Survey Sketches New Portrait of Aging America

Millions of Americans in their 50s face an uncertain future, lacking health insurance or pensions, or fearing that they will lose the benefits they do have. Almost half of people nearing retirement believe there is some likelihood that they could be laid off permanently during the next year and that their chances of landing a new job are 50-50 or less. There is general frustration with the retirement process as well. Nearly three-quarters of older workers would prefer to retire gradually, phasing down from full-time to part-time work instead of retiring abruptly as many are now forced to do.

These issues of work flexibility and job and benefits security are important to Americans nearing retirement, according to initial findings from a new and sweeping national survey of more than 13,000 people. The survey found that a substantial number of people—especially minorities—lack pension coverage or health insurance. The data suggest that some 4.5 million Americans in their 50s have no health insurance at all. Despite these constraints, however, these fiftysomethings are generous to their families, giving substantial amounts of time or money to adult children and grandchildren as well as to frail and aging parents.

This emerging portrait of Americans ages 51 through 61 and their spouses comes from the Health and Retirement Study (HRS), conducted by the University of Michigan's Institute for Social Research (ISR). The survey is one of the largest and most innovative longitudinal studies ever undertaken to understand better how people fare as they age. Funded by the National Institute on Aging (NIA) of the National Institutes of Health, the HRS was started in 1990 to address two critical social phenomena—the retirement of the "baby boom" generation and the aging of society generally. Data from the survey are expected to be widely used by researchers and policy makers looking at health care and pension reform.

"People nearing retirement are mostly in pretty good shape physically, mentally, and economically," according to study director F. Thomas Juster, PhD, a senior research scientist with the ISR's Survey Research Center and professor of economics at Michigan. "But behind the averages are large proportions of people falling into some category—ill or disabled, without pensions, insurance, or assets, or lacking family support—that may rob them of a satisfying and successful retirement." Juster presented early results of the study at a June 17, 1993, briefing in Washington, DC.

Key findings from the survey:

- Median income among HRS households was about $37,500, with median assets about $80,000. About 20 percent of the couples reported virtually no assets.
- About two-thirds of HRS respondents report themselves to be in excellent or very good health, but significant numbers are disabled. Among people who are not working, the most common reason for leaving the last job was poor health or disability. This group cites twice as many serious health problems as people staying at work, and at least four times the prevalence of a heart condition, chronic lung disease, or stroke. About 26 percent of currently disabled workers say employers accommodate their disability.
- About one in seven HRS respondents is not covered by any kind of health insurance. Noncoverage is substantially higher among black and especially among Hispanic households.
- Private pension coverage varies considerably. About two in five respondents will have no pension income at all, and about three in five can expect some. Pension coverage is strongly related to wage rates. Blacks and whites with the lowest wages are less likely to have a pension than those with the highest wages by a factor of 10.
- Job flexibility is a critical issue. Almost three-quarters of HRS respondents would prefer to phase down from full-time work to part-time work when they retire, in sharp contrast to actual behavior, where most people who retire leave the workforce entirely. About one-third of the people who would not look for another job are victims of "job lock," unable to leave because they might give up valuable pensions or health insurance benefits if they switched employers.

In addition to financial and health factors, the HRS also looks at how family needs and obligations affect the decision to retire. Family structure in this age group provides ample opportunities for intergenerational transfers of both time and money.

About 70 percent of married couples are part of four-generation families. Help to children and grandchildren is common and significant. More than one-third of HRS parents gave at least $500 to a child in 1992. Many grandparents, mostly grandmothers, provide more than 100 hours of child care per year. HRS respondents and their siblings give substantial help to frail parents. About two-thirds of those surveyed have living parents or parents-in-law, with about one-third having older, frail parents in need of personal care or requiring supervision. In three-generation families, HRS respondents favor children over parents. For those giving help to both children and parents, the median amounts are almost $4,000 to children and about $1,000 to parents.

These and other findings are from the first wave of the HRS, in which nearly 13,000 randomly sampled people were interviewed over the past year. Almost 70,000 households were screened to identify the HRS sample. The interviews averaged more than 90 minutes with principal participants, somewhat less with their husbands or wives. People were asked questions about their current job, including earnings, flexibility, and job demands; work history; assets and debts; pension programs; health conditions and health insurance; disability; family structure and family responsibilities; housing; and expectations about the future. In order to get critical information on minorities, the survey oversampled blacks and Hispanics. A special sample also was taken in Florida because of its high concentration of older people.

The NIA plans to continue the study for the next 12 years. "These early results are just the tip of the iceberg," says Richard Suzman, PhD, chief of

demography and population epidemiology at the NIA. "As we follow people into retirement, we will generate an astounding amount of high-quality data that researchers and policymakers have needed for years, since the last national retirement survey ended in 1979."

A new study piggy-backing on the HRS screening effort will be launched in October 1993. The study, called AHEAD, will look at the lives of the oldest Americans, especially those older than age 85. There is very little information on the oldest old, even though they represent the fastest growing segment of the population.

During its first 5 years, the HRS study is expected to cost about $13.5 million. It took about 18 months and significant funding to plan and conduct test runs of the study, with dozens of experts from the public policy and research communities, as well as government, advising the NIA on the study's design. Additional support for HRS comes from other Department of Health and Human Services agencies, including the Assistant Secretary for Planning and Evaluation and the Social Security Administration, as well as the Department of Labor.

1992 Household Survey Shows U.S. Drug Use Decline Continues

Results from the 1992 National Household Survey on Drug Abuse show a continuing overall declining pattern of drug use in the U.S. population. The number of Americans ages 12 and older currently using illegal drugs decreased 11 percent, from 12.8 million in 1991 to 11.4 million in 1992.

The survey also showed that, contrary to broader trends, use of drugs among those ages 35 and older is at the same level as in 1979. This level trend among older adults is believed to be related to the aging of the heavy drug using groups of the 1970s.

(In two other studies, drug use among college students and other young adults was found to be increasing after a period of decline, and drug and alcohol abuse was found to be responsible for 20 percent of all Medicaid spending for hospital care.

University of Michigan researchers said their annual survey showed use of marijuana and LSD on college campuses and among other young adults was up for the first time in several years. The Center on Addiction and Substance Abuse at Columbia University estimated that one of every five dollars for hospital care funded under Medicaid is for conditions brought on by abuse of alcohol, tobacco, and both legal and illegal drugs.)

The household survey is carried out annually by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Public Health Service and is intended to estimate the prevalence of legal and illegal drug use in the United States each year as well as to monitor trends in prevalence of drug use over time.

It is based on a multistage area probability sample of 28,832 people ages 12 and older throughout the nation and covers persons living in households and in some group quarters such as dormitories and homeless shelters. The survey covers a range of substances, from illegal drugs such as marijuana and cocaine, to alcohol, tobacco, and smokeless tobacco.

Findings from the 1992 survey show that the number of illicit drug users continued to decline from a peak of 24 million in 1979. Additional findings about specific drugs follow.

Illegal drugs. Since 1979, overall rates of current (last 30 days) illegal drug use have dropped in all age groups (12–17, 18–25, and 26–34) except those ages 35 and older, whose use of drugs has remained level. This observation has resulted in a general shift in the age distribution of illegal drug users. In 1992, 23 percent of illegal drug users were ages 35 and older, compared with only 10 percent in 1979.

Cocaine. The number of current cocaine users decreased 31 percent from 1.9 million in 1991 to 1.3 million in 1992. This is down from a peak of 5.8 million in 1985.

The number of occasional cocaine users (people who used in 1992 but less often than monthly) also continued a sharp decline, from 8.6 million in 1985 to 5.8 million in 1988, 4.3 million in 1991, and 3.4 million in 1992.

Frequent use of cocaine, defined as use on a weekly basis, remained unchanged between 1991 and 1992 at about 640,000 users. In fact, no significant change has occurred in this number since it was first estimated in 1985.

Marijuana. Marijuana is the most common illegal drug, used by 78 percent of all illegal drug users in 1992. Fifty-nine percent of current illegal drug users had used only marijuana, 19 percent had used marijuana and another illegal drug, and 22 percent had used illegal drugs other than marijuana in the past month.

Other illegal drug use. The study noted no major changes in the prevalence of the use of hallucinogens, such as LSD and PCP, between 1991 and 1992, while the prevalence of inhalant use, such as gasoline, glue, and nitrites, dropped slightly.

Nonmedical use of prescription drugs. The estimated prevalence rates for nonmedical use of psychotherapeutics (sedatives, tranquilizers, stimulants, or analgesics) in the past month also showed significant decreases between 1988 and 1992 and between 1991 and 1992.

Alcohol. The 1992 survey found that approximately 98 million people ages 12 and older had used alcohol in the past month, about 48 percent of the total population in this age group. Alcohol use has exhibited a gradual downward trend since 1988 when there were an estimated 106 million drinkers. In 1992 about 10 million Americans were heavy drinkers; no decreases have occurred in this measure since 1988. Heavy drinking is defined as taking five or more drinks per occasion on 5 or more days in the past 30 days.

Cigarettes. The survey found that 54 million Americans were current smokers in 1992, or 26 percent of the population. Current cigarette smoking has declined since 1988, when 29 percent of the population smoked tobacco.

Smokeless tobacco. An estimated 7.5 million Americans were current users of smokeless tobacco in 1992, about the same as in 1988. The rate of smokeless tobacco use in 1992 was 7.1 percent for men and 0.5 percent for women.

Dr. Elaine M. Johnson, Acting Administrator of SAMHSA, commenting on the results of the survey, said, "We are encouraged to note a broadbased decline in the use not only of illegal drugs, but also of alcohol and tobacco.

Other SAMSHA data show, however, that the number of hospital emergency room episodes caused by drug abuse has recently increased. This means that while fewer people may be using drugs, the impact of their use on the medical system continues to be a problem."

In addition, the survey's demographic variables provided further information on the impact of drug use on various subgroups in the U.S. population. Some changes by demographic variables:

Age. Among 12–17-year-olds, current illegal drug use decreased from 9.2 percent in 1980 to 6.1 percent in 1992. Decreases were also significant for the 18–25 and 26–34 age groups. As in the past, however, the rate of current illegal drug use in 1992 was highest among 18–25-year-olds (13 percent) and 26–34-year-olds (10 percent).

Race-ethnicity. Most illegal drug users in the United States in 1992 were in the white population—76 percent of all current users, or 8.7 million people. Fourteen percent of illicit drug users were African American (1.6 million) and 8 percent were Hispanic (0.9 million).

Decreases in illegal drug use rates have occurred since 1988 among whites (5.5 percent) and Hispanics (5.3 percent). The rate among blacks, which had increased from 7.8 percent in 1988 to 9.4 percent in 1991, also decreased to 6.6 percent in 1992.

Sex. Men continued to have a higher rate of current illegal drug use than women (7.1 percent versus 4.1 percent) in 1992. Among youths ages 12–17, rates of use were similar for males and females. In older age groups, however, the rates of use were substantially higher for men than women. These rates of use represent a significant decrease for both men and women since the 1988 levels of 9.0 percent for men and 5.8 percent for women.

Education. Illegal drug use rates remain highly correlated with educational status. Among 18–34-year-olds in 1992, those who had not completed high school had the highest rate of use (14.3 percent), while college graduates had the lowest rate (7.3 percent).

Employment. Current employment status was also highly correlated with rates of illegal drug use. For instance, 20.7 percent of unemployed 18–34-year-olds were currently using illegal drugs in 1992, nearly twice the rate for those employed full or part-time (10.7 percent).

Urbanicity-region. Since 1988, the difference in prevalence by population density has narrowed. The rate dropped significantly in large metropolitan areas, from 8.9 percent in 1988 to 6 percent in 1992, but it remained virtually unchanged in nonmetropolitan areas (5.8 percent in 1988 and 5.3 percent in 1992).

Copies of the results of the 1992 National Household Survey on Drug Abuse are available upon request from the press office of the Substance Abuse and Mental Health Services Administration, 13C–05 Parklawn Building, Rockville, MD 20857; tel. 301-443-8956.

County Health Department Develops Legionnaires' Control Guidelines

When an outbreak of legionellosis among transplant patients in a Pittsburgh hospital was linked to its water system, the Allegheny County Health Department quickly convened a task force of local experts who developed recommendations on how to prevent and control legionella infection in health care institutions.

"This is the first practical guide ever published in the United States on prevention and control of legionella infection in health care facilities," Allegheny County Health Director Dr. Bruce W. Dixon declared. "After performing an exhaustive review and evaluation of all available studies, our task force concluded there is no uniform opinion on legionella control and decided to offer several options that can be tailored to an individual institution's water system and patient population."

The recommendations include periodic testing of water systems, environmental sampling techniques, procedures to disinfect contaminated systems, plus design, operational, and maintenance methods to control legionella.

The task force issued the following guidelines for health care facilities:

- Test water systems—hot water tanks, faucets, and showerheads—annually, more often in units with transplant patients, who are more vulnerable to infection.
- When legionella are found, disinfect the water system if there are any current or prior cases of hospital-acquired Legionnaires' disease or if 30 percent or more of the samples are contaminated.
- Disinfect using one or any combination of these techniques—raise the chlorine content to 2–6 parts per million; heat water to 158 degrees and flush all outlets or heat water to 190 degrees and blend with cold water to achieve a purging temperature; apply ultraviolet irradiation; or use metallic ionization.
- Design, operate, and maintain water systems in specific ways that minimize the risk of legionella contamination.

The 20-page booklet containing the guidelines can be obtained by telephoning the Allegheny County Health Department in Pittsburgh at (412) 687-ACHD.

New Surgeon General's AIDS Report Provides Updated Information

"The Surgeon General's Report on HIV and AIDS," an updated version of the Public Health Service's 1986 report, addresses several new topics:

- The impact of AIDS on adolescents. Of persons diagnosed with AIDS, 19 percent are in their 20s, which means that they could have become infected while they were teenagers.
- The greater impact of AIDS on some minorities.
- The increase in HIV infection among women—who now comprise 11 percent of all AIDS cases—and their AIDS symptoms.
- The more than 4,000 children reported to have AIDS, and the many more uninfected children being orphaned by the deaths of their infected parents.
- New treatments for HIV and opportunistic infections that have lengthened the productive lives of persons living with HIV and AIDS.

• Changes in the Food and Drug Administration's drug testing and approval systems to make drugs available sooner.
• Possible vaccines—preventive and therapeutic.
• Other sexually transmitted diseases as factors in increasing susceptibility to HIV infection.
• Non-injecting drugs as a factor in HIV infection when they result in unprotected sex.
• Steps taken to eliminate or reduce HIV risks from blood transfusions, organ and tissue transplants, and artificial insemination.
• The increased risk of tuberculosis in HIV-infected people.
• Sports and HIV risk.
• The role of shared needles and syringes in HIV infection among intravenous drug users.
• The impact of discrimination against HIV-infected persons as a factor promoting the spread of HIV.
• The role of the family in HIV education.
• The necessity of open discussion of sexual issues and both personal and community action to prevent the spread of HIV.
• The value of early detection and treatment of HIV infection.
• More information on living with HIV and AIDS.

The report is available in English and in Spanish from the National AIDS Hotline. Telephone 1-800-342-AIDS, Deaf Access 1-800-243-7889 (TTY), Spanish 1-800-344-7432.

The full text of the report is available for downloading electronically from the Office of the Assistant Secretary for Health Bulletin Board System (OASH BBS). Telephone 202-690-5423.

National Plan Designed to Lower Breast, Cervical Cancer Death Rates

The Department of Health and Human Services (HHS) has developed the National Strategic Plan for the Early Detection and Control of Breast and Cervical Cancer to reduce breast cancer deaths by 30 percent and cervical cancer deaths by 90 percent through increased use of mammogram screening and Papanicolaou (Pap) smears.

Under HHS, three Public Health Service agencies—the Centers for Disease Control and Prevention (CDC), the National Cancer Institute, and the Food and Drug Administration—will represent the Federal Government in the public-private effort that includes such major voluntary organizations as the American Cancer Society and about 75 other groups working together on the project.

The plan seeks to increase to at least 80 percent the number of women ages 40 and older getting mammograms, as well as to increase the use of the Pap test. Only 41 percent of women older than age 40 follow the recommended guidelines for breast cancer screening, and the likelihood of having a mammogram decreases sharply to only 12 percent among women older than age 59. Risk of breast cancer increases significantly with age.

Without action to increase high quality screening and followup services, breast and cervical cancer will take the lives of more than half a million women during the 1990s. For both types of cancer, it is poor, elderly, and minority women who are least likely to be screened. Mortality rates are disproportionately high among these groups despite the existence of proven tools for early detection.

The plan calls for greater access to screening services, increased education of women and health care providers, and improved quality assurance measures for screening mammography and cervical cytology.

The strategic plan represents a national framework in which there are major roles for Federal, State, and local governments; national organizations; the private sector; and the general public. The plan includes six major components:

• Integration and coordination—providing better access to screening services, closing gaps in followup services (including diagnostic and treatment services), and establishing mechanisms to fulfill other plan components.
• Public education—meeting the information needs of the public to ensure that women are aware of the importance of screening and the availability of care.
• Professional education and practice—addressing the information and continuing education needs of health professionals to ensure effective screening and appropriate followup referrals.
• Quality assurance for breast cancer screening—ensuring consistent, high-quality breast cancer screening throughout the entire process of obtaining, interpreting, and reporting mammogram results.
• Quality assurance for cervical cancer screening—ensuring consistent, high-quality cervical cancer screening throughout the entire process of obtaining, interpreting, and reporting Pap smear results.
• Surveillance and evaluation—assessing whether programmatic efforts are achieving the desired results, increasing the number of women screened for these cancers, identifying their cancers earlier, and reducing fatalities.

CDC, the National Cancer Institute, and the Food and Drug Administration coordinated the development of the plan. In 1993, CDC entered into the third year of a national breast and cervical cancer mortality prevention program that will direct $71.3 million to support 30 State health agencies in developing an effective public health infrastructure system for breast and cervical cancer screening and followup services as mandated by the Breast and Cervical Cancer Mortality Prevention Act of 1990.

HRSA, NIAID Join Forces to Find Anti-TB Therapies

An interagency agreement has been reached between two Public Health Service agencies—the National Institute of Allergy and Infectious Diseases (NIAID) and the Health Resources and Services Administration (HRSA) to research selected compounds and natural products as possible therapies against *Mycobacterium tuberculosis.*

According to a memorandum of understanding, NIAID's Division of AIDS will provide $400,000 in Fiscal Year 1993 funds to HRSA's Division of National Hansen's Disease Program for the five-month research project. Researchers will study the effectiveness of more than 4,000 compounds and 1,000 natural products. HRSA and NIAID officials will review the project's findings and approve any experimental protocols that deserve additional research. HRSA officials will submit a final report to NIAID by Dec. 31, 1993.

Treatment Available for Male Impotence

Effective therapies for the 30 million men who suffer from impotence are available, according to a panel of National Institutes of Health (NIH) experts who met recently to discuss the problem.

A major roadblock, however, is that many affected men won't discuss the problem, either with their sexual partner or often with their physician, who, ironically, may also shy away from the topic, say the researchers. Such reluctance to address the condition on the part of both the patient and physician prevents many men from obtaining effective treatment.

The NIH Consensus Development Panel emphasized several crucial points—that men with this problem should obtain a thorough medical examination and treatment from a knowledgeable physician, and that counseling, which is often recommended, include both partners. Such psychological therapy may be useful as part of the overall treatment plan for all patients with erectile dysfunction (the term preferred by the panel), even if a physical cause has been identified. This may help relieve co-existing depression and anxiety, as well as improve sexual function.

The team of experts also negated the widely believed myth that erectile dysfunction occurs normally with age. Although the frequency of impotence does increase with age, it is not a consequence of aging, per se.

Erectile dysfunction may result from a variety of physical causes including high blood pressure, diabetes, vascular disease, and neurological disorders. Prescription medications such as those that treat hypertension may also be implicated, while psychological factors are sometimes to blame. Smoking can also adversely affect a man's ability to achieve erection.

A number of therapies are available. The panel suggested that psychological therapy be the initial option. If a physical cause is identified, the panel recommended that physicians first try the least invasive procedure available, such as medications (available through injection) that increase blood flow to the penis, or vacuum devices that achieve the same result.

Vascular surgery, a more complicated procedure, should only be conducted by qualified, experienced surgeons in a research setting.

These options help many affected men achieve a better quality of life, once they acknowledge the problem and obtain help.

"Increasingly, more and more men are seeking treatment that will allow them to return to a satisfactory (sexual) level and participate in a range of sexual activities," said the panel moderator, Michael Droller, MD, chairman of the Department of Urology, Mount Sinai Medical Center, New York.

—JUDY FOLKENBERG, Science Writer, Office of Communications, NIH.

Copies of the NIH Consensus Development Conference statement on erectile dysfunction are available from NIH Office of Medical Applications of Research, The Federal Building, Room 618, Bethesda, MD 20892; tel. 301-496-1143.

Nursing Research Gets New Status at NIH

The National Institute of Nursing Research (NINR) has become the 17th institute of the National Institutes of Health (NIH).

NINR began as a center at NIH in April 1986. With a structure and mission similar to an NIH institute, the center conducted research programs and supported research and training throughout the country with grants.

As an institute, NINR's purpose is to provide a strong scientific base for nursing practice, answering such questions as: How can nurses help mothers-to-be prevent low birth weight babies? How can the extent of a child's pain be determined so that the right help can be given? What can nurses do to help women deal with the typical symptoms of menopause? How can older people live independent lives as long as possible?

In addition to ameliorating illness, nurse scientists also study health promotion and disease prevention, including how to motivate people to adopt healthy lifestyles. Innovative approaches are developed and tested to improve the delivery of health care through high quality nursing services. Nursing research is strongly collaborative, and its practitioners work closely with those in many health disciplines to find answers to health problems.

Nursing research focuses on how people react to an illness and its treatment. For example, a medical researcher might study how to diagnose the HIV virus sooner, or which drugs and what doses are best to combat HIV infection. A nurse researcher, on the other hand, might study the symptoms patients are experiencing, such as eating problems or muscle wasting, whether they are caused by the disease or the treatment, and how they can be reduced to improve quality of life.

Although the change in status from center to institute does not involve a change in budget, NINR Director Ada Sue Hinshaw, PhD, RN, said, "It does send an important signal to the nursing community and the public." She emphasized that "it strengthens nursing research at the national level, increases its visibility within the health research community, and indicates a permanence and stability for this type of research."

Leprosy Literature Available on Compact Disc

Literature on leprosy covering the years 1913-91 has been compiled by the Leprosy Research Foundation on a compact disc for researchers.

Collecting, transcribing, and downloading the world's scientific literature on leprosy has taken 10 years. Included on the read only memory compact disc (CD-ROM) is a collection of 41,168 citations from 2,874 books and journals. About half of the citations include abstracts. The 8,148 of the pre-1984 Tropical Diseases Bulletin abstracts on the disc can be found in no other computer format.

The CD-ROM is available for $20 to cover postage and handling from Leprosy Research Foundation, 11588 Lawton Ct., Loma Linda, CA 92354; FAX: (909) 824-1361.

*U.S. G.P.O.:1993-342-341:80004