

2006

Surviving alone: the relationship between economic resources and health status in the unmarried later in life and what public policymakers can learn from this relationship

Susan M. Olson
Iowa State University

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Surviving Alone:
The relationship between economic resources and health status
in the unmarried later in life and what
public policymakers can learn from this relationship

by

Susan M. Olson

A thesis submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

Major: Political Science

Program of Study:
Steffen W. Schmidt, Major Professor
Richard W. Mansbach
Peter Martin

Iowa State University

Ames, Iowa

2006

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ACKNOWLEDGEMENTS

I want like to thank Dr. Steffen Schmidt for his guidance and support during my thesis project. Also, I want to thank Dr. Richard Mansbach for serving on my committee and providing valuable insight in regard to the structure of my thesis.

I want to thank Dr. Peter Martin for the opportunity to analyze data from the Iowa Unmarried Survivors Study and for the opportunity to work on the study as an interviewer. Without his guidance, support, and especially patience, I surely would not have been successful. He is not only an excellent mentor, but he is especially adept at teaching statistics to a statistically-challenged student like myself.

I am grateful for the opportunities each of my professors has given me to enhance my professional development in the fields of political science, gerontology and research.

I. INTRODUCTION

By now, most Americans are aware that our population is aging. The fact that more Americans are living longer lives is essentially very good news, especially for the baby-boom generation. The baby boomers, born between 1946 and 1964, have dominated our socio-economic landscape for much of the last half century, and their issues have driven public policy on a local and national level. When the baby boomers were children, demand soared for new schools and more teachers. As young adults, they flooded the workforce, which grew larger and faster than ever before or since. This year, the leading edge of the baby boom generation crossed the threshold of retirement, and with them came new challenges for public policymakers, government leaders and employers alike when it comes to issues like jobs, economic resources, Social Security, access to health services, and aging in place.

Specifically, the aging of the baby-boom generation does in itself portend challenges ahead for policymakers as it relates to surviving alone in later life. One reason relates to the decreasing tendency, especially by women of the baby boom, to remarry after divorce (Bumpass, Sweet & Martin, 1990; Schoen & Weinick, 1993). This will certainly represent unique challenges for policymakers as women over their working lives have earned less money, saved less, and lived longer than men. The number and proportion of older unmarried adults is increasing as well, and this trend is expected to continue. In 1971, only 2.8% of those age 65 years or older were divorced. By 1991, 5.5% of older adults were divorced (Census Bureau 1993). By 2020, it is projected that 7.8% of older men and 14.3% of older women will be divorced (Census Bureau 1992).

There also continues to be a steady demographic increase in the percentages of never-married young and older adults. This is in part true because of the increasing tendency, again among baby-boom women, to forego marriage altogether. Between 1970 and 2000, never-married women, age 30 to 40, rose from 6% to 22%. Never-married men entering mid-life increased even more substantially from 9% of 30% during this same time period (Census Bureau 2000a). It is important, as well, to recognize the fact that persons age 85 and older compose the fastest growing segment of the older adult population and are projected to comprise 24% of the total adult population by 2050 (Census Bureau 2000b).

Widowhood plays a large role in the overall discussion of the unmarried in later life as well. In 2002, almost half of all women 65 years of age and older were widows (46%) while 14% of men 65 years of age and older were widowers according to the 2002 Current Population Survey of the U.S. Bureau of the Census (Profile of Older Americans, 2003). Among women in their 50s, about 13% are widows (Atchley and Barusch, 2004). If current marital and demographic trends noted here continue, it is likely that individuals surviving into the later years of life alone will also proportionately increase over time.

It may, indeed, be time for policymakers to consider the policy implications of what it means to survive alone later in life. In a climate where economic risk is shifting away from employers and the government toward employees and retired citizens, the fundamental balance of risk in retirement income is being altered across America. If employers continue to reduce or eliminate their retiree medical benefits as predicted, and they continue to replace traditional defined-benefit pensions with 401(k) plans, the three pillars of a secure retirement as the boomers have come to know them (i.e., Social Security savings and pensions) may no longer be enough to secure a happy retirement. In today's America, retirees will also need

earnings from continued work and health insurance if they are to alter the balance of risk in retirement income posed by employers. One of the challenges for government leaders will be to craft policies that encourage employers to hire mature workers.

Piecing together a viable retirement without Social Security is an extremely improbable equation for most Americans. With Social Security, nearly 1 in 2 people over age 65 will live in poverty, instead of 1 in 10 who live in poverty today (Novelli, 2001). Social Security provides, and will continue to provide, an average of 40 percent of total retirement income and much more than that for lower and modest-income retirees. For a quarter of those age 65+, Social Security constitutes 90 percent or more of their income (Novelli, 2001). Most Americans will not have a viable retirement without Social Security, and it will continue to be a critical source of retirement income in the future.

Purpose of the Study

The purpose of this research was to compare three unmarried groups (the never married, the divorced, and the widowed) and three age groups (65-74 years of age, 75-84 years of age, and 85 years and older) with regard to individual attributes, such as education, economic resources, income, functional health, subjective health and access to health services. One of the goals of the research was to determine age, gender, and marital status similarities and differences among groups in order to describe the most disadvantaged group. Specifically, the research questions I hoped to answer were:

1. Which is the most disadvantaged marital group relative to gender, economic resources, income, and individual attributes? How are never-married older adults different when compared to divorced and widowed older adults?

2. Which is the most disadvantaged age group relative to economic resources, income, and individual attributes?
3. Is marital group status more significant a factor in functional health and subjective health than individual attributes?

With this research in hand, the goal shifted to the realm of public policy. The question I wanted to consider was how or if this research could be used to shape public policy in order to help the most disadvantaged group. What, if any, would the implications of this research be for public policy? And finally, was it possible to make any recommendations as to which public policies or programs might be crafted or redirected to best help the disadvantaged group?

II. RELATED LITERATURE

Numerous studies have compared married older adults to unmarried older adults but research investigations that define and differentiate well-being among unmarried older adults has been limited (Pinquart, 2003). The Iowa Unmarried Survivors (Martin and Bishop, 2006) is one of the first studies to address aging issues in three distinct unmarried groups of older adults (i.e., the never-married, the divorced, and the widowed) and three specific age groups (i.e., 65-74 years of age, 75-84 years of age, and 85-94 years of age) for differences in economic resources, income, education, functional and subjective health, and access to health services.

Marital Status Groups

Of the few studies that exist about never-married older adults, there is a tendency to agree on their socioeconomic and health statuses, but these studies often report conflicting findings as to their social involvement and social interaction patterns (Ward, 1979) which may indicate a person's need for governmental social programs and services. The level of education was a predictor of never-married status, but only for women (Spreitzer and Riley, 1974; Ward 1979). Other studies have also shown that the health status of never-married older adults was better than that of the other groups of single older adults, especially the divorced (Fengler et al., 1982; Stull & Scarisbrick-Hauser 1989; Ward, 1979).

There are few studies of divorced older adults. Of the research that exists about this group, however, divorced older adults are depicted as more likely to experience impaired health, more likely to be disadvantaged economically, and more isolated socially than the widowed (Choi, 1992; Fenwick and Barresi, 1981; Morgan, 1989). In general, previous

studies have found that the divorced and widowed groups of older single adults share more differences than similarities. As one study has suggested, it may be that adults who have never-married had more continuity in their lives, such as economic status, social ties, and living arrangements than the divorced, who have more often experienced multiple traumatic changes in those areas of their lives (Stull and Scarisbrick-Hauser, 1989). This continuity seems to indicate that the divorced are accustomed to single life and that they have achieved a measure of self-sufficiency. Because divorced women who remain single tend to have higher education and to be more likely to work than widowed women, they should be more like never-married women in terms of economic status.

Widowhood plays a large role in the overall discussion of single adults in later life when we consider the fact that 46% of all women 65 years of age and older are widows (Profile of Older Americans, 2003). This is a significant factor as researchers have associated lower perceived health with widowhood (Fenwick and Barresi, 1981). The significance of this fact grows even more salient as researchers report that widows are more likely to encounter income problems in later life (Atchley and Barusch, 2004). This is because many women find that they are too young to collect survivors' benefits at the time they become widows. About 13 percent of women in their 50s are widows, yet widows do not qualify for survivors' benefits under Social Security until the age of 60 (Social Security Administration). Even if the widow qualifies, household Social Security will decrease by one-third from its level before her spouse's death. The impact of widowhood on older men has received less attention than the effects on women. This should, however, serve as a stimulus for further research.

Age and Gender

Researchers have recently acknowledged the importance of age and gender in shaping one's life events (Choi, 2003). In particular, Choi analyzes the similarities and differences in economic resources and health status of never-married and divorced older adult women and men. His findings indicated that any differences between the never-married and divorced groups are likely to stem from different individual attributes, such as gender, race, education, and health status. Choi also notes that those with higher education are more likely to lack social support than those with lower education, and women are more likely to experience economic hardship than men. This may be because those with higher education are more independent and perhaps less likely to marry, or less likely to remarry if divorced or widowed, than are those with lower education. Choi also makes the connection between marital status and economic resources and the implications for policy calling for the expansion of relevant policies and service programs in preparation for the aging of the single women and men of the baby-boom generation (1996).

Other researchers have demonstrated the relevance of demographic change, culture, family and cohort experiences, as well as education, health, work, and personal relationships as being sources of well-being in later life (Settersen, 2002). Still other researchers have noted the importance of lifestyle factors that may contribute to cumulative strengths or weaknesses of the unmarried later in life.

III. METHOD

Participants

Participants for this study were sampled from a Midwestern state. The sample population included individuals of three marital groups (i.e., never married, widowed, and divorced) and three age groups (i.e., 65-74 years, 75-84 years, and 85 years and older). The sampling area consisted of a 10-county area in central Iowa, as well as additional counties in eastern and western Iowa. The majority of the sample was female and white, (i.e., 70.9% and 92.1%, respectively). Of the three marital groups surveyed, 28.6% were never married, 30.4% were divorced and 41% were widowed. Of the three age groups surveyed, 38.1% were 65 to 74 years of age, 36.7% were 75 to 84 years of age and 25.2% were 85 to 94 years of age. The income category of \$10,000-\$20,000 was cited 44.9% of the time by participants as representing their income level. In addition, 17.8% reported earning less than \$10,000 a year, 16% reported earning \$20,000-\$30,000, and 11% reported earning \$30,000-40,000. Only 10.2% reported earning over \$40,000 annually. Nearly one half (49.4%) of the participants were well educated (i.e., at least completed high school). Of the sample, 23.5% reported some college or post graduate education, 13.8% reported having a college education, 10.2% reported having a master's degree and 3.1% reported earning a Ph.D. Seventy percent of the participants rated their health as excellent or good. Demographic characteristics of the sample are summarized in Table 1 on page 9.

Table 1

Frequencies, Means, and Standard Deviations of Sample Demographics

Demographics				
	Frequency	Percentage	Mean	Standard Deviation
<i>Age</i>			78.23	8.11
<i>Gender</i>				
Male	66	29.1		
Female	161	70.9		
<i>Ethnicity</i>				
White/Caucasian	213	93.8		
African-American	11	4.8		
American Indian	3	1.3		
<i>Age Group</i>				
65 to 74	86	38.1		
75 to 84	83	36.7		
85 to 94	57	25.2		
<i>Marital Status</i>				
Never-married	65	28.6		
Widowed	93	41.0		
Divorced	69	30.4		
<i>Subjective Health</i>				
Excellent	32	14.2		
Good	126	55.8		
Fair	61	27.0		
Poor	7	3.1		

Note. Percentages adjusted for missing responses.

There are two issues worthy of note about the study's demographic profile. First, 4.8% of the participants in the Iowa Unmarried Survivors Study reported their ethnicity as African American. This is somewhat higher than the statistic reported by the U.S. Census Bureau in 2000, which reported 2.1% of Iowa's total population as Black or African American (U.S. Census Bureau, 2000). Second, sexual orientation was reported as follows: heterosexual (93.6%), gay/lesbian (1.8%), transgender (0.5%), other (4.1%).

Sampling results are noted in Table 2. Unmarried men in all age groups proved difficult to identify particularly men in the never married and divorced marital groups who were in the 75-84 and 85-94 age groups.

Of the many individuals contacted by the field interviewers, only a small number (21) refused to participate in the study. It is of interest to note that 18 of the 21 refusals were from the never-married group, and that the refusals were distributed across all three age groups within the one marital group. Health issues and lack of interest in the study were the reasons most often cited for nonparticipation.

Table 2

Sampling Results

Marital Status	Young old (65-74)		Old (75-84)		Old-old (85-94)		Total
	Men	Women	Men	Women	Men	Women	
Never-Married	n=8	n=13	n=5	n=18	n=4	n=19	n=67
Divorced	n=14	n=21	n=7	n=21	n=0	n=6	n=69
Widowed	n=8	n=21	n=12	n=20	n=10	n=20	n=91
Total	n=30	n=55	n=24	n=59	n=14	n=45	N=227

Study Design and Data Collection

A cross-sectional design was used for the Iowa Unmarried Survivors Study. Data collection, which was conducted from spring, 2005 through January 2006, consisted of in-home interviews of community residents who lived independently in their own homes, in assisted-living facilities or retirement villages. Residents were introduced to the study during group presentations at senior centers, area agencies on aging, retirement villages and civic groups, such as the Lion's Club. Other participants were identified through community networks with organizations, such as the Iowa Department of Elder Affairs, Polk County Senior Services, Retired Senior Volunteer Program and the recruitment efforts of field interviewers. Participants signed an informed consent, and received a modest monetary compensation for participation. The Survey Instrument consisted of a combination of question types, which included demographic questions about the participants' general background.

Measures

Participants in the Iowa Unmarried Survivors Study were assessed by a variety of measures including a wisdom scale, a religiosity scale, The Albany Life Events Scale, and others. For the purposes of this research only the following measures were used:

Sociodemographics. Past history and sociodemographic information was assessed by asking each participant to designate their current age, gender, ethnic background, marital status, sexual orientation, annual income, educational achievement, and subjective health.

Education. Participants were asked to select the highest level of education they had achieved from the following categories: (1) vocational/training School, (2) grade school,

(3) junior high school, (4) some high school, (5) high school diploma, (6) some college, (7) college degree, (8) some post graduate education, (9) master's degree, and (10) Ph.D.

Economic Resources. The Duke Older Americans Resources and Services procedures (OARS; Fillenbaum, 1988) were used to measure income and economic resources on a self-report basis. Participants were asked 7 economic resource questions that included: (1) "How do you feel you are doing financially as compared to other people your age?" (2) "How well does the amount of money you have take care of your needs?" (3) "Do you usually have enough to buy those little extras or small luxuries?" (4) "At the present time, do you feel that you will have enough money for your needs in the future?" (5) "Are your assets and financial resources sufficient to meet emergencies?" (6) "Are your expenses so heavy that you cannot meet payments, barely meet payments, or are payments no problem to you?" (7) "Is your financial situation such that you need financial assistance or help beyond what you are already getting?" A high score indicated that financial resources were not a problem. The OARS self-report measure was used because it maintains high reliability ($\alpha = .72$). Reliability for this study was $\alpha = .89$.

Income. Annual income was self-reported by participants. Income categories were: (1) less than \$10,000, (2) \$10,000-\$20,000, (3) \$20,000-\$30,000, (4) \$30,000-\$40,000, (5) \$40,000-\$50,000, and (6) \$60,000 and over.

Functional and Subjective Health. Health was assessed by using two measures: subjective health and functional health or well-being. The functional capacities of

participants were assessed by using the Self-care Capacity Scales from the Duke Older Americans Resources and Services Procedures (OARS; Fillenbaum, 1988). The self-report questions asked about the level of difficulty participants had with instrumental activities of daily living, (i.e., meal preparation, medication use, telephone use, shopping and the ability to get to places out of walking distance) and about physical activities of daily living (i.e., eating, dressing, bathing, getting outside, and walking). Participants were asked to indicate whether they could accomplish specific tasks “without help,” “with some help,” or whether they were “completely unable to do the task.” A high score indicated that the participant was able to do the task without help or with some help. The reliability of the functional assessment questionnaire of the OARS is high ($\alpha = .84$; Fillenbaum, 1988). The Cronbach’s alpha for this study proved highly reliable ($\alpha = .90$).

The Subjective Health Perceptions Scale from the OARS (Fillenbaum, 1988) was used to measure the overall health status of participants. The first question, which was a measure of perceived level of health, asked participants to evaluate their overall level of health as (1) poor, (2) fair, (3) good, and (4) excellent. The second question asked participants to compare their health to what it was like five years ago: (1) worse, (2) about the same and (3) better. The third question asked how much health troubles stood in the way of doing the things the participant wanted to do. Answer selections included: (1) A great deal, (2) A little or some, and (3) not at all. The final question asked participants to compare their health status with other people of the same age: (1) don’t know, (2) not as good, (3) as good, and (4) better. A high score indicated that the participant was in good or excellent health. The reliability of the OARS Subjective Health Perceptions Scale is $\alpha = .74$ and the Cronbach’s alpha for this study was $\alpha = .69$.

Access to Health Services. A series of six questions, based on the OARS Multidimensional Functional Assessment Questionnaire (Fillenbaum, 1988), was used to measure participants' access to health services. The questions asked about access to doctors, hospitals, emergency medical services, rehabilitative services, nursing services, pharmacists, home care equipment, and in-home services. A high score indicated access to these services. The Cronbach's alpha in this study was $\alpha = .81$.

Data Analyses. SPSS (14.0) was used to analyze the data. First, descriptive analyses (i.e., frequencies and means) were computed for all variables. Second, analyses of variance were computed to determine mean group differences for marital status (i.e., never-married vs. married vs. widowed), for age group (i.e., 65-74, 75-84 and 85-94), and for gender. In the third step, multiple regression analyses were computed to assess whether age, gender, education, economic resources, income and access to health services predicted functional health and subjective health.

IV. RESULTS

Results are presented in six analytical sections. Table 3 summarizes the overall descriptive information of the outcome variables. Relative to the scale midpoint, participants scored high in three outcome variable domains: perceived economic resources, functional health, and access to health services.

Table 3

Descriptive Results

Variables	Range	Midpoint	Mean	Standard Deviation
Education	2-10	6	5.97	1.77
Economic Resources	14-28	21	24.47	3.27
Functional Health	13-39	26	37.94	2.64
Income	1-6	3.5	2.56	1.32
Subjective Health	6-14	10.5	10.33	1.89
Access to Health Services	12-18	15	17.43	2.65

A deeper look within each outcome variable is represented in Tables 4-9. A closer review such as this allows for a more meaningful study of the individual attributes that shape the lives of our participants. A summary of educational attainment is presented in Table 4.

Table 4

Descriptives Results for Education

Variables	Frequency	Percentage
<i>Education</i>		
Grade school	8	3.6
Junior high school	3	1.3
Some high school	17	7.6
High school diploma	83	36.9
Some college	41	18.2
College degree	31	13.8
Some post graduate education	12	5.3
Master's degree	23	10.2
Ph.D.	7	3.1
Total	225	100.0

Participants were well-educated. Thirty-seven percent reported earning a high school diploma, 13.8 percent earned a college degree, and 10.2% reported completion of a master's degree. The results for perceived economic resources are provided in Table 5.

Table 5

Descriptives Results for Economic Resources

Variables	Frequency	Percentage
<i>Economic Resources</i>		
Q-1: Compared to others financially		
Worse	31	16.4
About the same	110	58.2
Better	48	25.4
Total	189	100.0
Q-2: Money take care of needs		
Poorly	25	11.1
Fairly well	121	53.5
Very well	80	35.4
Total	226	100.0
Q-3: Enough to buy extras		
Never	12	5.3
Sometimes	116	51.3
Often	98	43.4
Total	226	100.0
Q-4: Meet future needs		
Never	15	8.2
Sometimes	79	43.4
Often	88	48.4
Total	182	100.0

(table continues)

Table 5 continued

Variables	Frequency	Percentage
Q-5: Meet emergencies		
Never	22	11.1
Sometimes	78	39.4
Often	98	49.5
Total	198	100.0
Q-6: Meet payments		
Cannot meet payments	7	3.2
Barely meet payments	35	15.8
Payment no problem	180	81.1
Total	222	100.1
Q-7: Need financial assistance		
Never	15	7.2
Sometimes	58	27.9
Often	135	64.9
Total	208	100.0

Note. Totals may not add up to be 100 due to rounding.

The results in the economic resources portion of the study revealed that over three-quarters of the participants (i.e., 81%) reported no problem meeting their payment obligations. In contrast, however, 64.9% of participants reported they often needed financial assistance beyond what they were already getting. Just over half (i.e., 53.5%) reported that

the amount of money they had took care of their needs fairly well, 48.4 % reported that the amount of money they had would meet their future needs, and 39.4% reported that their financial resources sometimes were sufficient to meet emergencies. Table 6 presents the summary of results for income.

Table 6

Descriptives Results for Income

Variables	Frequency	Percentage
<i>Income</i>		
Less than \$10,000	40	17.8
\$10,000-\$20,000	101	44.9
\$20,000-\$30,000	36	16.0
\$30,000-\$40,000	25	11.1
\$40,000-\$50,000	12	5.3
\$60,000 and over	11	4.9
Total	225	100.0

Nearly 63% (i.e., 62.7%) reported an annual income of less than \$20,000, and more specifically, 17.8% reported earning less than \$10,000 each year. Sixteen percent earned from \$20,000 to \$30,000 and only 11% reported earning between \$30,000 and \$40,000 each year. Table 7 provides the results for functional health.

Table 7

Descriptive Results for Functional Health

Variables	Frequency	Percentage
<i>Functional Health (Activities of Daily Living)</i>		
Q-1: Can you use the telephone		
Completely unable to do	3	1.3
With some help	0	0
Without help	222	98.7
Total	225	100.0
Q-2: Can you get to places outside walking distance		
Completely unable to do	6	2.7
With some help	34	15.0
Without help	186	82.3
Total	226	100.0
Q-3: Can you shop for groceries or clothes		
Completely unable to do	3	1.3
With some help	23	10.2
Without help	200	88.5
Total	226	100.0
Q-4: Can you prepare your meals		
Completely unable to do	2	0.9
With some help	10	4.4
Without help	214	94.7
Total	226	100.0

(table continues)

Table 7 continued

Variables	Frequency	Percentage
Q-5: Can you do your housework		
Completely unable to do	8	3.5
With some help	40	17.7
Without help	178	78.8
Total	226	100.0
Q-6: Can you take your medication		
Completely unable to do	1	0.4
With some help	2	0.9
Without help	221	98.7
Total	224	100.0
Q-7: Can you handle your money		
Completely unable to do	2	0.9
With some help	4	1.8
Without help	220	97.3
Total	226	100.0
Q-8: Can you eat		
Completely unable to do	1	0.4
With some help	2	0.9
Without help	223	98.7
Total	226	99.0

(table continues)

Table 7 continued

Variables	Frequency	Percentage
Q-9: Can you dress and undress yourself		
Completely unable to do	1	0.4
With some help	3	1.3
Without help	222	98.2
Total	226	99.0
Q-10: Can you take care of your appearance		
Completely unable to do	1	0.4
With some help	3	1.3
Without help	222	98.2
Total	226	100.0
Q-11: Can you walk		
Completely unable to do	2	0.9
With some help	34	15.0
Without help	190	84.1
Total	226	100.0
Q-12: Can you get in and out of bed		
Completely unable to do	1	0.4
With some help	4	1.8
Without help	221	97.8
Total	226	100.0
Q-13: Can you take a bath or shower		
Completely unable to do	2	0.9
With some help	12	5.3
Without help	212	93.8
Total:	226	100.0

Note. Totals may not add up to be 100 due to rounding.

Participants reported high scores in all of the functional health domains including the ability to handle their own money. The lowest percentages were reported for activities that required walking (i.e., 84.1%). A relatively high percentage (i.e., 11.5%) also reported needing some help to shop for groceries or clothes. Table 8 describes how participants perceived their health.

Table 8

Descriptives Results for Subjective Health

Variables	Frequency	Percentage
<i>Subjective Health</i>		
Q-1: Rate overall health at the present time		
Poor	7	3.1
Fair	61	27.0
Good	126	55.8
Excellent	32	14.2
Total	226	101.0
Q-2: Health compared to five years ago		
Worse	65	29.4
About the same	132	58.5
Better	27	12.1
Total	224	100.0
Q-3: How much do health troubles interfere		
A great deal	48	21.2
A little or some	110	48.7
Not at all	68	30.1
Total	226	100.0

(table continues)

Table 8 continued

Variables	Frequency	Percentage
Q-4: Your health compared to others		
Not as good	14	7.0
As good	87	43.3
Better	100	49.8
Total	201	100.1

Note. Totals may not add up to be 100 due to rounding.

Two-thirds of participants (i.e., 70%) reported their health troubles stood in the way of things that they wanted to do, and one-third of participants (i.e., 29.4%) reported their health was worse than it was five years ago. In general, 55.8% considered their health to be good, and 14.2% considered their health to be excellent. Table 9 reports how participants viewed access to health services.

Table 9

Descriptives Results for Access to Health Services

Variables	Frequency	Percentage
Q-1: Do you have the medical services you need		
Disagree	2	0.9
Agree	224	99.1
Total	226	100.0

(table continues)

Table 9 continued

Variables	Frequency	Percentage
Q-2: Emergency medical services are close by		
Disagree	4	1.8
Agree	219	98.2
Total	223	100.0
Q-3: Rehabilitative services are close by		
Disagree	4	1.9
Agree	205	98.1
Total	209	100.0
Q-4: Nursing services are close by		
Disagree	13	6.4
Agree	190	93.6
Total	203	100.0
Q-5: Prescription drugs, pharmacies close by		
Disagree	3	1.3
Agree	222	98.7
Total	225	100.0
Q-6: Medical equipment, in-home services close by		
Disagree	10	4.8
Agree	198	95.2
Total	208	100.0

At least 93% of all participants reported that health services, such as doctors, hospitals, emergency services, rehabilitative services, prescription drugs, medical equipment, and in-home services, were close by.

The next analysis compared the three marital groups with regard to resources and outcome variables. Table 10 reflects the summary of marital group mean comparisons.

Table 10

Mean Comparisons for Marital Status Groups

Variables	Never-Married	Widowed	Divorced	<i>F</i>
Education	7.70 ^a	5.42 ^b	6.04 ^b	10.91 ^{***}
Economic Resources	24.66	25.06	23.46	2.88 ⁺
Functional Health	37.47	38.46	37.68	3.22 [*]
Income	2.71	2.62	2.33	1.56
Subjective Health	10.10	10.33	10.60	1.26
Access to Health Services	17.83	17.87	17.80	0.14

Note. Means with different superscripts are significantly different.

⁺ $p < .10$. ^{*} $p < .05$. ^{**} $p < .01$. ^{***} $p < .001$.

The post-hoc analyses revealed significant marital status differences in two domains: (1) Education: the never-married group scored higher than the widowed and the divorced groups, indicating never-married participants were more likely to have completed some college and (2) Functional Health: the widowed group scored significantly higher than the other two groups, indicating a greater ability to tackle the daily instrumental activities of life (i.e., handling money, taking medication, and preparing meals) as well as physical activities that required mobility (i.e., eating, getting dressed, and walking).

A statistical trend suggested that the widowed group had the highest perceived economic resources. The group scored higher than the divorced group when it came to having sufficient money to take care of current and future needs, meet emergencies, and make payments.

The next analysis compared the three age groups. The results revealed that more similarities than differences emerged across age groups with regard to resources and outcome variables. Table 11 summarizes the means comparisons for age groups.

Table 11

Mean Comparisons for Age Groups

Variables	Young Old (65-74)	Middle Old (75-84)	Old Old (85+)	<i>F</i>
Education	5.97	6.08	5.82	0.37
Economic Resources	23.88	24.57	25.08	1.50
Functional Health (ADLs)	38.43	37.61	37.67	2.45 ⁺
Income	2.63	2.44	2.57	0.46
Subjective Health	10.50	10.40	10.11	0.58
Access to Health Services	17.84	17.71	17.92	0.68

⁺*p* < .10. **p* < .05. ***p* < .01.

A statistical trend was obtained for functional health indicating that the young-old (i.e., 65 to 74 years of age) scored higher in activities of daily living than the other two groups. There were no post-hoc differences obtained.

The fourth analysis compared gender differences among participants. The results revealed a significant difference in one domain: income. More similarities than differences were obtained between men and women in the other outcome variables. Table 12 presents the summary results for gender.

Table 12

Mean Comparisons for Gender

Variables	Men	Women	<i>F</i>
Education	6.26	5.86	2.43
Economic Resources	24.13	24.65	0.77
Functional Health (ADLs)	38.22	37.84	0.96
Income	2.90	2.39	9.35**
Subjective Health	10.13	10.41	0.89
Access to Health Services	17.12	17.56	1.28

* $p < .05$. ** $p < .01$.

The fifth analyses concerned interactions among the three marital and age groups relative to the various outcome variables discussed in the study. A significant interaction was reported relative to access to health services. The age group by marital status interaction was significant, $F(4, 213) = 2.51$, $p < .05$. The result indicated that the never-married middle-age group (i.e., 75-84) reported the best access to health services, whereas the divorced middle-age group (i.e., 75-84) reported the lowest access to health services. There were no other significant interactions reported for the other outcome variables. Interactions were also

conducted by marital status group and gender relative to the outcome variables. No significant interactions were noted.

The final analysis was concerned with the prediction of subjective health and functional health. Regression analyses were computed to assess whether age, gender, education, economic resources, income, and access to health services predicted outcome variables. Table 13 summarizes the results of the regression analysis.

Table 13

Predicting Subjective Health and Functional Health

Predictors	Subject Health			Functional Health		
	β	Beta	t	β	Beta	t
Age	-.02	-.12	-1.33	-.04	-.13	-1.53
Gender	.12	.03	.31	-.31	-.05	-.59
Education	.04	.04	.38	-.16	-.11	-1.11
Economic Resources	.09	.16	1.56	.13	.16	1.68 ⁺
Income	-.23	-.16	-1.46	.27	.13	1.28
Access to Health Services	.21	.08	.84	.23	.17	1.91

⁺ $p < .10$. * $p < .05$.

Predictors of functional health included age and economic resources. The young-old group (i.e., 65 to 74 years) reported less need for help in accomplishing the tasks of both instrumental and physical activities of daily living. Participants with perceived greater economic resources also reported less need for assistance with activities of daily living. There were no significant predictors of subjective health.

V. DISCUSSION

IMPLICATIONS FOR PUBLIC POLICY

The purpose of this research was to define and differentiate well-being among distinct groups of unmarried older adults. This was accomplished by comparing three unmarried groups of older adults (i.e., never married, divorced, and widowed) and three age groups (i.e., 65-74 years of age, 75-84 years of age, and 85 years and older) with regard to individual attributes, such as education, economic resources, income, functional health, subjective health and access to health services. In accomplishing this objective, advantaged and disadvantaged marital and age groups were identified relative to these attributes. In effect, the present analysis helped to determine whether marital group status, age, and gender were significant factors when it comes to well-being later in life. In this research, individual attributes proved to be more significant than marital status, age or gender.

Descriptive Analysis

Descriptive analyses revealed that when compared with the scale midpoints, participants showed high scores in three of the six categories of individual resources including economic resources, functional health, and access to health services. The results for economic resources reported a contradiction of sorts. Just over 80% of the participants (81.1%) reported that making their payments was no problem and yet 64.9% reported that they often needed financial assistance. Perhaps payments do not represent a problem because extended family members, friends or service organizations provide financial assistance. All participants reported very high scores for functional health. At least 82% reported the ability to accomplish daily activities or tasks without help with the exception of housework, which reported a score of 78.8%. Access

to health services is an important resource, and all participants showed very high scores relative to this variable. This indicates that participants feel they have the access they need to doctors, medical facilities, rehabilitation services, prescription drugs and in-home services.

Low scores were obtained for income and subjective health. The results reported that 44.9% of participants' income was between \$10,000-\$20,000. Within this income category, 17.8% reported income less than \$10,000. The official government poverty threshold was \$9,060 for an individual 65 and older (Binstock, 2006). To put this result in perspective, we turn to Iowa's State Handbook of Economic, Demographic, and Fiscal Indicators for 2006. In Iowa in 2004, 6.1% of women and 5.1% of men age 65 to 74 lived in poverty compared to 9.7% and 6.5%, respectively, across the United States. In the same year, 12.4% of women and 6.5% of men ages 75 and over lived in poverty compared to 13.3% and 6.8%, respectively, nationally (Baer, 2006).

Iowa's relatively low poverty rates can be attributed in part to the Social Security program. An average wage earner (earning at the mean of the national wage index throughout his or her working life) can receive Social Security benefits as early as age 62 equal to approximately 125% (as a single individual) of the poverty threshold according to the Social Security Administration in 2004 (Binstock, 2006). Social Security benefits appear to substantially reduce the risk of poverty for older Americans, but if benefits are the sole source of income, beneficiaries are at relatively high risk of clustering just above the poverty threshold. For those who do not have access to other sources of retirement income, any fluctuation in Social Security benefits will be catastrophic. This implication alone should inform

policymakers as they consider what changes, if any, to make to Social Security benefits for older adults.

There are three specific recommendations that come to mind that may help future unmarried older adults who live at or near the poverty threshold. First, to help single men and women (as well as all middle-aged men and women) understand the economic insecurity and solitude that can come in old age and to prepare for their possible needs for long-term care, we should encourage them to plan for their future by having massive public information campaigns through the Social Security Administration, Area Agencies on Aging, and employers. The campaigns should include retirement planning and education on such matters as retirement income needs and financial preparation alternatives and options of savings and investment, inflation protection and pension distribution rules. Second, it is also necessary for public and private sectors to strengthen retirement income policies and programs. Especially, the federal government needs to strengthen the 1974 Employment and Retirement Income Security Act to improve pension coverage among low earners (especially women) and to guarantee their entitlement to pension benefits. Public assistance programs for older adults also need to be made easy to access and simple to apply, cutting down complicated bureaucratic obstacles and excessive paperwork. And finally, I would like to see public and private sectors institute or expand long-term care insurance systems, home health aide services, visiting nurse services, and other community services that help older adults remain at home.

The low score in subjective health was also important. Results showed that 70% of participants reported their health troubles interfered with what they wanted to do on a daily basis. If we also consider the 18% of respondents who reported having trouble getting to places

out of walking distance because they were unable to drive, we can see that transportation may be an issue. Given the fact that nearly 30 percent of households headed by someone age 65 and older are in rural communities like those in Iowa, where little if any public transportation is available, the question of how individuals will reach service providers becomes a challenging obstacle facing policymakers and city government leaders. City leaders can address this issue in part by offering local taxi services and working with senior centers on aging to build a network of ride sharing for older adults. Local government leaders can also improve traffic environments by recognizing that along with age comes the increased incidence of impairment, which for older adults may mean a change in driving behavior. Improving traffic environments by increasing the lighting at intersections, the size of signs and lettering, etc., is one way that city government leaders can improve the driving of not just unmarried older adults, but those who may drive them to their destinations. Although improvement costs may initially be a budgetary obstacle, the costs may well be offset by decreased medical costs associated with traffic accidents and violations by older adults.

The descriptive results suggest that we can be optimistic that unmarried older adults do well in later life. It may be important, however, to at least consider that the individuals who chose not to participate in the study (i.e., $N = 21$) may have scored lower in resources.

Marital Group Differences

The mean group analyses revealed significant marital status differences in two domains: education and functional health. For education, the never-married group scored higher than the widowed and the divorced groups, indicating never-married participants were more likely to complete some college. This somewhat agrees with other research. Spreitzer and Riley (1974)

and Ward (1979) found that level of education was a predictor of never-married status, but only for women. In this research, the never-married group was the smallest marital group representing 28.6% of unmarried populations compared to the divorced group (30.4%) and the widowed group (41%). This may have been a factor as to why the results were different from other research. For functional health, the widowed group scored significantly higher than the other two groups, indicating a greater ability to tackle daily instrumental activities of life (i.e., handling money, taking medication, and preparing meals) as well as physical activities that required mobility (i.e., eating, getting dressed, and walking). The results did conflict, however, with prior research in another important domain, perceived health. No significant differences were reported across the marital groups. Fenwick and Barressi (1981) associated lower perceived health with widowhood. Poor perceptions of health may be due to the fact that widows are also more likely to encounter income problems in later life (Atchley and Barusch, 2004). In effect, they may not be able to pay for affordable health care over time. Many women find that they are too young to collect survivors' benefits at the time they become widows. Even if a widow qualifies, household Social Security will decrease by one-third from its level before her spouse's death (Social Security 2006).

Generally, there were more similarities than differences in economic resources across the marital groups. A statistical trend was reported suggesting the widowed group had the highest level of perceived economic resources. The group scored significantly higher than the divorced group when it came to having sufficient money to take care of current and future needs, meet emergencies, and make payments. The trend in part agrees with other research.

Choi (1992), Fenwick and Barresi (1981) and Morgan (1989) reported that divorced older adults are often reported to experience greater economic adversity than other marital groups. Stull and Scarisbrick-Hauser (1989) suggested that this difference may be due to greater continuity in economic status, social ties, and living arrangements of widowed older adults. This indicates readjustment to single life is more difficult for older adults who experience divorce.

Age Differences

In addition to marital status, age and gender have recently been acknowledged by researchers as important across the life course (Choi, 2003). Again, more similarities than differences surfaced across age groups in this research with regard to resources and outcome variables. A statistical trend was obtained for functional health indicating that the young-old (65 to 74 years) scored higher in activities of daily living than the other two age groups. This means that the group was completely able to accomplish daily activities without help or assistance as opposed to needing some help or having the inability to do the activity all together.

Gender Differences

The results revealed that there were few gender differences indicating that unmarried men and women were quite similar in regard to economic resources. Even so, this was a bit surprising given the fact that other researchers, in particular Choi (2003), noted that women are more likely to experience economic hardship than men. Choi's research is reasonable given the fact that women are traditionally paid less than men, save less money, live longer and are less likely to receive a traditional pension. Since most women of the baby boom are not eligible for full Social Security benefits until they are 66 years old, working longer and delaying benefits

could improve financial security for women as well as retaining rights to her husband's retirement savings. Local government leaders and employers can do quite a bit to help older women, as well as men, remain in the workforce. In Iowa, for example, Governor Tom Vilsack has worked diligently with employers across the state to encourage the hiring of mature workers, and to implement phased retirement and flexible retirement arrangements for older workers.

Marital and Age Group Interactions

There was an interesting interaction revealed in the study among the marital and age groups relative to outcome variables. A significant interaction was reported relative to access to health services. The never-married middle-age group (75-84) reported the best access to health services whereas the divorced middle-age group (75-84) reported the lowest access to health services. Perhaps the divorced group simply had fewer extended family members or friends to arrange for or take them to their various medical appointments. This is important because there is an association between access to health services and doing well later in life. This, in turn, is important to policymakers because participants who had high access had better functional health. Better functional health generally means more independence and independence is one of the largest benefits to older adults in the discussion about aging in place.

Predictors

Predictors of functional health included age and economic resources. Participants with greater perceived economic resources reported less need for assistance with activities of daily living. This may be because those with greater economic resources joined health clubs, enjoyed more active vacations, and simply remained in better physical health over their life span. The

young-old group (65 to 74 years), specifically, reported less need for help in accomplishing the tasks of daily living.

Conclusions

In conclusion, more similarities than differences were identified across the marital status and age groups, which indicated that individual attributes proved to be more significant than marital status, age, or gender. In summary:

- (1) The never-married middle-age group (i.e., 75 – 84 years) reported the best access to health services.
- (2) The widowed group reported the highest functional health indicating a greater ability to tackle daily activities of living. And, a statistical trend revealed that the widowed group reported the highest perceived economic resources, scoring significantly higher than the divorced group.
- (3) The divorced middle-age group (75-84) reported the lowest access to health services.

Limitations

This study has a number of limitations. First, it is difficult to generalize the results to the total population because the sample of unmarried individuals was a convenience sample from a predominately rural Midwestern state. Second, unmarried individuals who rated higher on resources (i.e., greater education, and high socioeconomic status) may have been more willing to participate in the study than those with fewer resources. Third, we did not include a married comparison group. Fourth, the few age differences that were obtained may be due to cohort differences. A longitudinal study is needed to assess changes over time. Lastly, a more

comprehensive look at some of the measures is required to confirm definite conclusions about group differences. For example, more information is needed to assess physical health more closely.

Finally, the economic aspect of the study included only the subjective aspect of economic well-being and not the objective aspect of economic well-being (the ratio of income to the poverty level), which is certainly relative to policy making. The survey instrument did not include questions about participation in Medicare Plan A or B, Social Security, or private health insurance, which are issues that can inform how policymakers view future decisions.

Despite shortcomings in this study, the investigation provided satisfactory results. There are, however, other variables in the study that might have provided important clues to policymakers about which marital group requires more services. For instance, Choi (1996) suggests looking at the number of doctor visits and hospitalizations as one way to do this. The Iowa Unmarried Survivors Study does contain this type of data along with information about family units, which might inform the issue of how older unmarried adults reach service providers.

The fact that so many unmarried individuals do well in later life is encouraging to me. The results do suggest that even if we live alone later in life, our lives are manageable. For many unmarried older adults, independent living can mean one continues to enjoy life and the autonomy that living alone affords us. This is significant as the 85+ population continues to increase and as older adults elect to remain single later in life. Perhaps this can be a discussion

point for policymakers and others who make decisions about not only our well-being, but also how we can best remain independent in later life.

APPENDIX A

Participants were asked to select from the following educational achievement levels:

- (1) Vocational/Training School
- (2) Grade School
- (3) Junior High School
- (4) Some High School
- (5) High School Diploma
- (6) Some College
- (7) College Degree
- (8) Some Post Graduate Education
- (9) Master's Degree
- (10) Ph.D.

APPENDIX B

ECONOMIC RESOURCES / FINANCIAL SITUATION

The following questions relate to adequacy of your finances in meeting economic needs. Please read each statement and mark the answer that best reflects your situation.

1. How well do you think you are now doing financially as compared to other people your age?
 - 4 Better
 - 3 About the same
 - 2 Worse
 - 1 Don't know

2. How well does the amount of money you have take care of your needs?
 - 4 Very well
 - 3 Fairly well
 - 2 Poorly
 - 1 Don't know

3. Do you usually have enough to buy those little "extras," that is those small luxuries?
 - 4 Often
 - 3 Sometimes
 - 2 Never
 - 1 Don't know

4. At the present time, do you feel that you have enough for your needs in the future?
 - 4 Often
 - 3 Sometimes
 - 2 Never
 - 1 Don't know

5. Are your assets and financial resources sufficient to meet emergencies?
 - 4 Often
 - 3 Sometimes
 - 2 Never
 - 1 Don't know

6. Are your expenses so heavy that you cannot meet payments, barely meet payments, or are payments no problem to you?
 - 4 My payments are no problem
 - 3 I can barely meet payments
 - 2 I cannot meet payments
 - 1 I don't know

7. Is your financial situation such that you need financial assistance or help beyond what you are already getting?
- 4 Never
 - 3 Sometimes
 - 2 Often
 - 1 I don't know

APPENDIX C

INSTRUMENTAL ACTIVITIES OF DAILY LIVING FROM THE
OLDER AMERICANS RESOURCES SURVEY

Self-Care Capacity Subscale

Now I'd like to ask you about some of the activities of daily living, things that we all need to do as a part of our daily lives. I would like to know if you can do these activities without any help at all, or if you need some help to do them, or if you can't do them at all.

1. Can you use the telephone...
 - 3 Without help, including looking up numbers and dialing;
 - 2 With some help (can answer phone or dial operator in an emergency, but need a special phone or help in getting the number or dialing); or
 - 1 Are you completely unable to use the telephone?

2. Can you get to places out of walking distance...
 - 3 Without help (drive your own car, or travel alone on buses, or taxis);
 - 2 With some help (need someone to help you or go with you when traveling); or
 - 1 Are you unable to travel unless emergency arrangements are made for a specialized vehicle like an ambulance?

3. Can you go shopping for groceries or clothes (assuming she/he has transportation) ...
 - 2 Without help (taking care of all shopping needs yourself, assuming you had transportation);
 - 3 With some help (need someone to go with you on all shopping trips); or
 - 1 Are you completely unable to do any shopping?

4. Can you prepare your own meals...
 - 3 Without help (plan and cook full meals yourself); or
 - 2 With some help (could prepare some things, but unable to cook full meals for yourself)
 - 1 Are you completely unable to prepare any meals?

5. Can you do your housework...
 - 3 Without help (can clean floors, etc.);
 - 2 With some help (can do light housework but need help with heavy work); or
 - 1 Are you completely unable to do any housework?

6. Can you take your own medicine...
 - 3 Without help (in the right doses at the right time);
 - 2 With some help (able to take medicine if someone prepares it for you and/or reminds you to take it); or
 - 1 Are you completely unable to take your medicines?

7. Can you handle you own money...
 - 3 Without help (write checks, pay bills, etc.);
 - 2 With some help (manage day-to-day buying but need help with managing your checkbook and paying your bills); or
 - 1 Are you completely unable to handle money?

8. Can you eat...
 - 3 Without help (able to feed yourself completely)
 - 2 With some help (need help with cutting, feeding self some foods, etc.)
 - 1 Completely unable to feed yourself

9. Can you dress and undress yourself...
 - 3 Without help (able to pick out clothes, dress and undress yourself)
 - 2 With some help
 - 1 Completely unable to dress or undress yourself

10. Can you take care of your own appearance (i.e., combing your hair, washing your face)
 - 3 Without help
 - 2 With some help
 - 1 Completely unable to maintain appearance yourself

11. Can you walk...
 - 3 Without help
 - 2 With some help from a person or with the use of a walker, cane, crutches...etc.
 - 1 Completely unable to walk

12. Can you get in and out of bed...
 - 3 Without help
 - 2 With some help (with help from another person or with the aid of some device)
 - 1 Completely unable to get in and out of bed; completely dependent on someone else

13. Can you take a bath or shower...
 - 3 Without help
 - 2 With some help (need help getting in and out of tub or shower, need special attachments on tub or shower)
 - 1 Complete unable to bath yourself

APPENDIX D

ANNUAL / YEARLY INCOME

Participants were asked to select which of the following income levels best match their annual income:

- (1) less than \$10,000
- (2) \$10,000 - \$20,000
- (3) \$20,000 - \$30,000
- (4) \$30,000 - \$40,000
- (5) \$40,000 - \$50,000
- (6) \$60,000 and over

APPENDIX E

HEALTH STATUS / SUBJECT HEALTH

1. How would you rate your overall health at the present time?
 - 4 Excellent
 - 3 Good
 - 2 Fair
 - 1 Poor

2. How is your health compared to what it was like five years ago?
 - 3 Better
 - 2 About the same
 - 1 Worse

3. How much do your health troubles stand in the way of doing the things you want to do?
 - 3 Not at all
 - 2 A little or some
 - 1 A great deal

4. In comparison with other people your age, how would you consider your health status?
 - 4 Better
 - 3 As good
 - 2 Not as good
 - 1 Don't know

APPENDIX F

ACCESS TO HEALTH SERVICES

Participants were asked to select the answer that most closely matches how they feel about their access to health services:

1. I have the medical services (e.g., doctor, clinic, hospital) close by that I need.
 - 3 Agree
 - 2 Disagree
 - 3 Don't know

2. I have the emergency medical services (e.g., emergency room, urgent care clinic, on-call physician/nurse) close by that I need.
 - 3 Agree
 - 2 Disagree
 - 1 Don't know

3. I have the rehabilitative services (e.g., physical therapist, occupational therapist, rehabilitation clinic) close by that I need.
 - 3 Agree
 - 2 Disagree
 - 1 Don't know

4. I have the nursing services (e.g., in-home nurse, personal care attendant) close by that I need.
 - 3 Agree
 - 2 Disagree
 - 1 Don't know

5. I have the prescription drug services (e.g., pharmacists, pharmacies) close by that I need.
 - 3 Agree
 - 2 Disagree
 - 1 Don't know

5. I have the medical equipment and supply services (e.g., home care equipment and supply retailers, in-home services technicians) close by that I need.
 - 3 Agree
 - 2 Disagree
 - 1 Don't know

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