Health and Functioning Among Baby Boomers Approaching 60

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Objective. To investigate whether the health and functioning of the Baby Boom generation are better or worse than those of previous cohorts in middle age.


Results. In 2005, the mortality rate of 59-year-olds, the leading edge of the Baby Boom, was 31% lower than that of 59-year-olds in 1982 (8.3 vs. 12.1 per 1,000). There was a similar proportional decline in poor/fair health, but the decline reversed in the last decade. From 1997 to 2006, the prevalence of reports of four conditions increased significantly, but this trend may reflect improvements in diagnosis and treatment. Functional limitations and need for help with routine needs were stable, but the need for help with personal care, while quite low, increased.

Discussion. Trends varied by indicator, period, and age. It is surprising that, given the socioeconomic, medical, and public health advantages of Baby Boomers throughout their lives, they are not doing considerably better on all counts.

Key Words: Trends—Mortality—Chronic Conditions—Functioning—Disability—Baby Boom.

The consequences of declines in mortality for the health and functioning of the nation’s older adults have been the subject of much interest over the last quarter century. Indeed, spurred by Manton, Corder, and Stallard’s (1993) analysis of the National Long Term Care Survey, a vast literature has developed that explicitly focuses on trends in health and disability in late life. Although initially there was disagreement, a consensus has emerged among researchers in the field that there have been improvements in most measures of late-life functioning (see, e.g., Crimmins, 2004; Cutler, 2001; Freedman, Martin, & Schoeni, 2002; Freedman et al., 2004; Kramarow, Lubitz, Lentzner, & Gorina, 2007; Manton, Gu, & Lamb, 2006; Waidmann & Liu, 2000).

A recent report by the Institute of Medicine on the future of disability in America (Field & Jette, 2007) suggests that despite these improvements, the numbers of adults with disabilities will likely swell in the coming years as the large Baby Boom generation—those born during the years 1946–1964—reaches the ages associated with the highest rates of morbidity and disability. Undoubtedly, such a trend would have important implications for the provision of medical and social services, for the ability of future older adults to participate fully in society, including the workplace, and more generally for their quality of life. However, although the number of adults reaching older ages and thus experiencing elevated risks for debilitating conditions will certainly grow, there is debate about whether the Baby Boom cohort will enter later life with better or worse age-specific rates of morbidity and disability than earlier cohorts.

Only a handful of studies have taken up the question of trends in health and functioning of the adult population in the decades approaching retirement, and results have been conflicting. One study, using data from the National Health Interview Survey (NHIS), found from 1984 to 1996 an increase in the prevalence of needing help with personal care and routine household activities among adults aged 40–49 and 50–59 years, although the rates of such disability were very low (Lakdawalla, Bhattacharya, & Goldman, 2004). Another study, by Zack, Moriarty, Stroup, Ford, and Mokdad (2004), using data from the Behavioral Risk Factor Surveillance System (BRFSS), found an increase from 1993 to 2001 in the proportion of those aged 35–44, 45–54, and 55–64 years who reported poor or fair health. A third study, which relied on data from the Health and Retirement Study (HRS), suggested worse health and functioning among people aged 51–56 years in 2004 compared with 1992 (Soldo, Mitchell, Taily, & McCabe, 2007). However, Weir (2007) concluded from his analysis of the same cohorts using a different recode of the HRS data that although early Baby Boomers were more likely to report poor or fair health than the cohort born 12 years earlier, objectively their overall health and functioning were similar. Other recent analyses of health trends among the middle-aged adult population...
have been more positive. Using the NHIS, Martin, Schoeni, Freedman, and Andreski (2007) found a downward trend from 1982 to 2003 in reports of poor or fair health among adults aged 40–49 and 50–59 years. Mortality rates among adults also have continued to decline in recent decades (National Center for Health Statistics, 2007).

Several lessons have emerged from studying late-life health and functioning trends that are relevant to this new and growing literature focused on adults under age 65 years. First, trends are best assessed over a relatively long time horizon with multiple observations (Freedman et al., 2002); given annual variation, two data points may not necessarily constitute a trend (Crimmins, 1996). Second, different measures may move in different directions (Crimmins, 1996, 2004). For example, despite declines in most measures of late-life disability, reports of many chronic conditions among older adults have increased in recent decades (Crimmins, 2004; Crimmins & Saito, 2000; Freedman & Martin, 2000; Freedman, Martin, Schoeni, & Cornman, 2007). There are many reasons for such divergences, not the least of which is that no single indicator is a pure measure of health. For example, self-reports of chronic diseases may be influenced by access to health care, which in turn is a function of socioeconomic status. Moreover, indicators of functioning reflect the gap between an individual’s capacity and the environment in which activities are carried out. Accordingly, breadth of measurement is important before drawing conclusions about the health and functioning of a cohort. Third, care must be taken to ensure that methodological threats to validity—such as low response rates, use of screening questions, changes in question wording, changes in response rates, or omission of important groups such as the institutionalized population—do not bias conclusions (Freedman et al., 2002).

In this paper, we heed these lessons and expand on existing studies by assessing trends in mortality and multiple nonclinical indicators of health and functioning (including general health status, health conditions, physical functional limitations, and need for help with daily activities); by using annual data spanning from one to more than two decades, depending on the measure; and by covering the full age range of the Baby Boom. Our goal is to investigate whether the health and functioning of Baby Boomers are better or worse than those of previous cohorts in middle age.

**Methods**

**Data**

We use all-cause mortality rates from 1982 to 2005 that have been compiled from annual vital statistics and census tabulations and estimates (Human Mortality Database, 2008). For other health and functioning indicators, we rely on data from the annual NHIS from 1982 to 2006. Conducted by the National Center for Health Statistics, the NHIS is an ongoing survey of the civilian noninstitutional-ized U.S. population. The sampling plan follows a multi-stage area probability design. Application of sample weights that adjust for nonresponse (ranging from 10% to 15%, depending on the year) and for poststratification to the U.S. population by age, sex, and race/ethnicity yields annual estimates of the population’s health and functioning. From 1982 to 1996, the core section of the survey included questions about the health and functioning of all household members (Harris, Hendershot, & Stapleton, 2005). In 1997, the core was redesigned to include three components: the family core, the sample adult core (administered to a randomly selected adult), and the sample child core (administered to an adult about a randomly selected child).

Strengths of the NHIS include its broad range of items on health and functioning and relatively large sample sizes, which permit analysis of trends by five-year age groups. Sample sizes vary by the location of questions in specific components of the NHIS core and by survey year. The annual sample sizes by five-year age groups for our analysis range roughly from 2,300 to 8,100 for general health status, 1,900 to 3,800 for health conditions and functional limitations, and 4,300 to 8,100 for needing help with daily activities. A limitation of the survey is its exclusion of the military and institutionalized populations. However, the proportion of people aged 40–59 years, our focus, in these settings is very small (Decker, 2005; Department of Defense, various years; Sabol, Couture, & Harrison, 2007).

For measures that have been consistently collected for more than 19 years (mortality and general health status), we are able to compare the Baby Boom with an earlier cohort with no overlap. For example, in 2004, people aged 40–59 years were born approximately 1945–1964, and in 1982, those aged 40–59 years were born 1923–1942. When 19 or fewer years of consistent data are available (health conditions, functional limitations, and needing help with daily activities), some of our comparisons involve the oldest members of the Baby Boom (e.g., those born 1947–1951, who were aged 55–59 years in 2006) and those born prior to or during World War II (e.g., those born 1938–1942, who were aged 55–59 years in 1997). Other comparisons involve later-born members of the Baby Boom (e.g., those born 1957–1961, who were aged 45–49 years in 2006) and members closer to the leading edge of the Baby Boom (e.g., those born 1948–1952, who were aged 45–49 years in 1997).

**Health and Functioning Indicators**

In addition to all-cause mortality, we analyze general health status and indicators from each of the domains of the International Classification of Functioning, Disease, and Health (World Health Organization, 2001), namely, health conditions, impairments (represented by functional limitations), and activity limitations (reflected in need for help with daily activities). Details on each measure follow.
Since 1982, the NHIS has asked a question about general health status of people of all ages residing in the selected households or their proxies: “Would you say your health in general is excellent, very good, good, fair, or poor?” We focus on reports of poor or fair general health status (the lowest two of five possible responses) from 1982 to 2006.

Since 1997, NHIS has collected self-reports of selected chronic conditions from a randomly selected adult in the household. We highlight nine relatively common condition groups (specific conditions and reference periods indicated in parentheses below). For cancer (all types; ever), cardiovascular disease (heart and cerebrovascular disease; ever), lung conditions (asthma and emphysema; ever), and diabetes (ever), the questions generally take the form: “Has a doctor or health professional told you that you have . . . ?” We also include measures of mental distress (13 or greater on the 24-point K6 indicator [Kessler et al., 2002]; 30 days), obesity (body mass index $\geq$ 30, calculated from self-reported height and weight; current), vision problems (current), hearing problems (current), and musculoskeletal conditions (1997–2001: joint pain, 12 months, and neck/low back pain, 3 months; 2002–2006: arthritis and related diseases, ever, and neck/low back pain, 3 months). Analyses for 2001, when both new and old indicators of musculoskeletal conditions were available, indicate a 1.7-percentage-point decline in prevalence among 40–to 59-year-olds as a result of the definition change. Unfortunately, questions are not asked about other conditions (e.g., dementia, nervous system conditions) that might be associated with disability, and no information on severity of the conditions is ascertained.

Beginning in 1997, one adult per household was asked about difficulty with nine physical functions: walking a quarter mile; climbing 10 steps; standing 2 hr; sitting 2 hr; stooping, bending, or kneeling; reaching over one’s head; grasping small objects; carrying 10 pounds; and moving large objects. We use a response of difficulty with any one of these nine functions to indicate a physical functional limitation.

In the family core interview, NHIS asks about need for help with such personal care activities as eating or bathing, so-called activities of daily living (ADLs). NHIS also asks about need for help with such routine needs as household chores and shopping, so-called instrumental activities of daily living (IADLs). Prior to 1997, these questions were asked of people under age 60 years only if they reported limitation in everyday activities, such as working outside the home or doing housework. Given modifications in disability insurance benefits, which may have influenced reporting work limitation, the composition of the group of respondents eligible to be asked ADL and IADL questions may have changed over time prior to 1997 (Duggan & Imberman, in press). Moreover, at least for the 60–69 group (of whom both limitation in everyday activities and needing help with ADLs/IADLs were universally asked in the period prior to 1997), a small percentage reported needing help with ADLs or IADLs but not having an everyday activity limitation. Accordingly, we limit analysis of needing help with ADLs, IADLs, and either to the period 1997–2006, when ADL/IADL questions were asked of all adults without regard to everyday activity limitations such as that related to work.

Statistical Analysis
To assess trends in mortality and poor/fair health, we graph data by single years of age for 1982 and the latest year of data, 2005 and 2006, respectively. For all other outcomes, we present age-specific prevalence rates for five-year age groups (40–44, 45–49, 50–54, and 55–59) for selected years and fit for each five-year age group logistic regression models that control for calendar year and use all the years of data available. We also present prevalence rates for each outcome for the broader age group 40–59, which we standardized to the 1997 age distribution. These age-standardized prevalence rates can be interpreted as the rates that would have occurred had the population age distribution within the 40–59 group remained constant at 1997 levels. We explored several other standards (e.g., last year of data) and found that substantive conclusions about trends were robust. Finally, we fit logistic regression models for each outcome for the 40–59 group in which we include variables indicating calendar year and five-year age group. (For all models of poor/fair health for 1982–2006, because of a change in the use of proxies starting in 1997, we also control for proxy response, survey year 1997 or later, and interaction of the two.)

If a respondent is missing information on self-reported health, any of the functional limitations, or needing help with activities, the case is not included in that specific analysis. For these outcomes, the percentage of missing responses is considerably less than 1% for most age groups and survey years. For all conditions except obesity, we assume that those with no response do not have the condition. In the case of obesity, 3%–5% of responses regarding body weight are generally missing, and we omit those cases from the analysis.

In all models using the NHIS data, we use the “final basic weights” and adjust standard errors to account for the complex NHIS design.

Results
The annual age-specific death rates from all causes combined were substantially lower in 2005 than in 1982 when examined by single year of age over the age range 40–59 years. Rates for members of the Baby Boom are highlighted in the curve for 2005 in Figure 1. The improvements in survival are especially striking as age increases. For example, the mortality rate of 59-year-olds in 2005 (8.3 per 1,000), the leading edge of the Baby Boom, is 14.4% lower than 59-year-olds in 1997 (9.7 per 1,000) and 31.4% lower than that of 59-year-olds in 1982 (12.1 per 1,000).
Similar changes between 1982 and 2006 in reports of poor/fair health are shown in Figure 2. In 2006, 20.4% of people age 60 years (in that year the leading edge of the Baby Boom) reported that their health was poor or fair versus 28.3% in 1982, indicating a 27.9% decline. However, it appears that most of the decline at this age for this measure occurred in the earlier part of the period. The proportion reporting poor/fair health at age 60 years in 2006 is only 3.2% lower than that in 1997 (21.1%), and for most other ages, the rates in 2006 are higher than those in 1997. However, there is a substantial year-to-year variation.

Models of trends that use all 25 years of data indicate that reports of poor/fair health declined significantly for the 40–59 population and for groups aged 50–54 and 55–59 years from 1982 to 2006 (Table 1). Examining 2-year averages for 1982–1983 and 2005–2006, there also appear to be declines for those aged 40–44 and 45–49 years, but given low starting proportions and substantial annual variation, the changes are not statistically significant. Age-standardized results suggest that had the 1997 age distribution held for all four groups (although lung disease for 45- to 49-year-olds was significant only at \( p < .06 \)). In contrast, cardiovascular disease and mental distress increased significantly only for those aged 55–59 years, and musculoskeletal conditions declined only for the three youngest age groups and vision problems for the youngest. (Analyses of data from 1982 to 1996 [not presented here], when survey design was different, indicate for those aged 40–59 years increases in obesity and lung problems but decreases in cardiovascular and musculoskeletal conditions.) Summarizing the findings for 1997–2006 by five-year age group, there were significant increases in reports for three of nine conditions for those aged 40–44 years, two of nine for those aged 45–49 years, three of nine for those aged 50–54 years, and five of nine for those aged 55–59 years. Significant decreases occurred for two of nine among those aged 40–44 years, one each for 45–49 and 50–54, and none for 55–59 years.

Finally, rates of functional limitations, needing help with IADLs, and needing help with ADLs or IADLs among those aged 40–59 years show no change for 1997–2006 (Table 3). Need for help specifically with ADLs did increase significantly among 40- to 59-year-olds, but this change was small, and such need remained relatively rare in this population (about 1%). Moreover, only one age group—those aged 50–54 years—experienced significant increases in this outcome.

Table 1. Prevalence of Poor/Fair Health by Age Group (per 100 persons), 1982–2006

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<td>40–44</td>
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<td>45–49</td>
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<td>50–54</td>
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<td>55–59</td>
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<td>40–59</td>
<td>15.16</td>
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<td>11.39</td>
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Notes: *The \( p \) value for test of trend for the full 25-year period in a logistic model for each age group, using all data from 1982 to 2006; for the model for ages 40–59, 5-year-age-group controls are included.

*Standardized to 1997 age distribution.
Discussion

Trends in indicators of the health and functioning of Baby Boomers vary by measure, period, and age group. Thus, blanket statements about trends should be made with caution. For the two indicators for which we can compare the Baby Boom with a preceding cohort without overlap (mortality for 1982–2005 and poor/fair health for 1982–2006), Baby Boomers are doing better. Nevertheless, the decline in poor/fair health reversed in the last decade. For indicators available for only 1997–2006, we are comparing overlapping cohorts when we consider the entire 40–59 group, but for the 50–54 and 55–59 groups, we are more or less comparing the oldest members of the Baby Boom with those who were born prior to or during World War II. Trends in conditions and needing help with ADLs for people aged 40–59 years indicate that those born later do worse or only as well as those born earlier. We find the most concerning trends for these outcomes among people in their fifties. The indicators of less severe disability, namely, having any of nine functional limitations and needing help with IADLs only, are stable for all age groups.

Our findings with respect to mortality trends are consistent with declines documented more generally for the adult population (Jemal, Ward, Hao, & Thun, 2005; National Center for Health Statistics, 2007). The decline in poor/fair

Table 2. Prevalence of Conditions (per 100 persons), 1997–2006

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Notes: <sup>a</sup>The p values for test of trend for the full 10-year period in a logistic model for each condition and each age group, using all data from 1997 to 2006; for the model for ages 40–59, 5-year-age-group controls are included.

Table 3. Prevalence of Functional Limitations and Needing Help With Personal Care, Routine Needs, or Either by Age Group (per 100 persons), 1997–2006

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<td>40–44</td>
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<td>55–59</td>
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<td>40–59&lt;sup&gt;e&lt;/sup&gt;</td>
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<td>2.73</td>
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Notes: <sup>a</sup>Walking a quarter mile; climbing 10 steps; standing 2 hr; sitting 2 hr; stooping, bending, or kneeling; reaching over one’s head, grasping small objects; carrying 10 pounds; and moving large objects.

<sup>b</sup>Activities of daily living (ADLs), such as eating and bathing.

<sup>c</sup>Instrumental activities of daily living (IADLs), such as household chores and shopping.

<sup>d</sup>The p values for test of trend for the full 10-year period in a logistic model for each age group and each outcome separately, using all data from 1997 to 2006; for the model for ages 40–59, 5-year-age-group controls are included.

<sup>e</sup>Standardized to 1997 age distribution.
general health status that we found for the longer period is consistent with Martin and colleagues’ (2007) results from 1982 to 2003 for adults aged 40–49 and 50–59 years and older age groups, which also were based on NHIS data. The trend documented for poor/fair health for 1997–2006 is consistent with Weir’s (2007) report that relies on data from the HRS and that shows an increase in reports of poor/fair health from 1992 to 2004 among adults aged 51–56 years (although our positive trend is for the broader age range 40–59 years, not the 50–54 group in this later period). Moreover, analysis of data from the BRFSS by Zack and colleagues (2004) indicates an increase in poor/fair health from 1993 to 2001 among those aged 35–44, 45–54, and 55–64 years.

In sum, it appears that after a substantial decline in mid-life reports of poor/fair health in the 1980s and early-to mid-1990s, there has been a reversal of the trend. General self-assessments of health are predictive of mortality (Benyamini & Idler, 1999; Idler & Benyamini, 1997), functioning (Idler & Benyamini), and medical care use (Mutran & Ferraro, 1988), so this new trend may indicate an important change in health. However, the trend also may reflect societal changes in how people think about health. Indeed, Baby Boom members approaching old age might have greater expectations about their health than earlier groups and thus might be more critical in their assessments.

Our findings regarding trends in chronic conditions are mixed: Reports of musculoskeletal conditions among 40- to 59-year-olds have declined, whereas reports of cardiovascular disease, obesity, diabetes, and lung disease have increased. The musculoskeletal trend differs from Weir’s (2007) finding of an increase in arthritis among women aged 51–56 years, but the condition definitions we use are not the same. Our finding is consistent with improved pharmaceutical and surgical interventions (National Center for Health Statistics, 2003; Ward & Fries, 1998) as well as a lower rate of occupational injuries over the period (Bureau of Labor Statistics, 2001, 2007). It is also consistent, at a minimum, with the lack of increase in physical functional limitations that we found.

Although at face value the upward trends in cardiovascular disease, obesity, diabetes, and lung conditions may appear to reflect worse health, it is not clear whether such trends will translate into improvements or degradations in functioning. The increases in reports of cardiovascular disease are consistent with progress in diagnosis, acute care, secondary prevention, and subsequent survival among those with such conditions (Pearson, 2007). For example, although the prevalence of hypertension (a component of cardiovascular disease) has increased, its treatment has expanded (Hajjar & Kotchen, 2003). In addition, clinical measures from the National Health and Nutrition Examination Survey indicate that cholesterol levels, an important risk factor for heart disease, have decreased (National Center for Health Statistics, 2004), in part as a result of the substantial increase in the use of cholesterol-lowering medications. Increased reports of diabetes may reflect a change in threshold for reporting and increases in diagnoses and, presumably, treatment ( Gregg et al., 2004 ). In recent decades, the ratio of diagnosed to undiagnosed diabetes has increased especially for those who are obese. Our finding of increased reports of lung conditions differs from Weir’s (2007) finding of a decline in lung disease among men aged 51–56 years from 1992 to 2004. However, the definition of lung conditions in the two studies is not the same, and our analysis combines men and women. Women took up smoking later than men, and the benefits of smoking cessation are manifested with a lag for many diseases.

There is debate about the implications for health and functioning of the growing prevalence of obesity ( Cutler, Glaeser, & Rosen, 2007; Olshansky et al., 2005; Preston, 2005 ). On the negative side are the very rapid growth of obesity and the relation of obesity to various medical problems ( Sturm, Ringel, & Andreyeva, 2004 ). Also worrisome are the potential but unknown effects of lifelong obesity, a phenomenon that may increase as childhood obesity becomes more prevalent. On the more positive side are observations that the sequelae of obesity may be more treatable, although at some cost, than those of smoking were ( Buchwald et al., 2004 ) and that the cardiovascular risk profile of an obese person today is similar to that of a normal-weight person several decades ago ( Gregg et al., 2005 ).

The general lack of trends in functional limitations and need for help with routine needs activities is similar to the stability that Weir (2007) reports for a combination of functional limitations and ADL/IADL disabilities for the 51–56 population from 1992 to 2004. However, we did find for 1997–2006 an increase in need for help with ADLs for those aged 40–59 years and, in particular, for those aged 50–54 years. This result is consistent with the increase in need for help with ADLs/IADLs combined for ages 40–49 and 50–59 years that Lakdawalla and colleagues (2004) found for 1984–1996, although there was not an increased need for help specifically with ADLs. NHIS survey design was different for the period that they examined, and disability questions were asked only after positive responses regarding limitations in everyday activities, such as work, which may have changed over their study period. In any case, our analysis indicates that the level of needing help with personal care remains very low. Yet, because of costs associated with caring for adults with ADL limitations, this trend bears watching ( Goldman et al., 2005 ).

Although our analysis improves upon the existing literature by focusing on a longer time period, wider age range, and a variety of health and functioning measures, it is not without its limitations. In particular, for some measures, we were restricted to shorter observation periods than optimal. All measures were self-reported and, thus, subject to
influences of attitudes and expectations, among other factors. An important step for future analysis of trends will be to supplement self-reported measures with physiologic measures of health and performance-based measures of functioning as they become more available for nationally representative samples. A final limitation is that we focused solely on trends in population averages and did not examine distributional issues. Disturbing disparities in health by race/ethnicity and socioeconomic status in the United States persist at all ages (Smedley, Stith, & Nelson, 2003) and in some cases are growing (Ezzati, Friedman, Kulkarni, & Murray, 2008; Jemal, Ward, Anderson, Murray, & Thun, 2008). Indeed, there is evidence in the 70 and older population that education and income disparities in disability have grown, with the most disadvantaged experiencing absolute increases in disability prevalence from 1982 to 2002 (Schoeni, Martin, Andreski, & Freedman, 2005). Investigation of the association of trends in socioeconomic status with the trends found here is a critical next step.

Despite these limitations, our analysis underscores two points central to understanding the future health of older adults in the United States. First, one cannot draw conclusions about trends in mid-life health and functioning from patterns recently observed in later life. Indeed, the well-documented declines in late-life disability (Freedman et al., 2002, 2004; Manton et al., 2006) differ substantially from our result of overall stability in physical functional limitations and need for help with daily activities for the 40–59 group. Upward trends in cardiovascular disease, obesity, and diabetes shown here for ages 40–59 years do mirror patterns at ages 65 years and older for 1997–2004 (Freedman et al., 2007). But in the 65 and older population, cancer and musculoskeletal conditions have increased (vs. flat and down, respectively, for ages 40–59 years), lung disease has not changed (vs. up for 40–59), and mental distress and vision problems have declined (vs. flat for 40–59). It is beyond the scope of this paper to attempt to explain these age differences in trends, but possible factors include differential age of onset and progression by outcome, as well as enhanced survival of people experiencing early-life onset of health and functioning problems (Field & Jette, 2007; Verbrugge, Yang, & Juarez, 2004). Thus, one should not assume identical trends in mid- and late life. Moreover, actual mid-life health should be taken into account when forecasting the future health and functioning of the older population. With few exceptions (e.g., Goldman et al., 2005), projections generally assume that age-specific rates of late-life health and functioning will remain constant or that declines in rates will continue at the same pace as in the past.

A second major conclusion is that it is important not to overinterpret small changes over short periods in limited measures. Differences in trends in mid-life health across different indicators and surveys are reminiscent of the late-life trends literature from the 1990s (Freedman & Soldo, 1994). Indeed, it has taken fully a decade to understand the underlying reasons for the inconsistencies in late-life results, to obtain additional data points, and to reach consensus on trends (Freedman et al., 2004). Although it is early in the analysis of mid-life trends in health and functioning, a potentially fruitful avenue of investigation may be a coordinated analysis that seeks to reconcile differences that are found.

That said, at this stage of our knowledge, it is difficult to identify influences, besides behaviors associated with obesity, that hypothetically might result in poorer health overall for Baby Boomers in comparison with earlier cohorts. During the last half of the 20th century, there have been not only substantial advances in medical care but also improvements in public health, higher standards of living, and significant increases in educational attainment. Thus, it is perplexing that Baby Boomers are not doing considerably better than earlier groups on all counts. But only time will reveal the ultimate outcomes of the enormous changes experienced by Baby Boomers over the course of their lifetimes, so it is critical to continue to track their health and functioning as they approach and enter late life.

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