Key Factors Underlying Racial Disparities in Health Between Black and White Older Americans

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As the novel coronavirus has spread across the United States, Black Americans have been disproportionately affected by infections and deaths. Among Black Americans ages 65 and older, death rates from COVID-19, the disease caused by the coronavirus, appear to be three times that of their white peers.[1]

The pandemic has shone a spotlight on well-documented and long-standing health disparities between Black and white Americans. Compared with their white counterparts, Black men and women have lower life expectancies and a higher prevalence of health conditions such as hypertension, diabetes, dementia, stroke, and cancer.

Growing evidence suggests that a variety of social factors, not genetics, drive this health inequality—including lower levels of education and income, less access to and lower quality health care, and the toll that racism-related stress takes on the body's defenses. These factors combine with a higher risk of exposure at work and in multigenerational households to help explain why older Black adults have been especially vulnerable to COVID-19 (see Box 1, page 3).

This brief summarizes what we know about Black-white health inequality at older ages, focusing on the recent work of researchers supported by the National Institute on Aging. It explores trends and examines the underlying structural forces shaping racial health disparities. These findings can help lawmakers design policies to address these inequalities and help improve health and prevent early death among Black Americans.

COVID-19 and Other Risk Factors Widen the Black-White Life Expectancy Gap

In 2020, COVID-19 deaths appear to have eliminated many of the gains made since 2006 in closing the Black-white life expectancy gap.[2] Theresa Andrasfay and Noreen Goldman projected the gap in life expectancy at birth between Black and white Americans would widen by nearly 40% in 2020—from 3.6 years to more than 5 years—reflecting how the pandemic has "laid bare the risks associated with social and economic disadvantage." They estimated COVID-19 deaths would reduce average years remaining at age 65 by 1.7 years for Black people and 0.6 years for white people. As Andrasfay and Goldman point out, Black Americans' higher rates of chronic conditions and disease such as obesity and diabetes may underlie these life expectancy differences as these factors are linked to fatal COVID-19 infections.

Differences in obesity, smoking, and education levels help explain the Black-white disparity in premature death.[3] Using data on Americans ages 40 to 79 from the National Health and Nutrition Examination Survey, Irma T. Elo, Neil Mehta, and Samuel Preston explore what would happen to the Black-white mortality gap if Black Americans had the same obesity rate, smoking prevalence, and educational distribution as their white peers.

Elo, Mehta, and Preston find that key risk factors for premature death are obesity among Black women and smoking among Black men (see table). Lower educational attainment among both Black men and women also contributes to the Black-white mortality gap. Low educational attainment is associated not only with smoking and obesity but also with lifelong economic hardship, inferior access to health care, and a range of other factors pertinent to health, the researchers report. Smoking may be a way of coping with stressful life conditions, they suggest.

In 2010, diabetes was responsible for reducing life expectancy by slightly more

TABLE

Smoking, Obesity, and Education Levels Explain a Large Share of Black-White Differences in Premature Death

Key Risk Factors Contributing to Black-White Differences in Mortality Among Men and Women Ages 40-79 (in Percentages)

RISK FACTORS	MEN	WOMEN
Smoking	17%	6%
Obesity	1%	30%
Educational attainment	19%	25%

Source: Irma T. Elo, Neil Mehta, and Samuel Preston, "The Contribution of Weight Status to Black-White Differences in Mortality," *Biodemography and Social Biology* 63, no. 3 (2017): 206-20, https://doi.org/10.1080/19485565.2017.1300519.

BOX 1

Being Older and Black Creates a Double Jeopardy During the COVID-19 Pandemic

Adults ages 60 and older are at higher risk of severe illness and death from COVID-19, the disease caused by the novel coronavirus. However, older Black Americans are especially at risk. The latest provisional data from the Centers for Disease Control and Prevention show that while non-Hispanic Black adults make up 10% of the population ages 65 to 74, they account for 18% of COVID-19-related deaths in that age group.[1]

Black adults are overrepresented in high-contact jobs that cannot be done from home, increasing their exposure to the coronavirus. © kali9 via Getty Images

The pandemic's heavy toll on older Black Americans is linked to structural racism—larger systems of inequality embedded in major U.S. social institutions, Marc A. Garcia and colleagues argue.[2] These unequal structures limit Black Americans' access to quality health care and increase their overall risk for chronic disease, premature aging, and COVID-19 infection.

Black Americans have less wealth than white Americans and are more likely to live in multigenerational and extended family households, making it hard to isolate and increasing their risk of contracting COVID-19, Garcia and colleagues point out. Black adults are also overrepresented in high-contact jobs, such as food service and retail, which cannot be done from home. These jobs tend to be low-paying and lack health benefits and paid sick leave.

The stress of living in a society with compounding, daily instances of discrimination create "weathering," a process that increases stress hormones and inflammation, triggering premature aging, Garcia and colleagues explain. Weathering contributes to older Black adults' higher rates of obesity, cardiovascular disease, diabetes, hypertension, and chronic lung disease relative to white adults. These underlying conditions put older Black adults at higher risk of complications from COVID-19, and when they become ill, they are less likely than older white adults to have access to quality medical care.

Garcia and colleagues argue that structural racism "drives weathering processes resulting in the greater chronic disease burden" among Black Americans "that elevates their risk of health complications and death from COVID-19."

Linda M. Chatters, Henry Owen Taylor, and Robert Joseph Taylor point to several additional factors contributing to older Black adults' higher risk for illness and death related to COVID-19:[3]

- **Racial residential segregation:** A growing body of research shows that because of discriminatory housing practices such as redlining, older Black adults are more likely to live in racially segregated neighborhoods characterized by higher rates of poverty, lack of health care services and amenities (such as grocery stores and parks), and poorly maintained housing and infrastructure. In addition to contributing to higher rates of stress, chronic disease, and functional impairments, these neighborhood conditions influence and heighten older Black adults' coronavirus exposure and risk of severe infection.
- **Racial disparities in long-term care facilities:** The nursing homes and other group-living settings where older Black Americans live tend to be characterized by low levels of services, support, and oversight, jeopardizing residents' health and putting them at high risk of COVID-19 exposure and severe infection and death.

Reducing racial disparities in COVID-19-related deaths will require addressing multiple aspects of structural racism, but Garcia and colleagues argue that important starting points include ensuring that testing and vaccines are available in African American communities, that low-wage workers have access to personal protective equipment and economic relief, and that health organizations' practices do not have a disparate impact on older Black adults with low incomes.

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than one year among Black women at age 30 and by an average of about 10 months among all Americans, Preston and colleagues show in another study.[4] Given that life expectancy grew by only 0.1 years between 2011 and 2015, they argue that diabetes plays a major role in reducing U.S. longevity, particularly among Black women.

By age 50, Black parents are up to twice as likely as white parents to have experienced the stressful and traumatic death of a child, Rachel Donnelly and colleagues report.[5] Using data from the nationally representative Health and Retirement Study (HRS), they show that losing a child is related to heightened mortality risk among both aging Black and white parents.

"Black Americans already face higher mortality rates compared to white Americans, and the unequal burden of child death adds to their mortality risk," the research team writes. To reduce racial disparities in health and mortality, they argue for policies and programs designed to address "the unequal burden of family loss experienced in black communities."

Racial Health Disparities Remain Despite Some Progress

Risk of diabetes, heart disease, and stroke increase among Black adults as they age because of poor blood pressure control and diabetes prevention, Uchechi A. Mitchell, Jennifer A. Ailshire, and Eileen M. Crimmins show.[6] Using HRS data, they examine changes in health risks for diabetes, heart disease, and stroke measured by multiple cardiovascular and metabolic biomarkers. The researchers find that older Black adults began the study with a higher number of risk factors than older white and Hispanic adults, and their risk increased over four years, driven by increases in pulse pressure (a measure of stiffening arteries) and blood glucose (an indicator of diabetes).

As they age, Black adults experience more rapid physiological dysregulation, a decline in the body's ability to recover from stress or damage. Lifestyle and health care factors only explain a fraction of this difference, the researchers note. They point to a variety of potential explanations, including:

- **Economic hardship:** A larger proportion of Black adults reported inconsistent medication use due to costs.
- **Shortcomings in primary disease prevention**: Among individuals considered healthy at the beginning of the study, older Black adults were four times more likely to develop high blood glucose levels.
- **Structural factors:** Maintaining ideal biomarker levels is more difficult for populations that have encountered systemic discrimination and barriers to quality health care.
- **Difficulty managing chronic disease over time:** A difference in the onset of high-risk pulse pressure was observed between older Black and white adults who, at baseline, had successfully controlled their blood pressure.
- **The effects of discrimination-related stress:** The adverse effects of discrimination on blood pressure and other physiological outcomes are well documented and may explain why older Black adults, a population disproportionately exposed to discrimination, are less likely to maintain blood pressure and glucose control.

Older Black adults also have persistently higher rates of disability relative to white adults. Between 1980 and 2000, older white adults experienced consistent declines in disability rates, but older Black adults saw little improvement and possibly an increase in disability.[7] Miles G. Taylor, Scott M. Lynch, and Stephanie Ureña focus on disability related to inability to perform the basic activities of daily living, such as bathing and dressing, using the National Long-Term Care Survey. They identify three health factors strongly linked to disability among Black adults: stroke, diabetes, and heart attack. These factors also are related to obesity, which is implicated in increases in disability among the general U.S. population.

Disability rates among older Black adults improved very little between 1980 and 2000 and, in fact, may have increased during this time. © Erik Isakson via Getty Images

"Although we find no consistent improvements among older Black adults, and link these to particularly disabling conditions, it is possible that white older adults were simply more advantaged in terms of resources needed to carry out these tasks independently," they write.

Black adults may be less likely to have accessible home environments. For example, a decline in the share of white adults who have trouble bathing may reflect better physical function or an increase in the availability of walk-in showers in white households.

"Increased accessibility to medications and treatments for heart attack, stroke, and diabetes among older African Americans may reduce the severity of disablement," Taylor, Lynch, and Ureña write. Greater access to assistive devices (such as walkers and wheelchairs) and changes to living environments (such as grab bars and ramps) may contribute to better physical function among older Black adults.

There is also some good news. Improved diagnosis and treatment of high blood pressure and high cholesterol reduced racial disparities in cardiovascular disease (CVD) risk between 1990 and 2010, Mitchell and colleagues show.[8] The racial gap in CVD risk narrowed for women because of improved blood pressure and lipid profiles among Black women and increasing obesity prevalence among white women.

Whether these trends will continue or translate into further declines in disparities in deaths from CVD is unclear, they write. Recent increases in obesity may offset some of the improvements seen in the 1990s to 2010s and "may lead to a slowing or reversal of trends in racial disparities in total cardiovascular risk."

Disparities in Dementia Risk Relate to Differences in Education Levels

Expanded educational opportunities during the early part of the 20th century are related to recent declines in dementia prevalence among both older non-Hispanic Black and non-Hispanic white adults, Mark D. Hayward and colleagues show.[9] Their review of HRS data from 2000 to 2014 documents significant declines in dementia prevalence for both older non-Hispanic Black and non-Hispanic white adults. Non-Hispanic Black adults ages 65 to 74 experienced the steepest decline. Analysis demonstrates that higher levels of educational attainment are related to the recent declines in dementia prevalence.

Findings by Hayward and colleagues echo numerous studies that link more schooling with a lower risk of dementia. Researchers theorize that education may directly affect brain development by creating a cognitive reserve (stronger connections among brain cells) that older adults can draw on if their memory or reasoning ability begins to decline with dementia. They also suspect that people with more education may be better able to compensate or adapt in the face of disrupted mental functions. In addition, education brings multiple advantages: people with more education tend to have healthier lifestyles, higher incomes, better health care, and more social opportunities—all associated with better brain health.

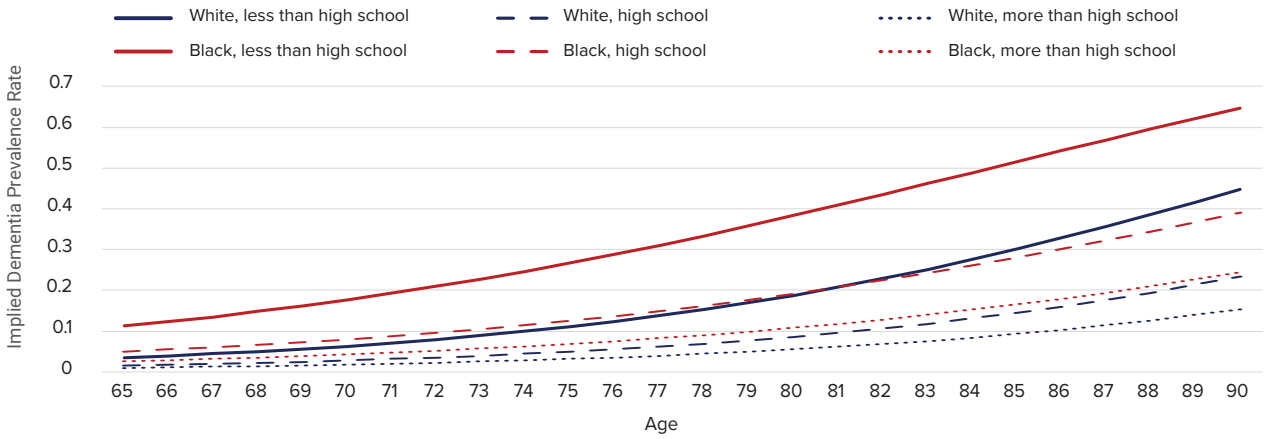
In a related study based on HRS data, Mateo P. Farina and colleagues use modeling techniques to simulate dementia prevalence among different racial and ethnic groups and find lower dementia prevalence in both Black and white Americans with more education, especially at older ages.[10]

However, they also find that Black adults who have not finished high school are at much greater risk of dementia than other groups, even white adults without a high school diploma (see figure). In fact, dementia prevalence for Black adults at age 65 without a high school diploma is similar to that of Black adults at age 75 with a high school education and white adults at age 85 with at least some college.

FIGURE

Older Black Americans Who Did Not Graduate From High School Face a Higher Risk of Dementia

Implied Dementia Prevalence Among Black and White Older Adults by Age and Education Levels, 2000-2014



Source: Mateo P. Farina et al., "Racial and Educational Disparities in Dementia and Dementia-Free Life Expectancy," *The Journals of Gerontology: Series B, Psychological Sciences and Social Sciences* 75, no. 7 (2020): Figure 1.

These findings show the importance of intersectionality—the overlapping of social disadvantages, compounding the impact—in explaining health disparities (see Box 2, page 9). "When race and socioeconomic status are combined in empirical research, they intersect in ways that typically exaggerate disparities because of the distinct racialized and class-based exposures that affect health outcomes," Farina and colleagues conclude.

Closing the gaps in educational attainment now is one way to reduce Black-white disparity in dementia prevalence in the future. © Willie B. Thomas via Getty Images

Vicki Freedman and colleagues identify large and growing disparities in dementia risk by race/ethnicity, which could slow progress in cutting dementia levels. Among those ages 70 and older, dementia prevalence in the non-Hispanic Black population is estimated at 12.7%, compared with 8.4% among non-Hispanic white adults.[11]

Closing gaps in educational attainment is one way to reduce this Black-white disparity in dementia prevalence. But more research is needed to "unpack the 'black box' of how early-life education decreases later-life dementia risk," writes Kenneth M. Langa.[12]

Bereavement also may be contributing to racial disparities in dementia risk, Debra Umberson and colleagues show.[13] Their analysis of HRS data provides evidence that experiencing the death of a child prior to midlife (before a parent reaches age 40)—a tragedy more common for Black parents than for white parents—is related to increased dementia risk. The researchers find links between child loss and a variety of factors that may raise dementia risk, including depression, diminished earnings, alcohol consumption and smoking, and cardiovascular disease.

Researchers also note the need for better methods to measure dementia prevalence across different groups. Estimates of the Black-white gap in dementia prevalence differ across data sources based on whether they determine dementia using cognitive tests (via those in the HRS) or physician diagnosis (via Medicare claims). Yi Chen and colleagues find that older Black adults and individuals with less than a high school education are more likely than older white adults and college-educated individuals, respectively, to be identified as having dementia based on cognitive tests only.[14] In contrast, dementia ascertained by only physician diagnosis yields similar prevalence rates for older Black and white adults and among older adults with different levels of education.

Chen and colleagues show that in the years following cognitive decline in older adults, only a small portion (15%) never receive a dementia diagnosis. However, Black and Hispanic adults, and people with low levels of education, are at higher risk of having a delayed or no dementia diagnosis. Both cognitive tests and a physician diagnosis have limitations, the researchers conclude, yet methodological advances and policy changes may be improving identification and diagnosis of dementia among different groups.

Racism-Related Stress Is Linked to Premature Aging and Chronic Disease

A growing body of research suggests that experiencing racism damages a person's health by triggering the release of stress hormones and a chain of biological events that cause premature aging, thereby increasing the risk of chronic disease.

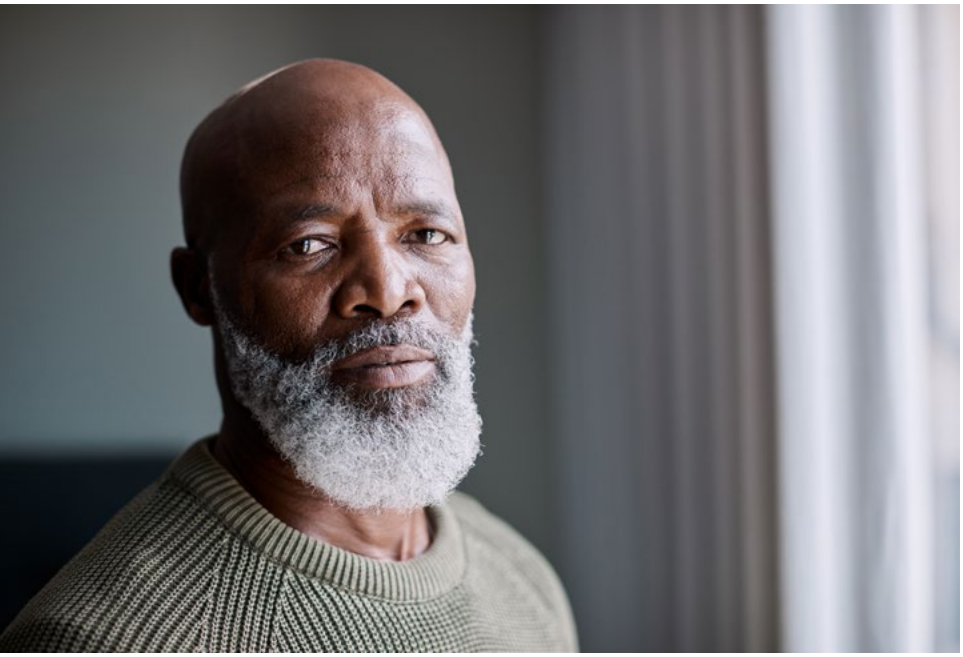
April D. Thames and colleagues focus on Black and white adults with similar socioeconomic backgrounds and stress levels, examining their experiences of racial discrimination and blood markers for stress and inflammation.[15]

Chronic inflammation can cause premature aging and organ damage, raising the risk of diabetes, heart disease, and high blood pressure. Genes that promote chronic inflammation—activated by the body's fight-or-flight stress response—are expressed more often in Black adults than in white adults, particularly Black adults who perceive greater levels of racial discrimination.

Thames and colleagues find that exposure to racism and discrimination could potentially account for more than 50% of the difference in the activity of inflammation-triggering genes between Black and white adults. The researchers suggest that racial discrimination should be perceived as a health risk factor on par with smoking, obesity, high blood pressure, and substance abuse.

Black men may be especially vulnerable to racism-related stressors. "Black men have some of the worst health profiles and shortest life expectancies of all race-gender groups in the United States," write Tyson H. Brown and Taylor W. Hargrove.[16] Using HRS data, they examine participants' perceptions of daily challenges associated with unfair treatment and of significant discrimination related to work, housing, lending, and the criminal justice and health care systems.

Brown and Hargrove argue that many traditional research tools developed for the white population do not capture the stressors "most salient for older Black men's health." Black men's disproportionately high risk of contact with the criminal justice system likely shapes their health, they suggest. Also, Black men often experience distress associated with trying to provide economically for their families despite "constrained economic opportunities and racial discrimination in many areas of life."



Racial discrimination should be perceived as a health risk factor on par with smoking, obesity, high blood pressure, and substance abuse. © kupicoo via Getty Images

Ryon J. Cobb and colleagues focus on allostatic load—the wear and tear on the body caused by chronic stress.[17] High allostatic load signals physical dysregulation and premature aging, which contribute to chronic conditions such as diabetes and heart disease. Drawing on a locally representative sample of around 1,200 Black and white adults in the Nashville Stress and Health Study, the researchers find Black adults have significantly higher allostatic loads.

Health disparities related to skin tone also underscore the insidious nature of racism. Cobb and colleagues show that levels of allostatic load vary by Black adults' skin tone, even after accounting for social and economic differences. The health disparities are largest between white and darker-skinned Black adults and smallest between white and lighter-skinned Black adults.

Because the interviewers identified participants' skin tone for this study, the findings can "more closely capture the degree to which individuals' experiences within racialized social interactions vary by how they are racially categorized based on color by others," the researchers write. The study uncovers the way racism stigmatizes and disadvantages those with the darkest skin the most.

BOX 2

Intersectionality: Disparities Compound to Increase Negative Health Impacts

Mounting evidence shows that health disparities related to race/ethnicity, gender, and socioeconomic status interact, increasing health disadvantages. The health risk of compounded disparities is not the sum of each but a multiple of all.

For instance, older Black females experience especially poor health, Tyson H. Brown and colleagues show based on data from the nationally representative Health and Retirement Study (HRS).[1] The researchers focused on self-reported health, a measure that previous studies show is more closely related to a person's actual health status.

Brown and colleagues demonstrate that the effects of racial/ethnic, gender, and socioeconomic disparities interact to produce inequalities in health among women. They show that Black and Mexican American women have elevated risks of poor health above and beyond what would have been predicted by simply examining race/ethnicity or gender alone. Having higher levels of education—an advantage—is more strongly related to better health among white men and women than among their Black and Mexican American peers.

Being a Black woman is associated with increased risk of having hypertension (high blood pressure) beyond that related to being Black or female separately, a study by Liana J. Richardson and Brown based on HRS data shows.[2] They also find that Black women experience elevated rates of hypertension at younger ages than do other racial or ethnic groups.

Race/ethnicity or gender alone do not fully account for the higher risks of poor health that Black women and Mexican American women experience. © FatCamera via Getty Images

"We interpret racial/ethnic and gender inequalities, not as effects of race/ethnicity and gender per se, but rather as a result of relations of domination and subordination stemming from racism, sexism, and their consequences for class inequality," Richardson and Brown write.

They emphasize the importance of taking gender into account when focusing on racial/ethnic disparities so interventions can target groups at highest risk. Policies and interventions should recognize that inequalities based on age, race/ethnicity, and gender operate together to increase hypertension risk, they argue.

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Unequal Health Care Access and Quality Contribute to Racial Health Disparities

Older Black adults are less likely than their white peers to have private insurance and more likely to rely on Medicaid or Medicare as their only health insurance. Black adults under age 65 who do not qualify for Medicare are also less likely than their white peers to have employer-provided health insurance, creating barriers to care. Black adults who are beneficiaries of Medicare are also more likely than their white peers to receive care in emergency rooms and nursing homes and report fewer doctor's office visits.[18]

Although disparities in health care access persist, the quality of hospitals treating mainly Black patients for heart attacks has improved over the past 20 years. Amitabh Chandra, Pragya Kakani, and Adam Sacarny examined data on Black and white Medicare patients treated for heart attacks.[19] Black patients received care at lower-performing hospitals more often than did white patients, even when they live in the same ZIP code or hospital service area, they report.

Although the performance gap between hospitals treating mainly Black patients and those treating mainly white patients shrank by more than two-thirds over the past two decades, these gains are a result of performance improvement at the hospitals treating mainly Black patients rather than reallocation of Black patients to better hospitals. Chandra, Kakani, and Sacarny find that improved hospital performance is linked to hospitals adopting use of beta-blocker medications. They suggest that the diffusion of similar low-cost but high-impact technologies may help further reduce disparities.

Many older Black adults mistrust the health care system because of a history of mistreatment and exploitation by health care providers and more recent experiences of family and friends. For 40 years, the Tuskegee Syphilis Study monitored but did not treat hundreds of unsuspecting Black men suffering with syphilis.[20] Calling the study an "egregious example of medical exploitation," Marcella Alsan and Marianne Wanamaker document that the study's health toll extended far beyond the test subjects. They find evidence that the 1972 public disclosure of the study led to heightened medical

Black men assigned to Black doctors are more likely to sign up for preventive health care services such as flu shots and cholesterol screening tests. © ER Productions Limited via Getty Images

mistrust, decreased health care use, and increased mortality before age 75 among Black men, particularly among those living in areas near the study's subjects.

Socioeconomic inequality and racism-related stress are at the root of Black-white health disparities, requiring policies and interventions targeting both economic inequality and exposure to high levels of stress.

Alsan and Wanamaker estimate that life expectancy at age 45 for Black men fell by up to 1.4 years in direct response to the study's 1972 disclosure. This decline in longevity could explain approximately 35% of the life expectancy gap between Black and white men and 25% of the gap between Black men and women in 1980. They argue the disclosure of the Tuskegee study may have stalled, or even reversed, pre-1972 gains in narrowing the racial gap in health care use and mortality.

More diversity in the physician workforce may help close racial health gaps by encouraging use of preventive health services. Older Black male patients assigned to a Black doctor have a much higher take-up of screening services than those assigned to a non-Black doctor.[21] Alsan, Owen Garrick, and Grant Graziani estimate that having more Black doctors could reduce the Black-white gap in men's cardiovascular mortality by 19% and in male life expectancy by 8%.

The research team points to examples of past abuse and neglect such as the Tuskegee Syphilis Study to help explain why Black men have higher levels of mistrust of the medical establishment. Whereas older Black adults represent 9% of the population ages 65 and older, Black doctors make up only 4% of U.S. physicians. "Given the current supply of Black doctors, a more diverse physician workforce might be necessary to realize these gains," they conclude.

A February 2021 survey by the Pew Research Center shows that a majority of Black Americans (61%) plan to get a COVID-19 vaccine or have already received one, a sharp rise from November 2020, when 42% told interviewers that they planned to get vaccinated. Over the three-month period, differences in vaccination plans shrank among Black, white, Hispanic, and Asian American adults.[22] In January 2021, about 37% of non-Hispanic Black participants reported in a U.S. Census Bureau survey that they will "probably" or "definitely" *not* get a vaccine, a higher share than among Hispanic, non-Hispanic white, or Asian participants.[23]

Older Americans with dementia, functional limitations, or other disabilities rely on unpaid family caregivers who enable them to live independently or in settings other than nursing facilities. Compared with their white peers, older Black care recipients are more likely to have dementia and incomes below the federal poverty line, report Chanee D. Fabius, Jennifer L. Wolff, and Judith D. Kasper.[24]

Using data from the National Study of Caregiving of the National Health and Aging Trends Study, Fabius, Wolff, and Kasper show that older Black care recipients are more likely than their white counterparts to receive care from an adult child or other relative rather than a spouse. Black caregivers are more likely than white caregivers to report financial strain and receive help from community organizations but less likely to report emotional difficulty related to caregiving. These findings underscore the importance of paid family leave and expanding faith- and community-based programs to better support older Black adults and their unpaid caregivers, the researchers suggest.

Racial Health Disparities Have Policy Implications

The COVID-19 pandemic laid bare long-standing racial health disparities woven deeply into U.S. social structures. Older Black adults have been disproportionately burdened by the pandemic—reflecting more limited health care access, greater job and household exposure to the coronavirus, and higher rates of underlying health conditions, all of which increase vulnerability to severe illness and death.

Trends summarized in this report show that Black-white health disparities related to cardiovascular disease narrowed somewhat related to improvements in diabetes and blood pressure control. Better prevention and treatment of chronic disease and obesity could help shrink the racial gaps in life expectancy and chronic disease.

But socioeconomic inequality and racism-related stress are at the root of Black-white health disparities, requiring policies and interventions targeting both economic inequality and exposure to high levels of stress. Comprehensive action is needed to close health gaps, including criminal justice reform, expanded health care access, job guarantees and desegregation of schools, jobs, and neighborhoods. There is no magic bullet to eliminate long-standing Black-white disparities in health and mortality, but understanding these gaps and their causes is an important first step toward achieving equity.

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The NIA Centers on the Demography and Economics of Aging and Alzheimer's Disease and Alzheimer's Related Dementias

The National Institute on Aging (NIA) of the National Institutes of Health supports research centers on the demography and economics of aging and Alzheimer's disease and Alzheimer's related dementias at the universities and organizations listed above. This publication summarizes new aging-related research, with emphasis on work conducted at the centers. Our objective is to provide decisionmakers in government, business, and nongovernmental organizations with up-to-date scientific evidence relevant to policy debates and program design.

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