without reported their health as fair or poor. A similar pattern is found for the effect of hypertension on reported health status; elderly persons without hypertension more frequently report their health as excellent or very good than do their counterparts with hypertension.

Arthritis and hypertension affect the elderly's ability to perform the various activities of daily living, and higher proportions of those with one or more activity limitations have arthritis or hypertension. A much better level of physical functioning is found among elders without arthritis. Nearly 23 percent of nonmetro elders with arthritis reported having difficulty with at least one ADL and IADL in 1984, compared with only 8 percent of elders without arthritis (app. table 5). Elderly persons with arthritis commonly have difficulty with the ADL's of walking, getting out, and transferring. The most frequently reported IADL difficulty for elders with arthritis is heavy housework. The same relationship is found for elderly persons with and without hypertension.

The effect of having arthritis or hypertension is magnified for the nonmetro elderly, who have a higher prevalence of these chronic conditions than do their metro counterparts. Wide residential differences are apparent in self-reported health status and physical functioning, with suburban elders faring better than either nonmetro or central city elders.

Restricted activity and bed disability days indicate disability, and may subsequently lead to doctor visits or the use of other formal health care services. Only 13 percent of elders aged 60 and older were restricted in activity over a 2-week period, and about 7 percent were restricted to bed in the 2 weeks prior to the interview (table 3 and app. table 3). While proportions of the youngest old and the oldest old who have either restricted activity or bed disability days do not differ significantly, a greater share of persons aged 75 and older were

⁵Data from unpublished tabulations from the NHIS Supplement on Aging.

restricted for a longer time in the 2-week period (app. table 3). Elderly persons who are restricted in activity or confined to bed can also be expected to depend more heavily on formal health care services.

A higher proportion of elderly persons in poorer health--those who either reported difficulties with ADL's and IADL's, or reported their health as fair or poor--reported having both restricted activity and bed disability days. About 28 percent of those in poorer health had restricted activity days in 1984, and nearly 20 percent were restricted for 6-14 days over a 2-week period (app. table 3). Nine to ten percent of elders in poorer health reported 6-14 bed disability days in the past 2 weeks, compared with only 3 percent of all persons aged 60 and older. Nonmetro elders with ADL-IADL difficulties are somewhat less likely to be confined to bed than are their metro counterparts; about 14 percent of nonmetro elders with one or more ADL-IADL difficulties were confined to bed in the past 2 weeks, compared with about 17 percent of their metro counterparts.

The best measures of the health status of the elderly are self-reported health and performance difficulties with ADL's and IADL's. Respondent-assessed health is one of the most informative measures of health; it is associated with mortality, life satisfaction, and objective measures of health status, such as physical exams and physician ratings. Performance of ADL's and IADL's are also telling measures of health; they are key indicators of the ability to live independently in the community, the use of paid home health care, the use of both hospital and physician services, and admission to nursing homes.

Self-assessments of health are closely correlated with performance of ADL's and IADL's; those who have difficulty performing ADL's and IADL's are more likely to report their health as fair or poor. Among the elderly who report difficulty performing ADL's and IADL's, 69 percent assessed their health as fair or poor, only 11 percent assessed their health as excellent or very good, and 20 percent as good.

Controlling for Selected Characteristics

How do the demographic and socioeconomic characteristics of the elderly affect their health status? The relationship between residence and health status was controlled by demographic characteristics, social support networks, and socioeconomic status. Age and race are two of the most important demographic characteristics affecting the elderly's health. Two indicators of social support networks include the type of living arrangements of the elderly and the availability of potential caregivers. Education and income are measures of socioeconomic

status. Income was selected over poverty status because the elderly with high or low income are more evenly distributed than are the elderly above and below poverty.

Demographic Characteristics. Age makes a difference in self-assessments of health (table 5 and app. table 4). Elderly persons aged 75 and older report their health to be excellent or very good less frequently than do elders aged 60-74. The oldest old are somewhat more likely to report their health as fair or poor than are the youngest old, which is consistent with the greater prevalence of activity limitations and functional disabilities among elders aged 75 and older.

With advancing age, physical functioning usually declines and the prevalence of ADL-IADL difficulties increases (table 6 and app. table 5). For example, only 12 percent of nonmetro elders aged 60-74 had difficulties with one or more ADL's and IADL's in 1984, compared with 26 percent of the nonmetro elderly aged 75 and older. Dawson, Hendershot, and Fulton (1987) also found that the proportion of elderly persons experiencing difficulty with personal care activities (ADL's) increased with age. Residential differences in performance of ADL's-IADL's are not significant for elders aged 75 and older. With advancing age, residential location seems to diminish in importance as a factor affecting physical functioning.

Minority elders report lower self-assessments and more activity limitations, and appear to be in poorer health. Both black and Hispanic elders are more likely to report their health as fair or poor than their white and non-Hispanic counterparts (table 5 and app. table 4). For example, 61 percent of black nonmetro elders reported fair or poor health in 1984, compared with 33 percent of their white counterparts. The poorer self-assessments of health by the black elderly may also partly reflect their lower socioeconomic status. A greater proportion of nonmetro elders, regardless of race or ethnicity, report their health as fair or poor than do their metro counterparts. In addition, 23 percent of nonmetro black elders had both ADL and IADL difficulties, compared with 15 percent of their white counterparts (table 6 and app. table 5).

Women can expect to live longer than men, but are older women in better or worse health than older men? A larger proportion of women aged 60 and older have activity limitations than do their male counterparts (app. table 5). This gender difference may partly reflect the fact that elderly women are older, on average, than elderly men. When all elders aged 60-74 and 75 and older are examined separately, however, gender differences remain. For example, among nonmetro women aged 60-74 in 1984, 13 percent had difficulty with both ADL's and IADL's, compared with 9 percent

of their male counterparts. Among nonmetro women aged 75 and older, where the age effect was greatest, 32 percent had both ADL and IADL difficulties, compared with 18 percent of the nonmetro men aged 75 and older.

Social Support Networks. Stronger social support networks are associated with better health status. Elderly persons who either live with their spouses or live alone are healthier than those who live with other relatives or nonrelatives. About 33 percent of nonmetro elders who lived alone or with their spouses reported their health as fair or poor in 1984, compared with 44 percent of nonmetro elders who lived with other relatives or nonrelatives (table 5). The elderly who live with their spouses also have fewer ADL-IADL difficulties. For example, 12 percent of nonmetro elders who lived with their spouses had ADL-IADL difficulties, compared with 20 percent of those who lived alone, and 28 percent of those who lived with others (table 6). It was expected, however, that elders living alone would fare worse than those living with others. Perhaps the elderly living with others do so because of their poor health and the need for assistance.

Having someone who can provide care appears to benefit health status. Lower proportions of the elderly report their health as fair or poor when they have someone (either a relative or nonrelative) available as a potential care-giver⁶ (table 5). Elderly persons who have no one to provide care have poorer self-assessments of health.

Elderly persons with no one available to provide care are also more likely to experience difficulties performing ADL's and IADL's. Among nonmetro elders in 1984, 24 percent who had no one to provide care had difficulties with both ADL's and IADL's, compared with 18 percent of elders with a nonrelative care-giver, 17 percent of those with a nonresident relative care-giver, and only 13 percent of those with a relative in residence available to provide care (table 6). The elderly in central cities are more likely to have no one to care for them than are the elderly in other areas, and their poorer health may reflect weaker social support networks. Having a household relative available to provide care appears to enable the elderly to take better care of their health.

Marriage confers health benefits to elderly persons in that one's spouse is the most important source of help in periods of illness. Married elderly persons living with their spouses are less likely to have difficulties with ADL-IADL's than are their unmarried counterparts.

Widowed, divorced, or separated persons fare worse in their ability to perform the various activities of daily living (app. tables 5 and 6). Divorced and separated persons have been found to be more likely to suffer from acute medical conditions and to have greater short-term disability than are persons in other marital statuses; formerly married persons appear to have the most chronic health problems (Verbrugge, 1979). Older persons living with their spouse and those who have a resident relative as a potential care-giver have the fewest functional limitations. Having no one as a potential care-giver is the most disadvantaged position.

Socioeconomic Status. Socioeconomic status is important for all measures of health, with important implications for the use of health care services by the elderly. Socioeconomic status plays a part in perceptions of health, with higher socioeconomic status associated with better health. Wide differences in health status are found among the elderly by income level, with a higher proportion of low-income elderly (earning less than \$20,000) reporting fair or poor health than their counterparts with incomes of \$20,000 or more (table 5). For example, 40 percent of nonmetro elders with incomes of less than \$20,000 reported their health as fair or poor in 1984, compared with 19 percent of their counterparts with incomes of \$20,000 or more. Residential differences within income group are still evident, as nonmetro elders are more likely to report poorer health than are their metro counterparts. The income effect on self-assessed health is magnified for the nonmetro elderly, due to their lower financial standing. Among the low-income elderly, a greater proportion reside in nonmetro areas than in either suburban areas or central cities.

Higher income is also associated with fewer ADL-IADL difficulties (table 6). Only 8 percent of nonmetro elders with incomes of \$20,000 or more had ADL-IADL difficulties in 1984, compared with 19 percent of their counterparts with incomes of less than \$20,000. In addition, 57 percent of the nonmetro elderly with incomes of \$20,000 or more had no functional limitations, compared with 37 percent of the low-income nonmetro elderly (app. table 6). Because a larger proportion of nonmetro elders have incomes of less than \$20,000 than do their metro counterparts, the strong income effect on health status makes low income an important factor in the health of the nonmetro elderly.

Educational attainment also reflects one's socioeconomic status. Higher education is also associated with fewer elders reporting fair or poor health. In 1984, 18 percent of nonmetro elders who had completed 1 or more years of college reported fair or poor health, compared with 24 percent of nonmetro elders who had completed 4 years of high school, and 46 percent who had not completed high

⁶This could be a relative or a nonrelative, either in the household or not, who could be counted on when needed to provide assistance to the elderly person.

school (table 5). Residential differences are apparent within educational categories. The effect of educational attainment on health status is especially significant for the nonmetro elderly, as they are more likely to be less educated than their metro counterparts. Among those with less than a high school education, a greater proportion reside in nonmetro areas than in either suburban areas or central cities.

The elderly with less than a high school education are more likely to have functional limitations than are their counterparts with higher education. About 20 percent of nonmetro elders with less than a high school education had one or more ADL-IADL difficulties in 1984, compared with only 10-12 percent of their better educated counterparts (table 6). A higher proportion of the elderly with at least 4 years of high school have no functional limitations, compared with those who had not completed high school (app. table 6). High school completion appears to be the decisive factor, with only slight improvements in physical functioning for those who had completed some college.

Older persons who are employed tend to be those who are able to work, and are in relatively good health. Employed elders perceive their health as excellent or very good more frequently than do their unemployed counterparts and those not in the labor force (app. table 4). This coincides with the finding that elderly persons who perceive themselves to be completely retired had poorer health assessments. A more positive outlook is probably associated with keeping active later in life. In addition, employed elderly persons are less likely than unemployed elderly persons to have difficulties in activities of daily living, probably due to the retirement of elderly disabled persons. Large differences in functional status by employment and retirement status may reflect the fact that many elders retire due to poor health.

When self-assessments of health and functional status are examined separately for the younger old, ages 60-74, and the oldest old, ages 75 and older, the same basic relationships between demographic and socioeconomic characteristics and health status are apparent.⁷ Residential differences in health status are smaller in magnitude for the oldest old than for younger elderly persons. The suburban advantage in health status seems to diminish somewhat for the oldest old. Poorer health is found among women, minorities, those with fewer sources of social support, and retired persons. Better health is found among the elderly living with their spouses. Higher socioeconomic status, measured by education and income

levels, is strongly associated with more positive self-assessments of health and fewer functional limitations. Residential differences, though smaller than those of education or income, are still evident. And because nonmetro elders have lower socioeconomic status than their metro counterparts, the effect on health status is more pronounced for the nonmetro elderly.

Role of Residential Location

The effects of residential location on health status are twofold. First, differences in self-assessed health and various measures of physical functioning are found by residential location. Suburban elders are more advantaged than their counterparts in nonmetro areas and central cities, with nonmetro elders performing the worst on measures of functional ability. Second, residential location affects health status indirectly, in that nonmetro elders are more likely to have those characteristics associated with poorer health. Nonmetro elders are more likely to be less educated and financially worse off than their metro counterparts, and lower socioeconomic status is strongly associated with poor health, as measured either by self-assessments or functional limitations. Nonmetro elders are also more likely to have certain chronic conditions (for example, arthritis and hypertension), which have a strong effect on health status and the ability to perform various activities of daily living. In addition, the more recent metro residents appear to be in poorer health than those who have resided in metro areas over a greater length of time. Although the survey data cannot distinguish recent metro residents who have changed residence within metro areas from those who have moved from nonmetro areas, some nonmetro residents may have moved to metro areas to be closer to relatives and/or health services.

Use of Health Care Services, by Residence

Do elderly persons residing in nonmetro areas use health care services to a greater or lesser extent than their counterparts in central cities and suburban areas? The nonmetro elderly are less likely to use formal health care services, such as physicians, hospitals, and nursing homes, than are their metro counterparts. The data on use of health services suggest that these services may be more accessible to those in metro areas. Among the elderly in fair or poor health, lower proportions of nonmetro elders use health services, and a smaller share use such services at a high level.

Health Care and Community Services Used

The network of health care services available in small towns and rural areas is more limited than that available in urban areas (Coward and Cutler, 1988). Formal health

⁷Unpublished tabulations by the author from the NHIS Supplement on Aging.

care is comprised of doctor visits, hospital stays, and nursing home stays. Use of formal health care services differs by residence, with nonmetro elders aged 60 and older less likely to have seen a doctor in the past year than were metro elderly persons aged 60 and older (table 7). For example, 21 percent of nonmetro elders had not seen a doctor in the past year, compared with 19 percent of the metro elderly (app. table 7). Nonmetro elders are about as likely to have been hospitalized or to have ever been in a nursing home as are their metro counterparts.

This study constructed a measure of formal health care service use by combining doctor visits, hospital stays, and nursing home stays. The elderly are classified as using no health care services, a moderate level of health care services, and a high level of such services. Moderate use is defined as either 1-11 doctor visits or hospital stays of 1-30 days in the past year, and no nursing home stays. High or extensive use of formal care is defined as either 12 or more doctor visits, hospital stays of 31 or more days, or any nursing home stays. In 1984, 81 percent of the elderly aged 60 and older used some type of formal health service: 79 percent in nonmetro areas, 81 percent in cities, and 83 percent in the suburbs (table 7). Central city elders were more likely to report high or extensive use of services (nearly 18 percent) than their suburban and nonmetro counterparts (about 14 percent each). This may reflect both poorer health and weaker social support networks among the elderly in cities.

Use of health care services is greater for those in poorer health and the oldest old. Elderly persons in poorer health are more likely to have seen a doctor, stayed in a hospital, and been a patient in a nursing home in the past year (table 7). For example, 30 percent of nonmetro elders 60 years old and older in fair or poor health had been hospitalized in the past year, compared with 18 percent of all nonmetro elders the same age. The oldest old are also more likely to have been hospitalized than are their younger counterparts. Sixteen percent of nonmetro persons 60-74 years old had stayed in a hospital, compared with 25 percent of their older counterparts. Nonmetro elders aged 75 and older are slightly more likely to have been hospitalized in the past year than are their metro counterparts.

Use of health care services by the older population generally indicates the overall number of persons needing care. It is also important to examine the use of health care services by those in poorer health to determine whether they are receiving medical care proportionate to their needs. Since one's health status reflects the need for health care, the relationship between health service use and residential location will subsequently be examined for those in poorer health. Those in poorer health are defined as those who report their health as fair

or poor. Virtually identical results are obtained when self-assessed health and difficulties performing ADL's and IADL's are used to define the subset of the elderly most in need of health care. When health status is taken into account, inequities in the use of health care services by residential location and other characteristics become apparent.

While fewer nonmetro elders use formal health care services than do either central city or suburban elders, residential location does not affect overall use of community services. About 19 percent of elderly persons aged 60 and older used one or more community service (table 7). The availability of services in the community is undoubtedly a factor in use, and actual use reflects both availability and level of participation by local residents.

Controlling for Selected Characteristics

Basic demographic characteristics, social support networks, and socioeconomic characteristics are expected to influence the use of health care services. Tables 8 and 9 show the effects of these control variables on health care service use.

Demographic Characteristics. Greater use of formal health care services occurs with advancing age. The oldest old tend to use some type of health care service and to use services more extensively than the younger elderly. For example, nearly 22 percent of nonmetro elders aged 60-74 did not use formal health care services in 1984, compared with 18 percent of nonmetro elders aged 75 and older. Among the nonmetro elderly, 18 percent of the oldest old used formal health care to a great extent, compared with 12 percent of the younger group (app. table 8).

Are elderly persons in poorer health using health care services proportionate to their needs? A higher proportion of the elderly in poorer health use health care services, compared with all older persons. Among nonmetro elders aged 75 and older, 32 percent in poorer health and 18 percent of all persons the same age were high users of formal health care services in 1984 (app. tables 8 and 9). Among those in poorer health, the oldest old are somewhat more likely to use health care services, and to use such services extensively, than are their younger counterparts. For example, 32 percent of nonmetro elders aged 75 and older in poor health used health care services extensively, compared with 24 percent of their younger counterparts (app. table 9).

Use of health care services does not differ significantly by race; however, black elders tend to use such services more extensively than do white elders. About 20 percent

of nonmetro black elders aged 60 and older used health care services to a great extent in 1984, compared with 13 percent of their white counterparts (app. table 8). This reflects the lower self-assessments of health and physical functioning of elderly blacks. Black elders in fair or poor health are also more likely to be high users of health care services than are comparable white elders (app. table 9).

Social Support Networks. Married persons who live with their spouse are slightly less likely to use health care services than are persons who live alone (table 8 and app. table 8). Married older persons seem to substitute informal health care at home for formal health care services. High use of health care services is greater among the elderly who live alone or with others--relatives or nonrelatives. Among the nonmetro elderly, 11 percent of those living with their spouse used health care services extensively in 1984, compared with 17 percent of elders living alone, and 18 percent of those living with others (app. table 8).

Strong social support networks may provide elders with many informal care-givers and may lead to less frequent use of formal health care services. Elderly persons who had a household relative who could provide care were slightly less likely to use health care services than were those without someone to provide care (table 8). Among the nonmetro elderly, 22 percent who had a household relative as a potential care-giver used no formal health care, compared with 20 percent of those with no one to provide care. Only 12 percent of nonmetro elders with a household relative as potential care-giver were high users of formal health care services, compared with 18 percent of their counterparts with no care-giver (app. table 8), reflecting the positive role of strong social support networks. Residential differences in services use are evident, with a greater share of the central city elderly extensively using formal health care services. Older persons with strong social support networks seem to substitute home unpaid health care for formal health care services. Among the elderly in fair or poor health, the strength of social support networks does not affect service use in a consistent manner (app. table 9).

Socioeconomic Status. Socioeconomic status, measured by income and education level, affects the health of the elderly, with higher socioeconomic status associated with better health. How is the use of health services affected by socioeconomic status? The elderly with higher socioeconomic status have less need for health care services; on the other hand, they can better afford to pay for such services. Higher income is associated with greater use of health care services (table 8). The low-income elderly in nonmetro areas were somewhat less likely to use formal health care services (79 percent) in 1984 than were their counterparts with incomes of

\$20,000 or more (81 percent). The low-income elderly also tend to use formal health care services more extensively than the high-income elderly. Among the nonmetro elderly, 15 percent of low-income elders used formal health care services extensively, compared with 10 percent of high-income elders (app. table 8). Higher income is also associated with higher use of health care services among those in fair or poor health (app. table 9). The fact that elders with lower socioeconomic status tend to be in poorer health, on average, implies that a large unmet need for services exists among this group.

Central city elders place greater demands on health services than do their suburban and nonmetro counterparts. Among the low-income elderly, 19 percent in central cities were high users of formal health care services in 1984, compared with 16 percent in the suburbs and 15 percent in nonmetro areas. In comparison, 15 percent of central city elders with incomes of \$20,000 or more used formal health care extensively, compared with 12 percent in the suburbs and 10 percent in nonmetro areas. Because elders with lower socioeconomic status also have poorer health, their overall use of health services reflects a gap between need for care and use of services. This has a greater effect in nonmetro areas because the nonmetro elderly have lower socioeconomic status, on average, than do their metro counterparts. Both residential location and socioeconomic status clearly affect health care service use.

Higher educational attainment is related to higher use of health care services among the elderly, in the same manner as higher income level. Eighteen percent of nonmetro elders with at least 1 year of college used no formal health care services, compared with 21 percent of their less-educated counterparts (table 8). The less-educated also tend to have poorer health status, which implies that a gap exists in the need for health care and the use of such services. This gap may be more critical in nonmetro areas, as nonmetro elders are, on average, less educated than their metro counterparts.

Because employed elders are generally in better health than their unemployed counterparts and those not in the labor force, do they use health care services less frequently? Employed elders are less likely to use health care services at all, and when they do, they are less likely than their nonworking counterparts to use such services extensively. Only 6 percent of employed nonmetro elders were high users of health care services in 1984, compared with 15 percent of their counterparts not in the labor force (app. table 8). Differences in use of services by residence were apparent, with 20 percent of central city elders not in the labor force being high users, compared with 16 percent of suburban elders and 15 percent of nonmetro elders.

Conclusions

Elderly persons with arthritis or hypertension also tend to have functional limitations, and hence are more likely to need regular physician and other health care services. In 1984, 16 percent of nonmetro elders with arthritis did not use formal health care services, compared with 26 percent of nonmetro elders without arthritis (app. table 8). Elderly persons with arthritis or hypertension not only use health care services more often, but also use these services more extensively. Residential differences are evident, with the metro elderly using services more than their nonmetro counterparts, and central city elders placing the heaviest demands on health care services.

Role of Residential Location

Residential differences in the use of formal health care services are apparent, with higher use by elders in metro areas. The SOA data on use of health care services suggests that these services may be more accessible to elders in metro areas. A lower physician-to-population ratio in rural areas suggests that rural elders may visit doctors less frequently because they are less accessible.

Use of health care services by length of residence in an area differs by metro-nonmetro residence. Elderly persons residing in nonmetro areas for a shorter time period used health care services less than longer term residents.⁸ On the other hand, greater use of health care services is found among more recent residents of metro areas. This suggests that the more recent residents of nonmetro areas may be both younger and healthier, and that nonmetro elders in poorer health may relocate to metro areas to obtain needed medical care.

Greater use of formal health care services is an indicator of poorer health. Among the elderly in fair or poor health, a marked increase is seen in both elders who use health care services and those who use health care services extensively. Residential differences persist, with lower proportions of nonmetro elders in poorer health using health care services and a smaller share using such services at a high level, compared with their metro counterparts. This pattern of residential use is fairly consistent for all variables in table 9 and app. table 9. Nonmetro elders may move to metro areas to obtain medical and health care services, as reflected in differences in high use of health services by length of residence (app. table 9). Among elderly persons in fair or poor health who had lived at their current residence for less than 1 year, a higher proportion of those in metro areas are high users of formal health care services than are elders residing in nonmetro areas.

The majority of elderly persons are, and perceive themselves to be, in good health. National survey data show that suburban elders rate their health better than their counterparts in cities and nonmetro areas, and also report fewer ADL, IADL, and functional limitations than do either nonmetro or central city elders. The health status of nonmetro elders and city elders is comparable on these measures. The nonmetro elderly are more likely to have certain chronic conditions, such as arthritis, than are their metro counterparts, and the presence of such chronic conditions is clearly associated with poorer physical functioning. Difficulty in performing personal care and home management activities, known as activities of daily living (ADL's) and instrumental activities of daily living (IADL's), may indicate some loss in the quality of life, but does not necessarily indicate a present or imminent need for health care and social services.

Residential differences in self-assessments of health and physical functioning are still evident when other factors--age, race, social support networks, income, and education--are held constant. Socioeconomic status, as measured by education and income, and residential location both affect the health of the elderly, with higher socioeconomic status associated with better health. This has a greater effect on the nonmetro elderly, as they are, on average, less educated and financially worse off than their metro counterparts. Social support networks among nonmetro elderly persons may ameliorate their poorer health to some extent, but not enough to overcome the effects of their lower socioeconomic status.

Health care services are expected to be less available to nonmetro elders, and the lower use of such services by the nonmetro elderly implies that this is indeed the case. The nonmetro elderly are less likely to use formal health care services--physician visits, hospital stays, and nursing home care--than their metro counterparts. These residential differences are still apparent when controls for demographic and socioeconomic characteristics are introduced. Central city elders tend to use health care services to a greater extent than do either nonmetro or suburban elders. When health status is controlled, residential differences in the use of health care services are evident. The nonmetro elderly use fewer health care services, compared with metro residents, than is commensurate with their health status. This suggests a gap between the nonmetro elderly's need for care, based on their poorer health status and lower socioeconomic standing, and the availability of services to meet this need. Lower socioeconomic groups may be disadvantaged with respect to access to health care, and new strategies are needed to increase the use of health care by such groups.

⁸Unpublished tabulations by the author from the NHIS Supplement on Aging.

The ability or inability of the elderly to obtain help with difficult personal care activities is an important factor in determining which individuals are able to remain in the community and which must enter nursing homes or other institutions for needed care and assistance. A substantial and growing number of the elderly have, or are at risk of developing, chronic conditions that impair their ability to function independently. This has important implications for long-term care and Federal spending, as well as for effective local planning for health care and other services. Health and social services need to be designed to provide better and more effective care for this population. An increasing number of private long-term care insurance policies and proposed public long-term care insurance programs rely on ADL measures to determine if an individual qualifies for benefits. Residential differences in functional limitations as well as access to and availability of services need to be considered in planning for services in particular areas.

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Table 1--Demographic and socioeconomic characteristics of the elderly, by residence, 1984¹

Characteristics	Residence				Nonmetro
	U.S. total	Metro		Total	
		Central city	Suburb		
		<i>Thousands</i>			
Number of elders	37,256	23,793	10,089	13,704	13,463
		<i>Percent</i>			
Demographic:					
Age:					
60-64 years	29.0	30.1	29.3	30.7	27.1
65-74 years	43.7	43.6	43.6	43.5	44.0
75-84 years	22.1	21.4	21.8	21.0	23.5
85 years and older	5.1	5.0	5.3	4.7	5.3
Gender:					
Male	42.8	42.2	39.9	43.9	43.8
Female	57.2	57.8	60.1	56.1	56.2
Race:²					
White	91.4	90.2	82.0	96.3	93.3
Black	8.6	9.8	18.0	3.7	6.7
Ethnicity:³					
Hispanic	3.1	3.9	5.2	3.0	1.7
Non-Hispanic	96.9	96.1	94.8	97.0	98.3
Marital status:					
Married	60.9	59.7	53.6	64.1	63.2
Widowed, divorced, or separated	34.7	35.5	40.0	32.2	33.2
Never married	4.4	4.9	6.4	3.7	3.7
Number of living children:					
None	11.9	12.6	15.4	10.5	10.7
1 child	17.4	18.2	19.9	17.0	16.0
2-4 children	54.4	55.5	51.4	58.5	52.6
5 or more children	16.3	13.7	13.3	14.0	20.7
Region:					
Northeast	23.2	28.0	25.5	29.9	14.6
Midwest	25.4	24.5	24.8	24.4	26.9
South	33.7	26.9	30.9	24.0	45.8
West	17.7	20.6	18.9	21.8	12.7

See footnotes at end of table.

Continued--

Table 1--Demographic and socioeconomic characteristics of the elderly, by residence, 1984¹--Continued

Characteristics	Residence				
	U.S. total	Metro			Nonmetro
		Total	Central city	Suburb	
	<i>Percent</i>				
Length of time at residence (years):					
Less than 1	5.1	5.1	4.6	5.5	5.0
1-10	31.3	29.7	29.3	30.1	34.1
11-20	23.2	24.2	24.7	23.8	21.3
At least 21	40.4	40.9	41.5	40.6	39.6
Socioeconomic:					
Education:					
Less than high school	47.8	44.8	49.3	41.6	53.2
High school, 4 years	31.6	32.8	30.8	34.3	29.4
College, 1 or more years	20.6	22.4	19.9	24.2	17.4
Employment status in past 2 weeks:					
Employed	21.2	22.2	20.8	23.3	19.3
Unemployed	1.1	1.1	1.2	1.0	1.0
Not in labor force	77.8	76.6	78.0	75.6	79.7
Income:					
Less than \$20,000	66.6	61.8	69.1	56.4	75.0
\$20,000 or more	33.4	38.2	30.9	43.6	25.0
Poverty status:					
Below poverty	14.3	11.2	15.1	8.3	19.8
Above poverty	85.7	88.8	84.9	91.7	80.2
Tenure:					
Home owned	79.1	76.3	68.4	82.2	84.2
Rented	18.3	22.0	30.2	16.0	11.8
Rent free	2.5	1.7	1.4	1.9	4.1
Retirement status:					
Completely retired	68.3	68.0	69.5	66.8	68.9
Living in a retirement community	3.7	3.7	3.3	4.0	3.6
Retired due to health ⁴	25.7	23.7	25.7	22.2	29.0
Now receiving retirement income	80.6	79.2	79.0	79.4	83.0
Number of retirement income sources: ⁵					
1	65.6	63.1	64.7	61.9	70.0
2-6	34.2	36.7	35.2	37.8	29.9

¹Elderly defined as aged 60 years and older.

²Excludes other races.

³Persons of Hispanic origin may be of any race.

⁴Excludes those who are not retired or who never worked.

⁵Excludes those with no retirement income.

Table 2--Social support networks and use of community services by the elderly, by residence, 1984¹

Characteristics	Residence				
	U.S. total	Metro			Nonmetro
		Total	Central city	Suburb	
			<i>Thousands</i>		
Number of elders	37,256	23,793	10,089	13,704	13,463
			<i>Percent</i>		
Living arrangements:					
Live alone	27.2	27.4	32.0	24.0	26.8
With spouse	59.6	58.5	52.4	62.9	61.7
With other relative or nonrelative	13.2	14.1	15.6	13.1	11.5
Social activities:					
See children: ²					
Less than once a year	94.0	94.0	93.7	94.1	94.0
1-12 times a year	.2	.2	.1	.3	.2
13 or more times a year					
In past 2 weeks:					
Saw friends/neighbors	70.9	71.3	68.4	73.5	70.2
Saw relatives	78.7	77.9	74.9	80.0	80.1
Went to church	51.8	51.2	50.7	51.5	52.9
Social support:					
Someone to provide care for a few weeks:					
No one	10.0	10.6	12.0	9.5	9.1
Household relative	56.1	56.1	50.8	60.0	56.0
Relative not in household	26.6	25.4	27.5	23.8	28.7
Nonrelative	5.1	5.6	6.9	4.6	4.3
Don't know or refused	2.2	2.4	2.8	2.1	1.9
Number of community services used:					
None	81.4	81.7	81.4	81.8	81.0
1	9.9	10.6	10.3	10.8	8.6
2 or more	8.7	7.7	8.3	7.3	10.4
Percent using selected community services:					
Senior center	12.7	12.2	11.3	12.9	13.5
Special transportation for elderly	3.6	3.5	4.0	3.1	3.7
Meals taken in senior center	7.1	5.7	6.2	5.3	9.6

¹Elderly defined as aged 60 years and older.

²Excludes never-married elders, elders with no child(ren), and elders with children at home.

Table 3--Summary measures of health status of the elderly, by age and residence, 1984¹

Characteristics	Residence				U.S. total
	Total	Metro		Nonmetro	
		Central city	Suburb		
<i>Percent</i>					
Elderly aged 60 years and older:					
In fair or poor health ²	30.9	28.8	31.5	26.8	34.7
With ADL-IADL difficulties ³	29.2	27.8	30.2	26.0	31.8
With 1 or more limitations ⁴	52.9	50.2	52.8	48.3	57.6
With arthritis	49.0	46.8	47.1	46.6	53.0
With hypertension	41.8	40.4	42.0	39.2	44.4
Restricted activity days ⁵	12.8	12.8	13.6	12.2	12.8
Bed disability days ⁵	6.8	7.0	7.4	6.7	6.3
Elderly aged 60-74 years:					
In fair or poor health	29.9	27.5	31.0	24.9	34.4
With ADL-IADL difficulties	23.8	22.3	25.1	20.3	26.4
With 1 or more limitations	48.0	45.2	47.8	43.3	53.2
With arthritis	47.3	44.7	44.9	44.5	52.1
With hypertension	40.5	39.1	40.9	37.8	42.9
Restricted activity days	12.2	12.2	13.0	11.7	12.2
Bed disability days	6.2	6.5	7.1	6.0	5.7
Elderly aged 75 years and older:					
In fair or poor health	33.6	32.5	33.0	32.0	35.5
With ADL-IADL difficulties	43.9	43.1	43.8	42.7	45.2
With 1 or more limitations	66.4	64.9	67.2	63.1	68.9
With arthritis	53.7	52.8	53.1	52.6	55.2
With hypertension	45.4	43.9	45.0	42.9	48.0
Restricted activity days	14.4	14.4	15.3	13.6	14.4
Bed disability days	8.2	8.5	8.1	8.8	7.9

¹Elderly defined as aged 60 years and older.

²From self-reported assessments of health.

³Includes those who report difficulty performing either personal care or home management activities.

⁴Includes those with difficulty in one or more functional activities.

⁵Restricted activity days and bed disability days refer to the past 2-week period.

Table 4--Functional status of the elderly, by residence, 1984¹

Characteristics	Residence				
	U.S. total	Metro			Nonmetro
		Total	Central city	Suburb	
		<i>Thousands</i>			
Number of elders	37,256	23,793	10,089	13,704	13,463
		<i>Percent</i>			
ADL difficulties:²					
Number:					
None	79.5	80.3	78.3	81.7	78.2
One	8.3	7.7	8.2	7.4	9.2
Two or more	11.7	11.2	12.5	10.3	12.4
Unknown	.6	.8	1.0	.6	.3
Have difficulty:					
Bathing or showering	8.3	8.3	8.7	8.1	8.4
Walking	16.3	15.3	17.2	14.0	18.0
IADL difficulties:³					
Number:					
None	75.4	76.4	74.0	78.1	73.7
One or more	24.0	22.9	24.9	21.3	25.9
Unknown	.6	.8	1.0	.6	.4
Have difficulty:					
Shopping for personal items	9.4	9.5	11.0	8.3	9.3
Doing heavy housework	21.3	20.7	22.7	19.3	22.4
ADL-IADL combined:					
No ADL or IADL difficulties	70.8	72.2	69.8	74.0	68.2
No ADL difficulties, 1+IADL's	9.2	8.7	9.3	8.2	10.2
1+ADL's, no IADL difficulties	5.1	4.7	5.0	4.6	5.8
1+difficulties, both ADL and IADL	14.9	14.4	15.9	13.2	15.8
Number of functional limitations:⁴					
None	46.8	49.4	46.7	51.5	42.2
One or more	52.9	50.2	52.8	48.3	57.6
One	12.6	12.1	11.8	12.3	13.6
2-3	14.6	14.1	14.3	13.9	15.5
4-10	25.7	24.0	26.7	22.1	28.6
Don't know	.3	.4	.5	.3	.2

¹Elderly defined as aged 60 years and older.

²Activities of daily living (ADL's) include bathing or showering, dressing, eating, transferring (getting in or out of a bed or chair), walking, getting outside, and using or getting to a toilet.

³Instrumental activities of daily living (IADL's) include preparing own meals, shopping for personal items, managing money, using the telephone, and doing heavy and light housework.

⁴Functional limitations refer to difficulty in the following 10 activities: walking a quarter of a mile, walking up 10 steps without rest, standing for 2 hours, sitting for 2 hours, stooping, crouching, or kneeling, reaching up overhead, reaching out as if to shake hands, using fingers to grasp, lifting or carrying 25 pounds, and lifting or carrying 10 pounds.

Table 5--Proportion of the elderly reporting their health as fair or poor, by residence and selected characteristics, 1984¹

Characteristics	Residence		
	Central city	Suburb	Nonmetro
	<i>Percent</i>		
Demographic:			
Age:			
60-74 years	31.0	24.9	34.4
75 years and older	33.0	32.0	35.5
Race: ²			
White	28.7	26.0	32.7
Black	45.1	48.0	61.0
Social support:			
Living arrangements:			
Live alone	30.0	24.1	32.8
Live with spouse	29.9	26.0	33.9
Live with other relative or nonrelative	40.2	35.2	43.8
Someone to provide care: ³			
No one	38.7	34.9	38.8
Household relative	30.5	25.8	33.0
Relative not in household	31.0	26.2	36.5
Nonrelative	29.8	25.2	35.7
Socioeconomic:			
Income:			
Less than \$20,000	35.9	32.9	40.4
\$20,000 or more	22.0	19.3	19.0
Education:			
Less than high school	39.7	36.2	45.7
High school, 4 years	25.1	21.5	24.2
College, 1 or more years	20.1	18.4	18.1

¹Elderly defined as aged 60 years and older.

²Excludes other races.

³Includes anyone (relative or nonrelative) who could be a potential care-giver.

Table 6--Proportion of the elderly with one or more ADL and IADL difficulties, by residence and selected characteristics, 1984¹

Characteristics	Residence		
	Central city	Suburb	Nonmetro
	<i>Percent</i>		
Demographic:			
Age:			
60-74 years	12.4	9.3	11.5
75 years and older	25.4	24.6	26.4
Race: ²			
White	15.9	12.9	15.2
Black	16.8	21.5	23.3
Social support:			
Living arrangements:			
Live alone	19.6	14.6	20.3
Live with spouse	11.2	9.9	11.5
Live with other relative or nonrelative	24.5	26.9	28.4
Someone to provide care: ³			
No one	24.9	24.3	24.0
Household relative	13.1	11.3	13.3
Relative not in household	15.5	12.7	17.1
Nonrelative	22.3	17.2	17.8
Socioeconomic:			
Income:			
Less than \$20,000	18.0	16.5	18.5
\$20,000 or more	11.0	9.4	7.9
Education:			
Less than high school	19.9	18.2	19.8
High school, 4 years	12.0	9.9	10.3
College, 1 or more years	11.6	9.2	11.5

¹Elderly defined as aged 60 years and older.

²Excludes other races.

³Includes anyone (relative or nonrelative) who could be a potential care-giver.

Table 7--Use of health care and community services by the elderly, by age and residence, 1984¹

Characteristics	Residence				
	U.S. total	Metro			Nonmetro
		Total	Central city	Suburb	
<i>Percent</i>					
Persons aged 60 years and older:					
Used formal health services ²	81.1	82.1	80.8	83.0	79.4
Any doctor visits	80.5	81.4	80.0	82.4	78.8
Any hospital days	17.7	17.2	16.7	17.6	18.4
Ever in nursing home	1.5	1.5	1.7	1.3	1.5
High formal service use ²	14.7	15.4	17.5	13.9	13.5
Used 1 or more community services ³	18.6	18.3	18.6	18.2	19.0
Persons aged 60 years and older in fair or poor health:					
Used formal health services	89.7	90.5	90.1	90.8	88.7
Any doctor visits	89.0	89.7	89.4	89.9	87.9
Any hospital days	30.4	30.7	29.7	31.7	29.8
Ever in nursing home	3.0	3.1	3.0	3.3	2.8
High formal service use	29.2	31.2	33.0	29.7	26.2
Persons aged 60-74 years:					
Used formal health services	79.8	80.7	79.5	81.6	78.2
Any doctor visits	79.3	80.1	78.8	81.1	77.7
Any hospital days	15.6	15.4	15.4	15.4	15.9
Ever in nursing home	.7	.8	.9	.7	.6
High formal service use	13.2	14.0	16.1	12.5	11.9
Used 1 or more community services	15.0	15.1	15.3	14.9	14.9
Persons aged 75 years and older:					
Used formal health services	84.5	85.9	84.5	87.0	82.3
Any doctor visits	83.7	85.0	83.4	86.3	81.5
Any hospital days	23.2	22.4	20.5	23.9	24.6
Ever in nursing home	3.6	3.6	4.0	3.2	3.7
High formal service use	18.7	19.4	21.3	17.9	17.6
Used 1 or more community services	28.0	27.4	27.2	27.6	29.0

¹Elderly defined as aged 60 years and older.

²Use of formal services is defined as either 1-11 doctor visits or hospital stays of 1-30 days in the past year, and no nursing home stays. High use of formal care was determined if the individual had either 12 or more doctor visits, had been hospitalized for 31 or more days, or had ever been in a nursing home.

³Community services consist of using a senior center, special transportation for the elderly, meals in a senior center, homemaker services, adult day care, and visiting nurse services.

Table 8--Proportion of the elderly who used no formal health care services, by residence and selected characteristics, 1984¹

Characteristics	Residence		
	Central city	Suburb	Nonmetro
	<i>Percent</i>		
Demographic:			
Age:			
60-74 years	20.5	18.4	21.8
75 years and older	15.5	13.0	17.7
Race:²			
White	19.5	17.1	20.6
Black	18.0	16.2	21.9
Social support:			
Living arrangements:			
Live alone	17.0	15.8	19.0
Live with spouse	20.4	17.8	21.1
Live with other relative or nonrelative	19.4	15.6	22.0
Someone to provide care:³			
No one	18.2	14.3	20.0
Household relative	21.2	17.6	22.3
Relative not in household	17.2	16.7	17.4
Nonrelative	15.2	16.1	21.2
Socioeconomic:			
Income:			
Less than \$20,000	18.4	17.2	20.9
\$20,000 or more	19.9	16.5	19.2
Education:			
Less than high school	19.7	17.0	20.8
High school, 4 years	20.0	17.3	21.3
College, 1 or more years	15.8	16.7	18.0

¹Elderly defined as aged 60 years and older.

²Excludes other races.

³Includes anyone (relative or nonrelative) who could be a potential care-giver.

Table 9--Proportion of the elderly in fair or poor health who used no formal health care services, by residence and selected characteristics, 1984¹

Characteristics	Residence		
	Central city	Suburb	Nonmetro
	<i>Percent</i>		
Demographic:			
Age:			
60-74 years	10.0	10.8	11.6
75 years and older	9.5	5.7	10.8
Race:²			
White	10.4	9.1	11.2
Black	8.8	11.3	13.0
Social support:			
Living arrangements:			
Live alone	8.5	7.3	9.8
Live with spouse	11.2	11.0	11.9
Live with other relative or nonrelative	8.6	5.5	11.6
Someone to provide care:³			
No one	11.4	7.5	14.2
Household relative	10.9	10.0	13.0
Relative not in household	8.9	8.2	7.8
Nonrelative	3.2	7.4	6.5
Socioeconomic:			
Income:			
Less than \$20,000	9.0	10.3	11.5
\$20,000 or more	10.2	6.1	10.7
Education:			
Less than high school	10.3	10.3	12.6
High school, 4 years	8.9	7.9	9.6
College, 1 or more years	6.6	8.1	3.2

¹Elderly defined as aged 60 years and older.

²Excludes other races.

³Includes anyone (relative or nonrelative) who could be a potential care-giver.

Appendix table 1--Social support networks and use of community services by the elderly, by age and residence, 1984¹

Characteristics	Residence				Nonmetro
	U.S. total	Metro		Suburb	
		Total	Central city		
<i>Thousands</i>					
Elderly aged 60-74 years:					
Number	27,110	17,533	7,353	10,179	9,578
<i>Percent</i>					
Living arrangements:					
Live alone	22.0	22.8	27.8	19.2	20.5
With spouse	67.2	65.7	58.6	70.8	69.9
With other relative or nonrelative	10.8	11.5	13.5	10.0	9.6
Social activities:					
See children-- ²					
Less than once a year	2.6	2.6	3.2	2.1	2.6
1-12 times a year	94.2	94.4	94.0	94.6	93.9
13 or more times a year	.1	.2	.1	.3	.2
In past 2 weeks--					
Saw friends/neighbors	72.7	73.3	70.4	75.4	71.6
Saw relatives	79.9	79.1	76.3	81.1	81.3
Went to church	53.3	52.8	52.7	52.9	54.3
Social support:					
Someone to provide care for a few weeks--					
No one	8.2	9.0	10.3	8.1	6.8
Household relative	61.0	60.8	55.1	64.9	61.5
Relative not in household	24.1	23.1	25.8	21.1	26.1
Nonrelative	4.6	5.1	6.5	4.1	3.7
Don't know or refused	2.0	2.1	2.4	1.9	1.8
Number of community services used:					
None	85.0	84.9	84.7	85.1	85.1
1	8.2	9.0	8.5	9.3	6.8
2 or more	6.8	6.1	6.9	5.5	8.1
Percent using selected community services:					
Senior center	11.3	11.1	10.2	11.8	11.7
Special transportation for elderly	2.5	2.5	3.2	2.0	2.4
Meals taken in senior center	6.1	5.0	5.9	4.4	8.0

See footnotes at end of table.

Continued--

Appendix table 1--Social support networks and use of community services by the elderly, by age and residence, 1984¹--Continued

Characteristics	Residence				
	U.S. total	Metro			Nonmetro
		Total	Central city	Suburb	
	<i>Thousands</i>				
Elderly aged 75 years and older:					
Number	10,145	6,260	2,736	3,524	3,885
	<i>Percent</i>				
Living arrangements:					
Live alone	41.0	40.3	43.3	37.9	42.3
With spouse	39.5	38.2	35.7	40.2	41.5
With other relative or nonrelative	19.5	21.5	21.0	21.9	16.2
Social activities:					
See children-- ²					
Less than once a year	2.7	2.8	3.3	2.5	2.4
1-12 times a year	93.4	92.7	92.7	92.7	94.4
13 or more times a year	.2	.3	0	.4	.2
In past 2 weeks--					
Saw friends/neighbors	66.1	65.7	62.9	67.9	66.7
Saw relatives	75.5	74.4	71.3	76.9	77.3
Went to church	47.8	46.7	45.4	47.8	49.4
Social support:					
Someone to provide care for a few weeks--					
No one	14.9	15.0	16.5	13.8	14.7
Household relative	42.8	43.0	39.5	45.8	42.4
Relative not in household	33.1	31.9	32.1	31.7	35.0
Nonrelative	6.5	7.0	8.0	6.2	5.7
Don't know or refused	2.8	3.2	3.9	2.6	2.2
Number of community services used:					
None	72.0	72.6	72.8	72.4	71.0
1	14.3	15.1	15.0	15.1	13.0
2 or more	13.7	12.3	12.2	12.4	16.0
Percent using selected community services:					
Senior center	16.3	15.3	14.4	16.0	17.9
Special transportation for elderly	6.4	6.2	6.0	6.3	6.9
Meals taken in senior center	9.9	7.6	7.1	8.0	13.6

¹Elderly defined as aged 60 years and older.

²Excludes never-married elders, elders with no child(ren), and elders with children at home.

Appendix table 2--Self-reported health status of the elderly, by age and residence, 1984¹

Characteristics	Units	U.S. total	Residence			
			Total	Metro		Nonmetro
				Central city	Suburb	
Elderly aged 60 years and older:						
Number	<i>Thousands</i>	37,107	23,702	10,037	13,665	13,405
Health status:						
Excellent or very good	<i>Percent</i>	38.0	39.5	37.4	41.0	35.3
Good	<i>do.</i>	31.1	31.8	31.1	32.3	29.9
Fair or poor	<i>do.</i>	30.9	28.8	31.5	26.8	34.7
Elderly aged 60-74 years:						
Number	<i>Thousands</i>	27,021	17,480	7,326	10,154	9,542
Health status:						
Excellent or very good	<i>Percent</i>	38.9	40.3	37.7	42.3	36.3
Good	<i>do.</i>	31.2	32.2	31.4	32.8	29.3
Fair or poor	<i>do.</i>	29.9	27.5	31.0	24.9	34.4
Elderly aged 75 years and older:						
Number	<i>Thousands</i>	10,086	6,223	2,711	3,512	3,863
Health status:						
Excellent or very good	<i>Percent</i>	35.5	37.0	36.8	37.2	33.1
Good	<i>do.</i>	30.9	30.5	30.2	30.8	31.4
Fair or poor	<i>do.</i>	33.6	32.5	33.0	32.0	35.5

¹Elderly defined as aged 60 years and older.

Appendix table 3--Disability among the elderly, by age and residence, 1984¹

Characteristics	Units	Residence				
		U.S. total	Metro		Nonmetro	
			Total	Central city		Suburb
Elderly aged 60 years and older:						
Number	<i>Thousands</i>	37,256	23,793	10,089	13,704	13,463
Restricted activity days in past 2 weeks:						
None	<i>Percent</i>	87.2	87.2	86.4	87.8	87.2
1-5	<i>do.</i>	4.8	4.6	4.7	4.5	5.1
6-14	<i>do.</i>	8.0	8.2	8.9	7.6	7.7
Bed disability days in past 2 weeks:						
None	<i>Percent</i>	93.2	93.0	92.6	93.3	93.7
1-5	<i>do.</i>	3.3	3.5	3.5	3.5	3.0
6-14	<i>do.</i>	3.4	3.5	3.9	3.2	3.3
Having 1 or more ADL or IADL difficulties:						
Number	<i>Thousands</i>	10,823	6,555	3,011	3,544	4,268
Restricted activity days in past 2 weeks--						
None	<i>Percent</i>	71.6	70.7	69.4	71.8	72.9
1-5	<i>do.</i>	8.6	8.3	9.0	7.7	9.0
6-14	<i>do.</i>	19.8	21.0	21.7	20.4	18.1
Bed disability days in past 2 weeks--						
None	<i>Percent</i>	83.8	82.5	82.4	82.6	85.7
1-5	<i>do.</i>	6.4	6.9	7.4	6.4	5.6
6-14	<i>do.</i>	9.9	10.6	10.2	11.0	8.7
Reporting health as fair or poor:						
Number	<i>Thousands</i>	11,478	6,820	3,162	3,657	4,658
Restricted activity days in past 2 weeks --						
None	<i>Percent</i>	72.8	71.2	70.9	71.5	75.2
1-5	<i>do.</i>	8.2	8.1	8.6	7.7	8.4
6-14	<i>do.</i>	19.0	20.7	20.5	20.8	16.4
Bed disability days in past 2 weeks--						
None	<i>Percent</i>	84.4	82.7	82.2	83.1	86.8
1-5	<i>do.</i>	6.7	7.4	7.7	7.1	5.7
6-14 days	<i>do.</i>	8.9	9.9	10.1	9.8	7.5

See footnote at end of table.

Continued--

Appendix table 3--Disability among the elderly, by age and residence, 1984¹--Continued

Characteristics	Units	Residence				
		U.S. total	Metro		Nonmetro	
			Total	Central city		Suburb
Elderly aged 60-74 years:						
Number	<i>Thousands</i>	27,110	17,533	7,353	10,179	9,578
Restricted activity days in past 2 weeks:						
None	<i>Percent</i>	87.8	87.8	87.0	88.3	87.8
1-5	<i>do.</i>	5.1	4.9	4.9	4.9	5.4
6-14	<i>do.</i>	7.1	7.3	8.1	6.8	6.8
Bed disability days in past 2 weeks:						
None	<i>Percent</i>	93.8	93.5	92.9	94.0	94.3
1-5	<i>do.</i>	3.4	3.7	3.6	3.7	3.0
6-14	<i>do.</i>	2.8	2.8	3.5	2.3	2.7
Elderly aged 75 years and older:						
Number	<i>Thousands</i>	10,145	6,260	2,736	3,524	3,885
Restricted activity days in past 2 weeks:						
None	<i>Percent</i>	85.6	85.6	84.7	86.4	85.6
1-5	<i>do.</i>	4.1	3.9	4.4	3.5	4.4
6-14	<i>do.</i>	10.3	10.5	11.0	10.2	10.0
Bed disability days in past 2 weeks:						
None	<i>Percent</i>	91.8	91.5	91.9	91.2	92.1
1-5	<i>do.</i>	3.0	3.0	3.2	2.9	3.0
6-14	<i>do.</i>	5.2	5.5	5.0	5.9	4.9

¹Elderly defined as aged 60 years and older.

Appendix table 4--Self-reported health status of the elderly, by residence and selected characteristics, 1984¹

Characteristics	Number of elders	Excellent or very good			Good			Fair or poor		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	<i>Percent</i>								
Demographic:										
Age:										
60-74 years	27,021	37.7	42.3	36.3	31.4	32.8	29.3	31.0	24.9	34.4
75 years and older	10,086	36.8	37.2	33.1	30.2	30.8	31.4	33.0	32.0	35.5
Gender:										
Male	15,898	38.4	41.5	36.1	31.1	31.5	28.3	30.5	27.0	35.6
Female	21,209	36.8	40.5	34.7	31.0	32.9	31.2	32.2	26.6	34.1
Race:²										
White	33,502	39.3	41.5	36.5	32.0	32.6	30.8	28.7	26.0	32.7
Black	3,167	28.7	28.2	20.9	26.2	23.8	18.1	45.1	48.0	61.0
Ethnicity:³										
Hispanic	1,155	26.4	30.0	20.1	28.9	38.3	35.5	44.6	31.7	44.4
Non-Hispanic	35,825	38.0	41.4	35.7	31.2	32.1	29.8	30.8	26.6	34.6
Marital status:										
Married	22,579	36.9	40.2	35.4	33.3	33.5	30.6	29.8	26.3	34.0
Widowed, divorced, or separated	12,798	37.7	41.3	35.6	28.4	30.3	28.1	33.9	28.4	36.3
Never married	1,635	39.1	46.1	31.3	29.7	30.3	34.5	31.3	23.6	34.2
Social support:										
Living arrangements:										
Live alone	10,072	42.3	43.8	39.0	27.7	32.1	28.2	30.0	24.1	32.8
Live with spouse	22,160	36.7	40.4	35.2	33.4	33.6	30.9	29.9	26.0	33.9
Live with other relative or nonrelative	4,875	29.9	38.4	27.5	29.9	26.4	28.6	40.2	35.2	43.8

See footnotes at end of table.

Continued--

Appendix table 4--Self-reported health status of the elderly, by residence and selected characteristics, 1984¹--Continued

Characteristics	Number of elders	Excellent or very good			Good			Fair or poor		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	<i>Percent</i>								
Someone to provide care:⁴										
No one	3,719	34.7	31.6	32.6	26.6	33.5	28.6	38.7	34.9	38.8
Household relative	20,827	36.9	41.9	36.6	32.6	32.3	30.4	30.5	25.8	33.0
Relative not in household	9,867	37.9	42.4	32.4	31.1	31.4	31.1	31.0	26.2	36.5
Nonrelative	1,896	41.7	42.9	40.6	28.5	31.9	23.8	29.8	25.2	35.7
Socioeconomic:										
Education:										
Less than high school	17,518	29.6	31.2	25.7	30.7	32.6	28.5	39.7	36.2	45.7
High school, 4 years	11,598	41.8	44.3	43.3	33.0	34.1	32.5	25.1	21.5	24.2
College, 1 or more years	7,562	51.0	52.9	51.7	28.9	28.7	30.1	20.1	18.4	18.1
Employment status in past 2 weeks:										
Employed	7,860	55.2	57.6	49.9	28.8	29.6	29.5	16.1	12.8	20.7
Unemployed	399	58.2	37.8	35.3	27.7	36.7	41.4	14.0	25.5	23.4
Not in labor force	28,848	32.4	35.9	31.8	31.7	33.1	29.9	35.9	31.1	38.3
Income:										
Less than \$20,000	23,487	32.7	34.1	30.7	31.4	33.0	28.9	35.9	32.9	40.4
\$20,000 or more	11,832	48.1	49.3	48.4	30.0	31.4	32.7	22.0	19.3	19.0
Poverty status:										
Below poverty	4,477	26.3	27.4	23.9	26.2	29.2	22.7	47.5	43.4	53.3
Above poverty	26,840	39.3	41.9	37.5	32.0	32.6	31.4	28.6	25.5	31.2
Retirement status:⁵										
Completely retired	25,347	32.6	35.8	32.0	31.6	32.9	29.5	35.8	31.3	38.6
Partly retired	3,076	44.1	51.8	40.6	32.9	31.0	31.3	23.0	17.1	28.1
Not retired	7,071	52.8	54.8	48.8	29.1	30.8	30.4	18.2	14.4	20.8

See footnotes at end of table.

Continued--

Appendix table 4--Self-reported health status of the elderly, by residence and selected characteristics, 1984¹--Continued

Characteristics	Number of elders	Excellent or very good			Good			Fair or poor		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	<i>Percent</i>								
Residential:										
Region:	8,599	36.8	41.7	38.9	34.0	33.7	34.1	29.2	24.6	27.0
Northeast	9,426	34.9	38.6	35.4	33.3	34.8	32.9	31.8	26.5	31.8
Midwest	12,500	36.6	39.9	32.6	26.9	28.7	26.0	36.5	31.4	41.4
South	6,582	42.9	43.7	40.9	31.0	31.4	33.0	26.1	24.9	26.1
West										
Length of residence:										
Less than 1 year	1,871	38.0	37.8	35.1	23.0	37.2	24.4	39.0	25.0	40.5
1-10 years	11,559	31.6	39.3	36.8	31.3	31.2	29.0	37.1	29.5	34.2
11-20 years	8,523	40.8	39.9	34.6	27.2	31.5	29.5	32.0	28.6	35.9
At least 21 years	14,889	39.3	43.1	34.6	34.1	33.1	31.6	26.6	23.8	33.8
Selected medical conditions:										
Hypertension:										
Has	15,517	27.0	30.4	27.2	32.3	34.8	30.0	40.8	34.8	42.8
Does not have	21,235	45.1	47.8	42.0	30.5	30.7	29.8	24.4	21.5	28.2
Arthritis:										
Has	18,179	28.3	31.5	27.5	30.5	33.8	28.6	41.2	34.7	43.9
Does not have	18,270	45.7	49.7	44.3	31.9	30.8	31.6	22.4	19.5	24.1

¹Elderly defined as aged 60 years and older.²Excludes other races.³Persons of Hispanic origin may be of any race.⁴Includes anyone (relative or nonrelative) who could be a potential care-giver.⁵Excludes those who never worked.

Appendix table 5--Functional status of the elderly, by residence and selected characteristics, 1984¹

Characteristics	Number of elders	No ADL-IADL difficulties			No ADL difficulties, 1 or more IADL difficulties			1 or more ADL difficulties, no IADL difficulties			1 or more difficulties with both ADL's and IADL's		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	<i>Percent</i>											
Demographic:													
Age:													
60-74 years	26,956	74.9	79.7	73.6	8.4	6.8	9.5	4.3	4.2	5.3	12.4	9.3	11.5
75 years and older	10,060	56.2	57.3	54.8	11.5	12.4	12.0	6.8	5.7	6.9	25.4	24.6	26.4
Gender:													
Male	15,839	78.5	80.3	74.1	5.1	5.0	6.8	5.7	6.1	7.3	10.6	8.6	11.7
Female	21,176	64.1	69.0	63.5	12.0	10.7	12.9	4.4	3.4	4.6	19.5	16.8	19.0
Race:²													
White	33,413	71.3	74.6	69.1	8.3	8.0	10.0	4.6	4.5	5.7	15.9	12.9	15.2
Black	3,164	63.0	58.4	57.3	13.9	14.3	12.6	6.3	5.7	6.9	16.8	21.5	23.3
Ethnicity:³													
Hispanic	1,154	61.6	72.4	64.1	9.8	12.1	15.3	5.4	2.9	5.7	23.1	12.6	14.9
Non-Hispanic	35,734	70.3	74.1	68.3	9.2	8.1	10.1	4.9	4.6	5.7	15.5	13.2	15.9
Marital status:													
Married	22,494	76.1	79.1	73.5	7.9	6.5	9.0	4.6	4.3	6.0	11.4	10.1	11.6
Widowed, divorced, or separated	12,799	61.8	63.7	58.5	11.7	11.5	12.6	5.1	5.2	5.1	21.3	19.5	23.8
Never married	1,623	67.1	73.3	64.3	5.8	9.5	10.8	6.7	3.5	8.9	20.3	13.7	16.0
Social support:													
Living arrangements:													
Live alone	10,058	65.3	70.0	61.0	9.8	10.7	12.7	5.3	4.8	5.9	19.6	14.6	20.3
Live with spouse	22,074	76.4	79.4	73.8	7.8	6.3	8.8	4.6	4.3	6.0	11.2	9.9	11.5
Live with other relative or nonrelative	4,884	57.2	55.1	54.9	12.9	12.7	12.1	5.4	5.3	4.7	24.5	26.9	28.4

See footnotes at end of table.

Continued--

Appendix table 5--Functional status of the elderly, by residence and selected characteristics, 1984¹--Continued

Characteristics	Number of elders	No ADL-IADL difficulties			No ADL difficulties, 1 or more IADL difficulties			1 or more ADL difficulties, no IADL difficulties			1 or more difficulties with both ADL's, and IADL's		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	<i>Percent</i>											
Someone to provide care: ⁴													
No one	3,739	57.0	59.7	54.2	11.3	11.2	15.7	6.8	4.8	6.1	24.9	24.3	24.0
Household relative	20,880	73.8	76.9	72.6	8.1	7.2	8.1	5.1	4.6	6.0	13.1	11.3	13.3
Relative not in household	9,897	68.9	73.9	65.7	11.3	9.2	11.8	4.3	4.2	5.3	15.5	12.7	17.1
Nonrelative	1,906	67.3	67.6	63.1	6.6	10.1	12.7	3.7	5.1	6.3	22.3	17.2	17.8
Socioeconomic:													
Education:													
Less than high school	17,512	63.0	66.3	60.7	11.0	9.8	12.5	6.1	5.7	7.0	19.9	18.2	19.8
High school, 4 years	11,572	75.3	78.6	77.0	8.1	7.6	7.5	4.6	3.8	5.2	12.0	9.9	10.3
College, 1 or more years	7,505	78.8	80.9	77.5	6.9	6.3	7.9	2.7	3.6	3.1	11.6	9.2	11.5
Employment status in past 2 weeks:													
Employed	7,823	90.6	91.0	88.3	4.3	3.1	4.9	2.3	2.7	4.3	2.8	3.2	2.5
Unemployed	394	91.4	83.0	69.8	5.4	5.9	6.9	0	3.2	5.4	3.2	7.9	17.9
Not in labor force	28,798	64.0	68.6	63.3	10.6	9.8	11.5	5.7	5.2	6.2	19.6	16.4	19.0
Income:													
Less than \$20,000	23,464	65.8	68.2	63.2	10.3	9.9	11.7	5.9	5.4	6.6	18.0	16.5	18.5
\$20,000 or more	11,804	79.3	80.8	81.9	6.7	6.1	6.4	3.0	3.7	3.8	11.0	9.4	7.9
Poverty status:													
Below poverty	4,489	54.5	55.0	50.7	12.7	13.6	15.3	6.9	7.7	7.7	25.9	23.7	26.3
Above poverty	26,818	73.3	75.5	72.0	8.3	8.0	9.3	4.6	4.3	5.6	13.7	12.3	13.1
Retirement status: ⁵													
Completely retired	25,330	63.7	68.5	62.5	10.6	9.8	11.9	5.9	5.3	6.2	19.7	16.3	19.4
Partly retired	3,070	83.8	86.5	80.9	6.6	4.7	5.4	2.9	2.9	5.8	6.7	5.9	7.9
Not retired	7,076	88.3	89.9	87.2	4.8	4.0	5.1	2.2	2.3	4.4	4.7	3.9	3.3

See footnotes at end of table.

Continued--

Appendix table 5--Functional status of the elderly, by residence and selected characteristics, 1984¹--Continued

Characteristics	Number of elders	No ADL-IADL difficulties			No ADL difficulties, 1 or more IADL difficulties			1 or more ADL difficulties, no IADL difficulties			1 or more difficulties with both ADL's, and IADL's		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	<i>Percent</i>											
Residential:													
Region:													
Northeast	8,567	71.1	76.3	71.7	8.7	7.3	7.6	4.8	3.7	5.6	15.4	12.7	15.0
Midwest	9,397	70.6	75.5	69.6	8.2	7.8	9.5	5.4	4.1	5.9	15.8	12.7	15.0
South	12,498	64.6	68.2	64.4	12.1	9.7	11.9	5.6	6.5	6.1	17.7	15.6	17.6
West	6,553	75.7	75.5	74.8	6.9	8.3	8.5	3.5	4.2	4.9	13.9	12.0	11.8
Length of residence:													
Less than 1 year	1,869	65.1	70.6	69.1	11.3	7.7	7.1	5.6	6.3	6.5	18.1	15.4	17.2
1-10 years	11,504	62.6	68.9	68.5	11.8	9.5	11.2	6.1	5.9	5.3	19.5	15.7	15.0
11-20 years	8,524	71.2	75.1	68.4	9.0	9.3	9.7	4.8	3.3	7.0	15.0	12.2	14.9
At least 21 years	14,890	74.5	77.6	67.7	7.4	6.6	10.0	4.2	4.0	5.6	13.9	11.7	16.7
Selected medical conditions:													
Hypertension:													
Has	15,550	60.2	67.1	60.5	12.1	9.9	11.9	6.4	5.2	6.7	21.3	17.8	20.9
Does not have	21,244	77.1	78.5	74.5	7.2	7.1	8.8	3.9	4.1	5.1	11.9	10.3	11.7
Arthritis:													
Has	18,220	57.7	62.7	57.4	12.3	11.2	12.2	6.6	6.7	7.8	23.4	19.5	22.5
Does not have	18,272	80.7	84.5	81.0	6.7	5.4	7.6	3.4	2.6	3.4	9.2	7.5	8.0

¹Elderly defined as aged 60 years and older.

²Excludes other races.

³Persons of Hispanic origin may be of any race.

⁴Includes anyone (relative or nonrelative) who could be a potential care-giver.

⁵Excludes those who never worked.

Appendix table 6--Functional limitations of the elderly, by residence and selected characteristics, 1984¹

Characteristics	Number of elders	No functional limitations			One to three limitations			Four or more limitations		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	-----Percent-----								
Demographic:										
Age:										
60-74 years	27,034	52.2	56.7	46.8	24.9	25.8	29.0	22.9	17.5	24.2
75 years and older	10,115	32.8	36.9	31.1	29.9	27.4	29.4	37.3	35.7	39.5
Gender:										
Male	15,885	56.3	60.3	49.0	24.8	23.1	27.4	18.9	16.6	23.6
Female	21,264	40.7	44.8	37.0	27.2	28.6	30.4	32.0	26.6	32.6
Race: ²										
White	33,543	48.2	52.1	43.1	26.2	26.4	29.4	25.6	21.5	27.5
Black	3,168	40.4	36.5	32.1	27.1	24.3	25.3	32.6	39.3	42.5
Ethnicity: ³										
Hispanic	1,163	38.1	46.1	42.2	27.8	30.8	17.0	34.1	23.1	40.8
Non-Hispanic	35,854	47.4	51.8	42.3	26.2	26.1	29.2	26.4	22.1	28.5
Marital status:										
Married	22,568	53.6	57.3	46.5	25.2	24.4	30.0	21.3	18.3	23.6
Widowed, divorced, or separated	12,847	37.3	40.2	33.1	28.2	29.5	28.6	34.5	30.3	38.3
Never married	1,636	51.5	49.5	51.6	23.8	30.2	18.8	24.7	20.3	29.6
Social support:										
Living arrangements:										
Live alone	10,099	39.7	44.3	34.9	28.9	30.5	29.9	31.4	25.2	35.2
Live with spouse	22,148	53.7	57.6	46.6	25.2	24.4	30.0	21.1	18.0	23.3
Live with other relative or nonrelative	4,902	39.1	35.8	36.2	24.4	27.2	22.0	36.5	37.0	41.9

See footnotes at end of table.

Continued--

Appendix 6--Functional limitations of the elderly, by residence and selected characteristics, 1984¹--Continued

Characteristics	Number of elders	No functional limitations			One to three limitations			Four or more limitations		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	<i>Percent</i>								
Someone to provide care:⁴										
No one	3,739	35.3	34.8	30.3	25.7	28.8	29.0	39.0	36.5	40.7
Household relative	20,876	52.0	56.1	47.0	25.3	24.1	28.7	22.7	19.7	24.3
Relative not in household	9,900	43.5	48.5	37.8	28.3	29.2	30.0	28.2	22.3	32.1
Nonrelative	1,906	44.4	46.4	39.8	27.6	30.9	26.9	28.0	22.6	33.3
Socioeconomic:										
Education:										
Less than high school	17,574	39.4	41.0	34.9	26.7	29.0	29.3	33.9	30.0	35.8
High school, 4 years	11,595	54.0	56.8	48.8	25.5	25.5	30.9	20.5	17.7	20.2
College, 1 or more years	7,551	55.0	62.5	54.6	27.0	23.0	25.4	18.1	14.5	20.0
Employment status in past 2 weeks:										
Employed	7,838	70.4	71.3	64.9	21.3	22.0	25.7	8.4	6.6	9.4
Unemployed	399	56.0	64.3	51.4	34.9	19.5	24.1	9.2	16.2	24.4
Not in labor force	28,912	40.6	45.4	36.7	27.5	27.6	29.9	32.0	27.1	33.3
Income:										
Less than \$20,000	23,553	41.2	43.2	36.8	27.6	29.5	30.1	31.2	27.3	33.1
\$20,000 or more	11,809	59.5	61.8	57.1	23.3	22.2	26.9	17.1	16.0	16.0
Poverty status:										
Below poverty	4,500	29.1	28.4	28.1	27.2	29.2	26.4	43.8	42.4	45.6
Above poverty	26,869	49.9	53.1	44.7	26.4	26.5	30.5	23.7	20.4	24.9
Retirement status:⁵										
Completely retired	25,429	40.4	45.4	35.9	27.5	27.5	30.3	32.1	27.1	33.7
Partly retired	3,082	56.3	61.8	51.8	27.4	26.1	31.8	16.3	12.1	16.4
Not retired	7,087	69.2	70.1	64.3	20.9	22.4	23.6	9.9	7.5	12.1

See footnotes at end of table.

Continued--

Appendix 6--Functional limitations of the elderly, by residence and selected characteristics, 1984¹--Continued

Characteristics	Number of elders	No functional limitations			One to three limitations			Four or more limitations		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	----- <i>Percent</i> -----								
Residential:										
Region:										
Northeast	8,614	52.0	56.5	49.7	24.0	22.5	28.3	24.0	21.0	22.1
Midwest	9,433	44.3	50.7	44.0	29.5	27.8	28.3	26.2	21.5	27.7
South	12,524	41.7	46.8	38.0	27.3	26.1	29.4	31.0	27.0	32.5
West	6,578	52.1	51.1	45.4	23.5	29.6	30.4	24.4	19.3	24.2
Length of residence:										
Less than 1 year	1,873	43.7	50.1	41.3	26.7	23.5	28.9	29.7	26.5	29.9
1-10 years	11,573	40.3	45.9	42.0	26.9	27.2	29.8	32.8	26.8	28.2
11-20 years	8,553	49.1	51.1	42.8	22.9	29.0	28.4	27.9	19.9	28.8
At least 21 years	14,918	50.5	56.3	42.3	27.8	24.2	29.0	21.7	19.5	28.7
Selected medical conditions:										
Hypertension:										
Has	15,581	35.3	42.5	32.2	27.5	28.6	31.2	37.2	29.0	36.6
Does not have	21,300	55.8	57.6	50.5	25.3	24.6	27.4	18.8	17.8	22.1
Arthritis:										
Has	18,266	28.4	33.5	26.1	32.1	32.7	33.0	39.5	33.8	40.9
Does not have	18,306	63.7	68.2	61.2	21.2	20.1	24.4	15.2	11.6	14.4

¹Elderly defined as aged 60 years and older.

²Excludes other races.

³Persons of Hispanic origin may be of any race.

⁴Includes anyone (relative or nonrelative) who could be a potential care-giver.

⁵Excludes those who never worked.

Appendix table 7--Use of health care services by the elderly, by age and residence, 1984¹

Characteristics	Units	Residence				
		U.S. total	Metro			Nonmetro
			Total	Central city	Suburb	
Elderly aged 60 years and older:						
Number	<i>Thousands</i>	37,256	23,793	10,089	13,704	13,463
Doctor visits in past 12 months:						
None	<i>Percent</i>	19.5	18.6	20.0	17.6	21.2
1-11	<i>do.</i>	67.8	68.0	64.8	70.3	67.4
12 or more	<i>do.</i>	12.7	13.4	15.2	12.1	11.4
Short stay in hospital in past 12 months:						
None	<i>Percent</i>	82.3	82.8	83.3	82.4	81.6
1-30 days	<i>do.</i>	16.2	15.8	15.3	16.1	17.0
31 or more days	<i>do.</i>	1.5	1.5	1.4	1.5	1.4
Ever resident/patient in nursing home:						
Yes	<i>Percent</i>	1.5	1.5	1.7	1.3	1.5
No	<i>do.</i>	97.5	97.3	96.7	97.8	97.9
Unknown	<i>do.</i>	.9	1.1	1.6	.8	.6
Use of formal health care services:						
No use	<i>Percent</i>	18.9	17.9	19.2	17.0	20.6
Moderate use	<i>do.</i>	66.4	66.7	63.3	69.1	65.9
High use	<i>do.</i>	14.7	15.4	17.5	13.9	13.5
Having 1 or more ADL or IADL difficulties:						
Number	<i>Thousands</i>	10,823	6,555	3,011	3,544	4,268
Doctor visits in past 12 months--						
None	<i>Percent</i>	10.5	9.5	8.4	10.4	12.1
1-11	<i>do.</i>	63.6	62.8	61.4	64.0	64.9
12 or more	<i>do.</i>	25.8	27.7	30.2	25.6	23.0
Short stay in hospital in past 12 months--						
None	<i>Percent</i>	68.7	69.0	69.1	68.9	68.3
1-30 days	<i>do.</i>	27.4	27.0	27.3	26.7	28.1
12 or more days	<i>do.</i>	3.9	4.0	3.6	4.4	3.6
Ever resident/patient in nursing home--						
Yes	<i>Percent</i>	4.3	4.4	4.1	4.6	4.1
No	<i>do.</i>	95.3	95.1	95.3	95.0	95.4
Unknown	<i>do.</i>	.5	.5	.5	.4	.5
Use of formal health care services--						
No use	<i>Percent</i>	9.6	8.5	7.7	9.3	11.2
Moderate use	<i>do.</i>	59.4	58.7	57.3	59.9	60.6
High use	<i>do.</i>	31.0	32.7	35.0	30.8	28.2

See footnote at end of table.

Continued--

Appendix table 7--Use of health care services by the elderly, by age and residence, 1984¹--Continued

Characteristics	Units	Residence				Nonmetro
		U.S. total	Metro			
			Total	Central city		
Reporting their health as fair or poor:						
Number	<i>Thousands</i>	11,478	6,820	3,162	3,657	4,658
Doctor visits in past 12 months--						
None	<i>Percent</i>	11.0	10.3	10.6	10.1	12.1
1-11	<i>do.</i>	63.8	62.5	60.4	64.3	65.6
12 or more	<i>do.</i>	25.2	27.2	29.0	25.6	22.3
Short stay in hospital in past 12 months--						
None	<i>Percent</i>	69.6	69.3	70.3	68.3	70.2
1-30 days	<i>do.</i>	26.8	26.9	26.3	27.4	26.6
31 or more days	<i>do.</i>	3.6	3.9	3.4	4.3	3.2
Ever resident/patient in nursing home--						
Yes	<i>Percent</i>	3.0	3.1	3.0	3.3	2.8
No	<i>do.</i>	96.1	95.6	95.4	95.8	96.7
Unknown	<i>do.</i>	.9	1.2	1.6	.9	.5
Use of formal health care services--						
No use	<i>Percent</i>	10.3	9.5	9.9	9.2	11.3
Moderate use	<i>do.</i>	60.6	59.3	57.1	61.1	62.4
High use	<i>do.</i>	29.2	31.2	33.0	29.7	26.2
Elderly aged 60-74 years:						
Number	<i>Thousands</i>	27,110	17,533	7,353	10,179	9,578
Doctor visits in past 12 months:						
None	<i>Percent</i>	20.7	19.9	21.2	18.9	22.3
1-11	<i>do.</i>	67.2	67.4	64.1	69.7	67.0
12 or more	<i>do.</i>	12.0	12.8	14.7	11.4	10.7
Short stay in hospital in past 12 months:						
None	<i>Percent</i>	84.4	84.6	84.6	84.6	84.1
1-30 days	<i>do.</i>	14.4	14.2	14.1	14.3	14.8
31 or more days	<i>do.</i>	1.2	1.2	1.2	1.2	1.1
Ever resident/patient in nursing home:						
Yes	<i>Percent</i>	.7	.8	.9	.7	.6
No	<i>do.</i>	98.4	98.2	97.7	98.6	98.9
Unknown	<i>do.</i>	.8	1.0	1.4	.7	.5
Use of formal health care services:						
No use	<i>Percent</i>	20.2	19.3	20.5	18.4	21.8
Moderate use	<i>do.</i>	66.6	66.7	63.4	69.1	66.3
High use	<i>do.</i>	13.2	14.0	16.1	12.5	11.9

See footnote at end of table.

Continued--

Appendix table 7--Use of health care services by the elderly, by age and residence, 1984¹--Continued

Characteristics	Units	Residence				
		U.S. total	Metro			Nonmetro
			Total	Central city	Suburb	
Elderly aged 75 years and older:						
Number	<i>Thousands</i>	10,145	6,260	2,736	3,524	3,885
Doctor visits in past 12 months:						
None	<i>Percent</i>	16.3	15.0	16.6	13.7	18.5
1-11 visits	<i>do.</i>	69.2	69.7	66.6	72.1	68.3
12 or more visits	<i>do.</i>	14.5	15.3	16.8	14.2	13.2
Short-stay hospital episode days in past 12 months:						
None	<i>Percent</i>	76.8	77.6	79.5	76.1	75.4
1-30 days	<i>do.</i>	21.0	20.1	18.4	21.4	22.5
31 or more days	<i>do.</i>	2.2	2.3	2.1	2.5	2.1
Ever resident/patient in nursing home:						
Yes	<i>Percent</i>	3.6	3.6	4.0	3.2	3.7
No	<i>do.</i>	95.1	94.9	94.1	95.6	95.5
Unknown	<i>do.</i>	1.2	1.5	1.9	1.2	.7
Use of formal health care services:						
No use	<i>Percent</i>	15.5	14.1	15.5	13.0	17.7
Moderate use	<i>do.</i>	65.8	66.5	63.2	69.1	64.7
High use	<i>do.</i>	18.7	19.4	21.3	17.9	17.6

¹Elderly defined as aged 60 years and older.

Appendix table 8--Use of formal health care services by the elderly, by residence and selected characteristics, 1984¹

Characteristics	Number of elders	None used			Moderate use			High use		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	<i>Percent</i>								
Demographic:										
Age:										
60-74 years	26,830	20.5	18.4	21.8	63.4	69.1	66.3	16.1	12.5	11.9
75 years and older	10,007	15.5	13.0	17.7	63.2	69.1	64.7	21.3	17.9	17.6
Gender:										
Male	15,750	23.2	19.4	22.5	61.2	68.4	64.8	15.6	12.1	12.8
Female	21,087	16.5	15.2	19.2	64.8	69.6	66.7	18.7	15.2	14.1
Race:²										
White	33,268	19.5	17.1	20.6	63.9	69.4	66.4	16.6	13.5	13.1
Black	3,139	18.0	16.2	21.9	60.4	63.6	58.2	21.6	20.3	19.9
Ethnicity:³										
Hispanic	1,152	20.9	17.9	17.1	49.2	64.4	67.1	29.9	17.7	15.8
Non-Hispanic	35,564	19.1	17.1	20.6	64.1	69.3	65.9	16.8	13.6	13.5
Marital status:										
Married	22,388	20.3	17.9	21.2	64.7	69.8	67.4	15.0	12.4	11.3
Widowed, divorced, or separated	12,736	17.6	14.7	18.3	61.7	68.1	64.4	20.7	17.1	17.3
Never married	1,621	19.0	23.0	30.1	62.3	64.9	52.6	18.8	12.1	17.3
Social support:										
Living arrangements:										
Live alone	10,014	17.0	15.8	19.0	63.4	68.6	64.3	19.6	15.6	16.7
Live with spouse	21,977	20.4	17.8	21.1	64.7	70.0	67.6	14.9	12.2	11.3
Live with other relative or nonrelative	4,846	19.4	15.6	22.0	58.6	65.8	60.1	22.0	18.6	17.9

See footnotes at end of table.

Continued--

Appendix table 8--Use of formal health care services by the elderly, by residence and selected characteristics, 1984¹--Continued

Characteristics	Number of elders	None used			Moderate use			High use		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	<i>Percent</i>								
Someone to provide care:⁴										
No one	3,723	18.2	14.3	20.0	59.0	66.0	62.3	22.8	19.7	17.7
Household relative	20,783	21.2	17.6	22.3	63.2	69.2	65.6	15.6	13.1	12.2
Relative not in household	9,864	17.2	16.7	17.4	65.9	70.4	68.0	17.0	12.8	14.5
Nonrelative	1,891	15.2	16.1	21.2	62.8	68.6	64.0	22.0	15.3	14.8
Socioeconomic:										
Education:										
Less than high school	17,404	19.7	17.0	20.8	59.4	67.2	64.5	21.0	15.8	14.7
High school, 4 years	11,536	20.0	17.3	21.3	66.4	70.3	67.1	13.6	12.4	11.7
College, 1 or more years	7,479	15.8	16.7	18.0	69.4	70.5	69.0	14.8	12.8	13.0
Employment status in past 2 weeks:										
Employed	7,794	25.6	22.9	27.4	65.8	69.4	66.5	8.6	7.7	6.1
Unemployed	397	30.6	20.9	15.7	62.4	67.5	70.3	7.0	11.6	14.0
Not in labor force	28,646	17.3	15.2	19.0	62.7	69.0	65.7	20.0	15.8	15.3
Income:										
Less than \$20,000	23,352	18.4	17.2	20.9	62.8	67.1	64.3	18.8	15.6	14.7
\$20,000 or more	11,751	19.9	16.5	19.2	65.2	71.7	70.7	14.9	11.9	10.0
Poverty status:										
Below poverty	4,461	21.0	18.1	21.9	54.0	63.3	58.4	25.0	18.6	19.8
Above poverty	26,715	18.6	16.5	20.3	65.7	70.1	67.5	15.7	13.4	12.2
Residential:										
Region:										
Northeast	8,537	20.6	17.8	21.3	60.2	68.1	65.3	19.1	14.1	13.4
Midwest	9,355	21.2	18.0	20.2	64.0	69.7	65.9	14.8	12.3	13.9
South	12,413	17.7	14.7	19.8	65.6	72.4	67.1	16.7	12.9	13.1
West	6,532	16.9	17.5	23.7	63.0	66.1	62.1	20.0	16.4	14.2

See footnotes at end of table.

Continued--

Appendix table 8--Use of formal health care services by the elderly, by residence and selected characteristics, 1984¹--Continued

Characteristics	Number of elders	None used			Moderate use			High use		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	----- <i>Percent</i> -----								
Length of residence:										
Less than 1 year	1,856	17.9	15.2	25.0	61.0	69.5	60.2	21.0	15.4	14.8
1-10 years	11,457	19.6	16.7	21.6	59.3	67.8	64.4	21.1	15.5	14.1
11-20 years	8,493	17.9	16.1	18.5	64.3	70.5	68.6	17.8	13.4	12.9
At least 21 years	14,811	19.7	18.2	20.3	65.7	69.2	66.6	14.6	12.7	13.1
Selected medical conditions:										
Hypertension:										
Has	15,471	7.9	7.6	10.4	69.8	74.8	71.7	22.3	17.6	17.9
Does not have	21,139	27.4	23.1	28.9	58.8	65.4	61.2	13.8	11.5	9.9
Arthritis:										
Has	18,117	12.0	12.3	15.5	65.6	69.8	66.3	22.4	17.9	18.2
Does not have	18,185	25.7	21.2	26.4	61.3	68.6	65.6	13.1	10.2	7.9

¹Elderly defined as aged 60 years and older.²Excludes other races.³Persons of Hispanic origin may be of any race.⁴Includes anyone (relative or nonrelative) who could be a potential care-giver.

Appendix table 9--Use of formal health care services by the elderly in fair or poor health, by residence and selected characteristics, 1984¹

Characteristics	Number of elders	None used			Moderate use			High use		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	<i>Percent</i>								
Demographic:										
Age:										
60-74 years	8,003	10.0	10.8	11.6	57.1	61.1	64.8	32.8	28.1	23.6
75 years and older	3,338	9.5	5.7	10.8	56.9	61.2	56.9	33.6	33.1	32.4
Gender:										
Male	4,881	12.9	11.9	12.2	58.6	60.8	63.6	28.5	27.3	24.1
Female	6,461	8.0	7.1	10.6	56.1	61.4	61.5	35.9	31.6	27.9
Race:²										
White	9,639	10.4	9.1	11.2	56.6	61.6	62.6	33.0	29.3	26.2
Black	1,560	8.8	11.3	13.0	58.5	59.8	59.1	32.7	28.9	27.9
Ethnicity:³										
Hispanic	457	9.1	15.9	12.3	41.6	50.3	64.5	49.3	33.8	23.2
Non-Hispanic	10,839	10.0	9.0	11.2	58.2	61.5	62.4	31.8	29.5	26.4
Marital status:										
Married	6,695	11.2	10.9	11.9	59.2	63.4	65.5	29.7	25.7	22.5
Widowed, divorced, or separated	4,155	8.2	5.7	9.9	55.2	56.5	57.5	36.6	37.8	32.6
Never married	481	11.2	14.0	14.2	52.7	64.3	57.7	36.1	21.7	28.1
Social support:										
Living arrangements:										
Live alone	2,890	8.5	7.3	9.8	55.8	55.7	58.2	35.7	37.0	32.0
Live with spouse	6,546	11.2	11.0	11.9	58.9	63.3	65.6	29.8	25.7	22.4
Live with other relative or nonrelative	1,905	8.6	5.5	11.6	54.4	59.9	56.6	37.0	34.6	31.8

See footnotes at end of table.

Continued--

Appendix table 9--Use of formal health care services by the elderly in fair or poor health, by residence and selected characteristics, 1984¹--
Continued

Characteristics	Number of elders	None used			Moderate use			High use		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	-----Percent-----								
Someone to provide care: ⁴										
No one	1,383	11.4	7.5	14.2	50.3	57.5	55.7	38.3	35.0	30.1
Household relative	6,110	10.9	10.0	13.0	58.6	60.7	62.4	30.5	29.4	24.6
Relative not in household	3,092	8.9	8.2	7.8	59.9	65.2	64.0	31.1	26.5	28.2
Nonrelative	564	3.2	7.4	6.5	54.0	63.2	71.5	42.8	29.4	22.1
Socioeconomic:										
Education:										
Less than high school	7,084	10.3	10.3	12.6	55.3	61.2	62.8	34.4	28.5	24.6
High school, 4 years	2,690	8.9	7.9	9.6	60.5	64.3	62.3	30.6	27.8	28.0
College, 1 or more years	1,407	6.6	8.1	3.2	59.7	55.2	62.8	33.8	36.7	34.0
Employment status in past 2 weeks:										
Employed	1,270	10.1	18.2	19.9	69.1	65.2	70.2	20.8	16.6	9.8
Unemployed	85	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)
Not in labor force	9,986	9.8	8.0	10.3	55.5	60.5	61.4	34.6	31.4	28.3
Income:										
Less than \$20,000	8,541	9.0	10.3	11.5	56.9	59.7	62.3	34.0	30.0	26.2
\$20,000 or more	2,336	10.2	6.1	10.7	58.1	63.9	63.8	31.6	30.0	25.5
Poverty status:										
Below poverty	2,185	7.4	11.8	12.3	50.7	54.5	57.8	41.9	33.7	29.9
Above poverty	7,531	9.8	8.5	11.4	59.7	62.5	64.2	30.5	29.0	24.4

See footnotes at end of table.

Continued--

**Appendix table 9--Use of formal health care services by the elderly in fair or poor health, by residence and selected characteristics, 1984¹--
Continued**

Characteristics	Number of elders	None used			Moderate use			High use		
		Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro	Central city	Suburb	Nonmetro
	<i>Thousands</i>	<i>Percent</i>								
Residential:										
Region:										
Northeast	2,253	11.9	8.2	10.4	52.2	59.2	56.8	35.9	32.7	32.7
Midwest	2,791	11.7	8.2	10.0	58.3	65.6	61.4	30.0	26.2	28.5
South	4,628	7.8	10.3	11.8	62.2	65.0	65.2	29.9	24.7	23.0
West	1,669	8.7	10.4	13.5	50.7	53.1	56.1	40.6	36.5	30.5
Length of residence:										
Less than 1 year	628	2.4	7.9	10.2	59.1	60.4	62.1	38.6	31.7	27.7
1-10 years	3,810	9.6	7.7	12.5	53.5	58.3	60.6	37.0	34.0	26.9
11-20 years	2,693	8.5	10.0	9.8	56.7	61.8	63.8	34.9	28.2	26.4
At least 21 years	4,137	12.3	10.3	11.4	60.4	63.6	63.4	27.3	26.2	25.2
Selected medical conditions:										
Hypertension:										
Has	6,072	5.2	5.0	7.1	59.4	63.8	62.9	35.4	31.2	30.0
Does not have	5,178	15.0	13.5	16.4	55.1	58.3	62.1	30.0	28.2	21.5
Arthritis:										
Has	7,205	7.6	8.1	10.3	56.8	59.8	60.6	35.6	32.1	29.2
Does not have	3,950	13.4	10.3	13.9	57.5	63.9	66.6	29.1	25.8	19.5

(B) Base too small to show percentages.

¹Elderly defined as aged 60 years and older.

²Excludes other races.

³Persons of Hispanic origin may be of any race.

⁴Includes anyone (relative or nonrelative) who could be a potential care-giver.



SUMMARY OF REPORT

Family Support Act's Likely Effect on Rural Poverty Outlined in New Report

Number 15, April 1993

Contact: Robert A. Hoppe (202) 219-0807

The Family Support Act will help some rural poor escape from welfare rolls, but it is not a cure for poverty or welfare, according to a new USDA report. The new report, *The Family Support Act: Will It Work In Rural Areas?*, from USDA's Economic Research Service, examines the potential effectiveness of the Family Support Act (FSA) of 1988 in rural areas.

The Family Support Act's emphasis on education and training will help the rural poor become self-supporting. However, the act is targeted largely at poor families headed by women and, thus, will not reach all of the poor. In addition, certain conditions specific to rural areas, such as lack of services and jobs and geographically scattered services, could hinder success.

The FSA is major welfare reform legislation that focuses on the Aid to Families with Dependent Children (AFDC) program, which is targeted largely at female-headed families. Goals of the FSA are to encourage work by AFDC parents through the Job Opportunities and Basic Skills Training (JOBS) program and to encourage responsibility of absent parents for their offspring through stricter enforcement of child-support provisions. The act could eventually reduce welfare dependency and costs to the Government. Most of the provisions have already taken effect, but it is still too early to gauge how successful the FSA will be.

The poor population in female-headed families is large and growing in rural areas. About 30 percent of the rural poor now live in female-headed families. This means, however, that the FSA will not reach the remaining 70 percent of the rural poor. Furthermore, the FSA will not equally affect all poor, female-headed families.

Success of the act depends on success of State and local officials at implementing it. They differ greatly in their ability to take advantage of the FSA. Some of the most serious obstacles to success of the act are related to characteristics of rural areas themselves: the lack of services and jobs. Rural areas have fewer services than urban areas and more geographically dispersed

services. And, the lack of jobs may mean that rural labor markets have difficulty absorbing graduates of the JOBS program.

A related problem is the southern concentration of nonmetro poor in female-headed families. The Southern States in particular may have problems meeting matching requirements necessary to fund the services required by the act.

The act does have features favorable to rural areas. Extending Aid to Families with Dependent Children-Unemployed Parent (AFDC-UP) to all States is helpful to the rural poor, who tend to live in States that did not previously have the program. The number of rural poor meeting the eligibility criteria for the new program is relatively small, however. The act also provides funding to encourage States to provide transportation and child care for JOBS participants. The act's emphasis on education and training should also help some rural AFDC parents with low skills, training, and education levels escape poverty and welfare dependency. And, the work orientation of the act should fit the work ethic of rural people, both the poor and the nonpoor.

To Order This Report...

The information presented here is excerpted from *The Family Support Act: Will It Work In Rural Areas?*, RDRR-83, by Robert A. Hoppe. The cost is \$15.00.

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