

BSPS MEETINGS

Tuesday 6 July 2004

BSPS AGM 2004

The Annual General meeting of the British Society for Population Studies will be held on at 10.30am at the London School of Economics, Graham Wallas Room, 5th Floor, Main Building, Houghton Street, London WC2A 2AE. All members are invited to attend. To be followed by:

British Society for Population Studies Day Meeting

Although there is no charge for this meeting, which is open to members and non-members, please pre-register by emailing pic@lse.ac.uk (phone 020 7955 7666, fax 020 7955 6831) so that the various preparations can be made.

Late fertility – how late can you wait?

To be held at London School of Economics, Graham Wallas Room, 5th Floor, Main Building, Houghton Street, London WC2A 2AE on 6th July 2004 from 11.15am.

Organised by Steve Smallwood – Office for National Statistics.

The aim of this one-day conference is to provide insights into current trends in later fertility from two perspectives. Firstly the biological perspective. While life spans continue to increase, the natural length of a woman's childbearing life is thought to be finite. However, medical innovation may allow the extension of the childbearing span of women. The first part of the conference will therefore explore three issues – the biological perspective on fertility and infertility, the availability of data on the use of fertility treatments, and the ethical implications for the use of fertility treatments. The second consideration will be from the demographic perspective, looking at female intentions, trends in first births and characteristics of older mothers.

11.15 – 11.30 Coffee

11.30am. Introduction to the conference – Steve Smallwood (Office for National Statistics)

11.40am. Ovrang Djahanbakhch (Professor of Reproductive

Medicine, Barts and the London School of Medicine, Queen Mary's University of London) – The biology of fertility – what we know about current limits to childbearing, current issues in fertility and infertility, what does the technology make possible.

12.10pm. Alison Macfarlane (Professor of Perinatal Health, City University) – Statistics on the use and outcome of techniques for medical management of subfertility in the United Kingdom: what we can count, what we don't know and what we need.

12.45pm. Lunch (Not provided)

1.45pm. Françoise Shenfield (Clinical lecturer – Infertility, University College London Hospitals) - The ethics of ART.

2.15pm. Steve Smallwood (Office for National Statistics) - Late fertility in the United Kingdom – past history and future intentions.

2.45pm. Tea

3.00pm. Francesco Billari (Associate Professor of Demography, Istituto do Metodi Università Bocconi) - Is there a rectangularisation in first births?

3.40pm. Laurent Toulemon (Institut National d'Études Démographiques) - The characteristics of later mothers.

4.20pm. Discussion – led by Discussant Mike Murphy (London School of Economics – President of BSPS)

4.45pm. Close

British Society for Population Studies Annual Conference 2004

As previously announced, the BSPS 2004 Annual Conference will be held at the University of Leicester Halls of Residence from 13-15 September 2004. Booking forms and the provisional programme should be despatched to members by the middle of June. Please distribute these as widely as possible and encourage interested non-members to attend.

NOTICES

Website development

As announced in the last Newsletter, redevelopment of the BSPS website will commence shortly. All members will receive a form in the post. This will ask you to confirm that you are happy to have the details that you give on the website in the Directory of Members. This part of the site will be password protected and accessible to members only. If you would like your website, or sites which you think will be of interest to other members, linked from the BSPS site, please contact R.Sear@lse.ac.uk

Members whose subscriptions are not up-to-date will not be included in the online Membership Directory. You know who you are.

Competition to design a new BSPS logo

In conjunction with the development of the new website, Council has decided to announce a **competition to design a new logo for the BSPS**. The closing date for entries is **31 July 2004** and a prize of **£100 in book tokens** will be awarded to the winning entry. Please send entries to the BSPS Secretariat, PS201, London School of Economics, Houghton Street, London WC2A 2AE. Entries as email attachments can be accepted. If sending as a graphics file, please send in PDF format as well. Whilst it will be possible to have a new logo on the website in colour, you are reminded that the design should work equally well in black and white, for use on the letterheading etc.

OTHER NOTICES

Please find attached details of the latest in our series of Royal Geographical Society (with IBG) Environment & Society Forum events. Census 2001: The Findings is a one day conference, to be held here at the Society on June 9th 2004 and examines the most recent findings from the Census 2001 and how these findings may influence public policy.

We have a wide range of high profile, expert speakers from the four key areas of ethnicity, health, inequalities and demographics who represent the interests of stakeholders. We anticipate a stimulating and thought provoking day with plenty of time for discussion.

We would be most grateful if you could circulate this information leaflet to your colleagues or associates who might be interested in attending this event. If you would like to receive additional copies by post please reply to h.saunders@rgs.org

If you or your colleagues would like to be kept informed of forthcoming Environment and Society Forum events, please join our mailing list by emailing: env&socforum@rgs.org

Plenary theme: Ethnicity, refugees, and group conflict.

Plenary speakers:

Mustaq Khan – SOAS – expected to speak on Palestine
Peter Gilroy – Kent Social Services – expected to speak on asylum seekers and local authorities

David Coleman – Oxford University – expected to speak on international migration

David Voad – University of Manchester – expected to speak on religion

Strand sessions on:

Health; Migration and population distribution; local government; ethnicity, refugees, and group conflict; historical demography; ageing; mortality; fertility; reproductive health; families and households. There will also be a **poster session** during the reception on the first evening. Posters will be displayed throughout the Conference and, this year, there is a **poster prize of £100 in book tokens** for the poster adjudged to be the best by one of the plenary speakers. Entertainment is being arranged for the second evening.

Registration will be £50 for members and £75 for non-members. An accommodation package will be available covering the entire Conference for £110 (shared bathroom facilities, but only with 2 other rooms), or £140 ensuite. Twenty-four hour stays and day registration will also be possible. Please wait until you receive a booking form before booking.

OTHER MEETINGS

22nd - 24th June 2004

PopFest 2004
School of Geography, University of Leeds

PopFest is a conference organised by postgraduates for postgraduates with an ethos to provide a relaxed, supportive forum for students to come together to present work and discuss ideas in a friendly environment.

The conference transcends disciplinary boundaries and is an ideal forum for all postgraduates regardless of their stage of research. In the past PopFest has proved invaluable as a spring board for junior researchers and many of last years delegates went on to present their work at international conferences.

If you are a postgraduate student with an interest in population studies I hope you will consider attending. If you know of any postgraduates in your department who maybe interested please forward this e-mail onto them.

you can find more information at the conference website:
<http://www.geog.leeds.ac.uk/conferences/popfest2004/PopFest04.html>

We will be accepting abstracts that arrive before the start of next week 19th of April so this is your last chance to apply.

We look forward to hearing from you soon, Daniel Vickers, Peter Shepherd, Faisal Butt (PopFest Organising committee)

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Parkes Foundation Small Grants Fund 2005

The Parkes Foundation Small Grants Fund helps to promote research into the biosocial sciences. Priority is given to the support of research which involves the integrated study of biological and social features of human populations. Relevant disciplines are anthropology, demography and population studies, ecology and environmental studies, nutrition, and population genetics.

Grants are directed particularly towards helping **graduate research students** meet their field work costs, but others may apply. Undergraduate projects, however, are not supported. Grants are small usually not exceeding £600.

The application form, on which applications **must** be submitted, can be obtained from the Executive Secretary at the above address, by post or e-mail; detailed instructions will be sent with the form

The closing date for applications is **31 January 2005**; applications will be considered by the Trustees and awards will be made in March/April 2005.

In 2004, grants were awarded to

Sofie De Broe, Division of Social Statistics, University of Southampton
(uptake of family planning services in Guatemala)

Ila Fazzio, Dept of Biological Anthropology, University of Cambridge
(child risk of under nutrition among African pastoralists)

Papiya Guha, International Institute for Population Sciences, Mumbai,
India
(effects of indigenous medicines and homeopathy on reproductive morbidity)

Alison Krentel, London School of Hygiene & Tropical Medicine
(altruistic behaviour related to mass drug administration for LF in Indonesia)

Peter Raynes, London School of Hygiene & Tropical Medicine
(antiretroviral therapy for MV/AIDS in Papua New Guinea)

Lucy Thomycroft, Dept of Anthropology, University College London
(resource use, land management and conservation in a Mayan village)

Amanda Webber, Oxford Brookes University
(risks of human - wildlife conflict in Uganda)

Ekua Yankah, London School of Hygiene & Tropical Medicine
(vulnerability of young men to STI in Rio de Janeiro)

March 2004

▶ REPORTS OF PREVIOUS MEETINGS

The British Society for Population Studies together with the International Longevity Centre UK (ILC-UK) hosted a one-day conference DATA NEEDS FOR PLANING AN AGEING SOCIETY in the British Telecom Centre at 81 Newgate Street in London.

This conference was intended to look at: the information needs of organisations in the public and private sectors in planning for an ageing society, how they are met, and the challenges involved in doing so. It brought together over 100 demographers, forecasters and suppliers of primary data, as well as information users in the public and private sectors. The meeting made the BBC news website *'The normally sedate world of demography has been convulsed by a passionate debate about whether we will all continue to live longer, which took place at a conference sponsored by the International Longevity Centre-UK and the British Society for Population Studies.'* See

<http://news.bbc.co.uk/1/hi/business/3660597.stm>

The sessions covered:

Main sources of data in the UK –government and other important sources, strengths and weaknesses

Population projections and forecasts – methods and assumptions, accuracy and errors, projections that are important for planning and decision making

Demographic controversies

Projecting social trends

Population subgroups

Views of information end-users

Cecilia Tomassini, ONS opened with a presentation on ***Current demographic data availability***

She pointed out that new generations of older people are marked by two important characteristics: *size* and *diversity*. The fall in fertility, advancements in mortality and ageing of the baby-boom generations have all conspired to swell the numbers of the over 65s in the UK, from 7.3 million (13.2%) in 1971 to a

projected figure of 12.7 million (20.9%) in 2021. The oldest old (85 and over) are the fastest growing group.

The earliest and historically most important factor in this ageing process is the decline in fertility rates. This

is compounded by the decline in mortality rates, which have fallen substantially in many countries over the past century as the result of a combination of advances in public health, medical improvements, and standards of living. The final factor is the rise in post-World War II fertility rates, called the “baby boom” and the ageing of the baby boom cohorts will soon accelerate population ageing.

The overall population above age 65 in general displays a great variety for example in health, kin availability, income and working patterns. The fact that more people arrive at older ages means a greater diversity among the elderly population, since they are less selected by previous life hazards. Survey

design should now more than ever be able to catch this diversity. So if on one side there is a need to hold measurements constant, on the other side there is a need to update and modify measurements that reflect the emerging reality of older people.

It follows that also in reporting on older people there is an emerging need to ensure that the older population is broken down by more than age and sex. Surveys on older people in the 1970s and 1980s were designed to collect information on about 10 per cent of the population, nowadays we need to investigate almost 20 per cent of the population.

The availability of individual-level survey data on older people changed the approach of focus from macro-indicators (e.g. dependency ratios) to explanatory models more able to identify differences in behaviour and to analyse the relations between outcomes and independent variables across of range of disciplines such as demography, social policy, epidemiology, economics, etc. An example is that demographic patterns of kin availability could raise the question whether family care will decline and therefore the impact on the supply of formal care services. Similarly research into the extent of socio-economic differences persist into older ages has implications for effects on health and mortality.

There are alternative ways in which information could be collected:
Longitudinal data

Ageing is a social process that cannot be adequately understood without reference to the whole of the life course. Longitudinal (or retrospective history) data are better to disentangle and clarify the complex relationships between demographic events, health, work and family structure.

Examples of British longitudinal data sources include the Retirement Survey, the British Household Panel Survey, the ONS Longitudinal Study, and recently the English Longitudinal Study on Ageing. However, the weaknesses of longitudinal data should be acknowledged. If data are collected retrospectively, the interviewed older people are the survivors of previous life hazards and therefore could be a selected sample of the population. Reliability of recall of information far back in time may also be an issue.

Cross-sectional studies in the UK

The majority of data collected on older people in the UK are from cross-sectional surveys. The most important ones are the Family Resources Survey, the Expenditure and Food Survey (previously named Family Expenditure Survey), the General Household Survey, the Health Survey for England, the Labour Force Survey and the Omnibus Surveys. Sample sizes for 65+ vary from around 9,000 for the FRS, to 4,000 for the HSE, and to 3,000 for the GHS.

ONS is developing plans to combine the GHS, LFS (including the boost samples), EFS, and the Omnibus surveys into a single integrated, modular survey, the Continuous Population Survey. There are many benefits to this, in particular, the ability to provide better information on key social and socio-economic variables (such as housing, ethnicity, health), improve inter-censal monitoring of key variables and provide a wider range of information at sub-regional level, e.g. Local Authority District.

Weaknesses in cross-sectional surveys are that they rarely include retrospective questions for old people (e.g. fertility history, employment history, household history), or kin network (availability and proximity), care arrangements or the level of education attained.

Almost all surveys include only the population resident in private households. For many population groups those excluded will form an extremely small proportion of the whole, but for the very old or those suffering certain types of ill-health, the proportion is large enough to seriously bias the findings. For example, the proportion of people aged 85 and over living in institutions in Great Britain is 18 per cent.

The Census, SAR and the ONS LS are the best sources for analysing the demographic characteristics of older people in communal establishments. But the special long-term care module in the 2000 Health Survey for England, which included around 2,400 older people living in institutions, is a welcome move.

Few studies have sufficient people aged 85 and over to obtain reliable results, and again the Census, SAR and the ONS LS are the best sources on very old people. In particular, there are very few surveys with sufficient older people from ethnic minorities, with the exception of the recent Home Office Citizenship Survey in 2001 that included a boosted sample of people from ethnic minorities.

Recent developments

Large population-based household surveys could consider instituting the collection of biological markers (e.g., blood as in the 2000 Health Survey for England), physiological measurements (e.g., height, blood pressure or handgrip strength), and environmental measurements (e.g., exposure to dangerous agents) in addition to the usual demographic, socioeconomic, and/or health data. Also data on siblings or parents can shed valuable light on both genetic and environmental factors that determine health and behaviour.

Cross-national comparative data

Examples include:

- EUROSTAT New Cronos Database (for macro indicators)
- European Community Household Panel;
- The Survey of Health, Ageing and Retirement in Europe (SHARE);
- European Social Survey; and
- Eurobarometer Surveys

Cross-national studies conducted within a framework of comparable measurement can be a substantially more useful tool for the analysis of policy impact than studies of single countries. The differential rates of population ageing throughout the world that result from differences in fertility and mortality histories provide a unique opportunity for countries to learn from each other's experiences. The concomitant economic and social changes (e.g., in pension reform) that are occurring differentially in Europe and the growing awareness among policy makers of issues rising from

global ageing, induce a set of economic and social challenges over the next half-century.

If policy makers recognise the importance of the coming changes, they will have the opportunity to develop policies and programs for coping with changing population age structures.

Mike Murphy, LSE talked about *Population projections and forecasts*.

The key points are that:

- Falling fertility and greater longevity are creating an ageing society
- Government population forecasts are central to virtually all other socio-demographic projections
- Fertility, immigration and mortality are the central pillars of these forecasts
- Population projections often reveal major policy issues which will arise in future due to demographic change

However:

- Projections are made for households, marital status and labour force, but there are no official projections for a number of other important subgroups such as families, social class, availability of children, ethnic group, and health status.
- Considerable delays exist in sub-national and sub-group population projections which require Census base populations.
- Care must be taken when interpreting the implications of demographic trends for policy.
- They can be misrepresented, especially if combined with data inadequacies. Expert advice and great care must be taken when interpreting them.
- If population projections are to be central to formulating areas of future policy, steps must be taken towards a more regular and methodically sound provision of sub-national and sub-group forecasts, such as ethnic minorities, households, marital status and families.

Having future estimations of the demographic makeup of the population is crucial for planning virtually all services, since these underpin most other projections, which are usually made by multiplying the proportion of people with a given characteristic (eg. the percentage aged 85-89 in poor health) by the projected population in that group in future (ie. the projected numbers aged 85-89).

Not only are the future numbers of elderly people important, but so are those for the whole population, as the ageing is defined as the *proportion*, rather than the *absolute numbers*, of older people in a given population, and therefore depends on the number of younger people as well.

British official national population projections have been produced by the Government Actuary's Department (GAD) for the past half century and published every two years (the last set in December 2003). Other agencies also make projections for Britain, such as EUROSTAT (but the most recent set was produced in 1999, although a revised set is expected in late 2004), and the UN whose latest set courageously projects populations until 2300.

The production of projections is crucial for highlighting future issues. In Japan, for example, even conservative assumptions about population trends in the next half century shows a rise in the numbers of women aged 80 to be nearly three times as many as the number of girls born in 2050.

Fertility

National population projections require information on the base population by age and sex, and assumptions about future fertility, mortality & migration. Fertility rather than mortality has been the main driver of ageing (although mortality is becoming more important in recent periods), and fertility was very volatile in the decades following WWII.

There was a substantial 'baby boom' of children born in Britain that peaked around the early 1960s, and whose mothers are reaching age 65 about now, and whose members will therefore reach age 65 in the period centered around 2030. However, recent patterns suggest that women now having children will have about 1.7 children on average, which would lead to long-term population decline in the absence of immigration

Migration

Migration has also been very volatile, especially in recent years, and forecasting it is therefore subject to substantial error. However, current assumptions suggest that the numbers will be sufficient to keep overall population numbers growing modestly for the first few decades of the century. Net migration for ages above 45 is expected to be close to zero.

Mortality

Mortality changes are the most important component for projecting numbers of older people. As a result of declining mortality (and higher number of births in the post WWII period), the numbers of older people will grow in the future. However, the magnitude of this rise is unclear, since mortality improvement has been substantially under-estimated in most countries in recent decades. The number of men aged 85 and over in 2011, for example, is now expected to be twice as high as projected 30 years ago:

Uncertainty in UK Population forecasts

The conventional way of allowing for the inevitable uncertainty in projections is to provide alternative projections under different ('variant') assumptions about fertility, mortality and migration. The alternative official projections for 2050 cover a range between about 55 and 75 million in the UK between the lowest and highest assumptions:

The variant assumptions used in 2000-based population projections are:

- Long-term average children per woman
High 1.94 Principal 1.74 Low 1.54
- Long-term annual net inward migration
High 195,000 Principal 135,000 Low 75,000
- Annual mortality rate improvements at 2025
High 1½% Principal ¾% Low 0%

Similarly the proportion aged 65 and over is predicted at being between about 21% and 29%, depending on the scenario, as compared with the present value of 16%.

While variant projections show the effects of alternative assumptions, they do not show how likely or unlikely such alternatives are. Probabilistic projections that provide more conventional statistical measures of likely uncertainty have been prepared for the EU (by Wolfgang Lutz and Sergi Scherbov).

Other projections

In addition to the overall national population projections, a number of others are made, such as of households, marital status and labour force. The last full set for household and marital status (for which the published open-ended age band is 75+, therefore reducing their use for looking at elderly populations) and sub-national ones were based on 1996 population estimates. Revised sets will be produced in 2004 for marital status and 2005 for households when updated base populations taking account of the 2001 Census are available, but the fact that the latest available projections are known to be deficient and out of date, does mean that there is a substantial gap in the period around the decennial census. Some projections of cohabitation have also been produced. The last set of official ethnic group projections for England & Wales was 1976-based (although a number of local authorities have produced their own projections), and there is presently a discussion of whether a new set should be produced.

The lack of projections can lead to serious misinterpretations of the future situation. There is widespread concern about the availability of children as potential care-givers to older people in years to come. However for the next three decades or so, more elderly people will have living children than any period in Britain's history: for example, people born around 1940 who had high fertility in the early 1960s will not reach age 80 (when needs tend to increase) until around 2020.

There are no official projections made of health status. The recent Treasury study of health financing, ('The Wanless Review'), pointed out that there is considerable uncertainty over what will happen to the health status of older people, even to the extent of whether their health will improve or not (even if the predominant view is that there will be less ill health in old age, a so-called 'compression of morbidity').

There then followed two presentations about future prospects for mortality, with rather different emphases.

S. Jay Olshansky University of Illinois at Chicago discussed whether *Human Life Expectancy will Decline in the 21st Century?*

Key points

- Huge reductions in infant and youth mortality since 1900 have accounted for the majority of the gains in increased life expectancy. Today, around 98% of children survive to reach 21 years of age as compared to 75% in 1900.

- Further increases in life expectancy must therefore arise from reductions in adult mortality. This will be more problematic given the nature of disease in older life and will not have as great an effect on average longevity given their natural remaining life span.
- It is likely for these reasons that the astounding gains in life expectancy over the previous century will not continue indefinitely into the future. Current US administration estimates for future life expectancy are probably overestimates.
- We may well discover that, like other species, the human body has a maximum potential lifespan, even if such a limit on the duration of life is not fixed by a genetic program.

The main reason for the substantial improvement in mortality in the twentieth century was largely the reduction of infant mortality. The large numbers of deaths which used to take place at a younger age have been averted, shifting the modal age of death. Between 1900 and 1910, 82% of the increase in male longevity, and 66% of female, was due to improvements in life expectancy in the 0-20 age group. By the decade 1990 to 2000 this accounted for a mere 12% and 14% respectively. In comparison the 65 to 84 age range grew from a minimal contribution to 29% and 40% contribution to increases in longevity by 2000. Thus future gains in longevity they will have to take place by

primarily reducing mortality in older, adult life. However, reductions in mortality rates produce decreasing returns in terms of life expectancy. A 50% reduction in mortality at all ages from all causes amongst women in 1985 would have resulted in an additional 8 or so years on average. Extending life into 100s would have required reductions in death rates of over 85%, and to 120 years, nearly 100%. A cure for cancer in 1985 would have only boosted life expectancy from 71 to 74 for men and 78 to 81 for women, and a theoretical cure for all cardiovascular diseases, diabetes and cancer, (an incredible 75% reduction in mortality), would only boost life expectancy to 86.4 and 95 respectively. We cannot, therefore, expect linear improvements in longevity to continue indefinitely, although such an assumption is sometimes made: indeed to do so would result in the untenable conclusion of a life expectancy of 0 in 1750.

There also remains the issue of what *actual* changes in life expectancy we can expect over the next few decades. A recent report of the Technical Panel Advice to the Social Security Administration in 2003 advised an upward revision of life expectancy beyond that already expected. This was based on three historically correct but not necessarily prophetic trends; the increase in maximum lifespan in Sweden from the late 19th century, the mortality declines in G7 nations during the latter half of the 20th century, and the steady rise in record life expectancy at birth for the last 150 years. It was also based on the unfounded speculation of negligible senescence being engineered for humans in the 21st Century. However, the issue of whether human life expectancy may decrease in the 21st century should be considered seriously. Natural selection will tend to confer advantages on those who survive throughout the reproductive period (but whether or not they continues to survive long past this period has little outcome on the success of their offspring in passing on their own genes). Evolution

has engineered the lifespan of our species according to our ability to reproduce and nurture our young. It seems therefore likely that were life expectancy to continue to increase, we might discover a general maximum life expectancy of the human species beyond which the process of ageing and cellular decay would become too generalised to be countered. Further advances in longevity may well have to come from a manipulation of the ageing process itself.

Many human societies around the world have enjoyed an unprecedented rise in life expectancy over the last century. However we must be wary of assuming that this trend will continue indefinitely into the future for the following reasons:

- Most of the major gains in life expectancy in the 20th Century came from massive reductions in mortality in younger age groups. Now that this has largely been addressed, future reductions in mortality must tackle older age groups if they are to significantly improve life expectancy.
- The nature of mortality and disease in adult life, especially old age, is considerably different from that found in juvenile age groups, eg. Cancer, brain failure, and heart disease.
- Not only are adult diseases proving harder to eradicate, their removal also yields less benefit to overall longevity as those who suffer from them are, by nature, closer to the end of their natural life-span.
- If we are to extend average human life to over 100 for men and women it would require a reduction in mortality of around 85%, akin to curing all cardiovascular diseases, diabetes, cancer, pandemic obesity and presumably by the time society arrives at this point, AIDS and other diseases currently on the rise. This is currently not feasible in the short to medium term.

Longevity may hit the ceiling of the maximum possible life-span for the human body in its current form. All organisms have a natural life span which, by imperative of evolution, corresponds to their genetic design and reproductive cycle. Further efforts to achieve massive increases in longevity may need to tackle the genetic process of ageing itself.

In contrast, Graziella Caselli Dipartimento di Scienze Demografiche, Università degli Studi di Roma “La Sapienza” presented an alternative view *Enjoy longer life: lessons from the past and prospects for the future: An overview.*

Key Points

- Steps must be taken to ensure that the elderly in England & Wales can enjoy the same life expectancy as, for example, their French and Italian counterparts.
- Low elderly mortality countries have achieved exceptionally high over 65 life expectancy and there is no reason why this should not continue to increase in the future
- Giving priority to the quality of life and providing the best available care, when necessary, will probably further increase observed longevity and the number of extremely old
- To deal with this situation, a better understanding is urged of the interplay among the plasticity of aging/mortality and the environment - local conditions, the built environment and the importance of caring
- Action starts with information and data collection

- One of the first steps should be the development of reliable health measures that can monitor functional health status, the level of frailty and the quality of life of the oldest old. The implementation of an international ageing survey can probably contribute a lot.

The presentation focussed on survival trends and cause-specific mortality among elderly people in five low-mortality countries that represent different geographical realities: England-Wales and Sweden for northern Europe; France for central Europe; Italy for southern Europe; and Japan, the country where men and women live longest. By looking at links between health status and population survival, speculations are made on the need for health policies that foster both increased elderly survival and especially improved quality of remaining life.

Population ageing represents, in one sense, a human success story. Most societies now enjoy the luxury of ageing. In many low mortality countries, seventy out of a hundred women live until they are 80, and more and more have the chance of becoming nonagenarians and even centenarians. A remarkable decline in old age

mortality throughout the western world has recently occurred, posing the researcher and societies with new challenges and opening up fresh horizons in life expectancy trends. In Japan, for example, from 1970 to 2001, life expectancy at age 65 for both sexes combined increased by 41 percent and at age 80 by about 55 percent. This is a feature common to most low mortality countries and may be largely traced to the spectacular decline in cardiovascular diseases and certain cancers.

Perhaps in the future these trends will continue and extend to other causes where, for the moment, little change has occurred. Such a hypothesis is all the more realistic in that recent changes are linked, both to more efficacious medical care, and to a growing awareness on the part of the general public regarding questions of health and the crucial role played by life style and behaviour. This includes improved dietary habits, for example, and a better attitude to risk factors, particularly to smoking, alcohol abuse, dangerous driving, etc. This awareness, which prevails among more recent, better educated and informed cohorts, not only produces immediate results, but should spare coming generations the accumulation of risks which were and continue to be the burden particularly of older cohorts. Many studies today (in particular those that refer to a slowing down in the mortality rates at oldest ages) suggest that a part of the decrease in old old mortality is a result of frailer elderly dying at younger ages, thus creating a very old population in exceptionally healthy shape, probably as a result of genetic traits and/or lifestyle.

These hypotheses, at a time when the sheer number of the oldest old are growing rapidly, have important policy implications. The decline in mortality at advanced ages plays a major role in determining future numbers of the elderly and especially of the very old population. James Vaupel has noted that the remaining life expectancy of 80-year-old women in England and Wales is about 50 percent higher today than in 1950. Consequently, the number of female octogenarians is

about 50 percent higher than it would have been had oldest-old mortality remained at 1950 levels. In absolute terms, as Kevin Kinsella and Victoria Velkoff pointed out, this means that there are more than one-half million oldest-old British women alive today who would otherwise have died.

However, the growing number of elderly could become a source for concern as these two aspects are inexorably linked to a rise in health care demand. Deterioration or an improvement in the health status of the population has far reaching social and individual consequences. Emerging trends in elderly mortality and health raise important questions regarding social expenditure on health and the likelihood that the mortality decline will be sustained in the future.

An analysis of mortality trends by itself, even by cause of death, will not provide useful indications for policy makers in the field of public health. When monitoring the health status of the population it is important to recognize the interplay between mortality and morbidity and consider whether there is a trade-off between longer life and worsening health, or in other words, whether longevity means prolonged disability and to what extent. While it is an easy matter, at least in countries with updated current statistics, to obtain information on elderly mortality trends and features, including by cause of death, it is not so easy to obtain data that link these to information available on morbidity and health. Morbidity data, if available, have often been acquired from surveys that do not allow linkages to be made. Health surveys, on the other hand, gather data on self-perceived individual health whereby indirect measures can be built on the population's poor health and good health at different ages.

Considerable inequalities in life expectancy persist between countries, for example, almost five years less at birth for men and almost three for women in England & Wales compared with Japan. While there are many reasons for this disadvantage there are also common features and some aspects may offer explanations and a glimpse towards the future.

Since 1900, for the four selected countries, three major features emerge regarding the increase in average lifespan occurring during most of Omran's epidemiological and health transition:

1. Relative increase in life expectancy
2. A decrease in mortality at older ages
3. The changing impact of disease on older age mortality

Younger ages made greater gains in life expectancy during the first half of the century. Towards the end of the 20th Century, older age groups began to see much greater. Increasing life expectancy now primarily reflects elderly mortality trends, visible in the four countries considered here.

A major difference in life expectancy between England and Wales and the other three countries has centred on ischaemic heart diseases. Although it has improved between 1970 and 1998, it is still far worse in Britain.

Ischaemic and other heart and circulatory diseases remain considerably more prevalent in the UK than in the other countries, and that these are responsible for the majority of the difference in life expectancy at later ages, especially for males. Death by cerebro-vascular diseases in 1998, however, has tended to be less prevalent in the UK, although the differential advantage is not

so great as that enjoyed by other countries in ischaemic diseases relative to the UK.

Since the 1980s a cautious approach has usually been taken to future mortality developments, to such an extent that at times mortality is assumed to remain constant or a date has been fixed beyond which no further drop is foreseen. Subsequent mortality trends have often superseded these forecasts. Ex-post examinations of demographic mortality projections for developed countries have always considerably underestimated the decreases that actually occurred, so that life expectancy forecasts at each age are always lower than in reality.

Jenny de Jong Gierveld Netherlands of the Interdisciplinary Demographic Institute (NIDI) and Vrije Universiteit Amsterdam discussed *Future living arrangements of older people in Europe*.

Household composition and living arrangements are crucially important determinants of quality of life and well-being in later life. Sharing a household with a spouse or partner provides older adults with intimacy and daily support. Older adults who live in one-person households, on the other hand, have to rely on network members outside the household when they need help.

The size and composition of living arrangements of older adults are affected by a complex set of determinants, including:

- changes in the older adults' partner status (widowhood or divorce),
- changes in the children's partner status (leaving the parental home to form a household with a partner, or returning to the parental home after union dissolution)
- a decline in the health of one of the partners, resulting in hospitalisation/ institutionalisation or may be in co-residence of older adults and (married) children.

Values, norms and standards concerning an optimal life style are important determinants as well. These values and standards are linked to processes such as secularisation and individualisation, which broaden the opportunities for individuals to decide for themselves how they wish to organise their lives.

An individualistic lifestyle is characterised, for example, by a preference to live independently for as long as possible, either as a couple (without children) or in a one-person household, after widowhood or divorce.

Co-residence of older people with their (married) children tends to be characteristic of more traditional patterns of family life. In *Rethinking households; an atomistic perspective on European living arrangements*, Verdon builds on the work of Burch, Ermisch, Overton, and others to develop a series of

basic postulates about the minimal household units, which he reconceptualised as 'minimal residential units' or MRUs. These are the 'residential atoms' from which all residential groups are built.

Verdon's basic premise is that “*Any adult who is normally constituted psychologically will want to run his or her everyday life; hence adulthood spells a desire for everyday economic and domestic autonomy*”

This suggests an agenda for research:

- to what extent do older adults seek residential autonomy by living in one- or two-person households
- has the proportion of older adults living in one- and two-person households increased in recent years; and
- is a further refinement of one- and two- person households possible, and does this support our thinking about future developments?

To obtain an in-depth understanding of the processes underlying these developments, patterns in Britain and the Netherlands were compared, for married men and women, living in a two-person household without children and others; and for older adults in one-person households.

In addition, new trends among older people were considered, such as unmarried cohabitation.

The percentage of men and women living as couples rises into the 60s and then falls away again into later life, largely as a result of spouse mortality and other pressures such as partners going into long-term care. Unsurprisingly, a greater percentage of men live with their spouses in older age groups due to better life expectancy ratios amongst women relative to men (i.e. although there are less of them a greater percentage have living spouses). The percentage of both is on the increase, due to overall gains in life expectancy being shared by both sexes.

As age progresses, people become most likely to live alone. Although this may be forced by factors such as death of a partner, it runs consistently with the axioms of Verdon that older people do, on the whole, seek to maintain their independent housing arrangements wherever possible.

Throughout later life the great majority of older people are choosing to live independently, with a spouse, or with an unmarried partner. In other words, in MRUs.

A recent phenomenon observed in the Netherlands is “latting”, or Living Apart Together (LAT)

Adults aged 55 and over at last dissolution of a marriage are less likely to remarry, but are three times more likely to begin Living-Apart-Together than those who are younger than 55 years at last dissolution. Adults with only one dissolution were twice as likely to remarry whereas those with two (or more) dissolutions were more likely to have a LAT relationship.

Amongst some of the motives mentioned for latting are

- A strong wish to stay independent. “He is a rather authoritarian personality.....He is always trying to fix things for me...”
- A partner’s personality: “After a long period of living alone, you have your fixed habits. It is more difficult than starting a relationship from scratch.....”

- Financial arrangements: “I have only one daughter and a bit of money, and she has children... and I would rather give my money to my daughter and grandchildren...”

Conclusions

- there is a trend towards an increase in small residential units: (i.e. 1 & 2 pp households)
- this trend is recognizable under younger and under older old people
- the trend is towards ageing together (as a married couple)
- recent cohorts of older people report unmarried cohabitation
- living apart together (LAT) is starting among older adults; and is most appreciated by older widows
- at younger old ages one refrains from co-residence with children. As a result, institutionalisation is postponed

After lunch, Lucy Haselden, Ethnicity and Identity Branch, ONS talked about *the changing profile of Britain’s minority ethnic groups*.

The ethnic minority population is growing. It represents a segment of society which is relatively young now but is ageing. The overwhelming majority – 92% - of the population of Britain today is White. But that leaves 8% of the population coming from other ethnic backgrounds. Some 2% of the population is from an Indian background, 2% is from a Pakistani or Bangladeshi background and 2% is black with the remainder made up of mixed, Chinese and other ethnic groups. However that the proportion of people from non-White groups has grown over the last 10 years from 6% to 8% of British population. There are now 1.5 million more people from non-White groups

The white and non-white populations have very different age structures. Most non-white people are either of first or second generation immigrants and, because immigrants tend to be young when they move country, only a small proportion of the non-white group has yet to reach old age. Also some of these groups have a larger number of children than the white groups so there are higher proportions in the very young age bands.

Although 15% of the White British population is aged 65 or over, the proportions for the other ethnic groups are much lower. In fact, only 6% of the non-White population fall into this age band which works out as about 235,000 people in total. However, there is considerable variability between the ethnic groups: for example the Black Caribbean population isn’t that different from the White British population with 12% of them aged 65 or over, whereas just 2% of Black Africans fall into this age category

Despite their size, the primary trend in ethnic minority groups over 65 is one of growth. In 1991, 8% of black Caribbeans were aged 65 or over but by 2001 that figure had risen to 12%. And similar things are happening in the other ethnic groups: the proportion of Indians aged 65 or over has grown from 4% in 1991 to 7% in 2001.

Therefore the non-white population is showing an older age structure. It is hard to predict exactly what their age structure will look like in the future but it will depend on:

- Immigration – how many new people arrive in this country and how old they are when they come.
- Emigration – there is some evidence that some people from ethnic minority groups return to their country of birth when they retire but we need to do more work to find out exactly how many people do this and whether it is confined to people from particular ethnic backgrounds.
- Finally, birth and death rates for each ethnic groups will affect their future age structure

ONS has started doing some work on population projections for different ethnic groups but this work is still very much in its infancy. One of the problems we are facing is the lack of data specifically about ethnicity. In particular, there is a proposal to put an ethnicity question on birth and death records which will allow us to accurately record birth and death rate.

The different characteristics of the non-white population means they will have different needs as they grow older. We must therefore begin to prepare to ensure the system adequately caters for their needs. These might include separate health requirements and adjusted social services to reflect different living arrangements. We should also expect an inequality in pension status due to differences in employment statuses and remain aware of what policy needs they may have.

Among the key characteristics of the minority ethnic population will determine the services they are likely to require from society as they get older are:

- Health
- Family composition and living arrangements. (This links with kind of care needed.)
- Employment. (There are few up-to-date data on pension provision among the different ethnic groups but information on labour market traits is useful because factors such as unemployment, economic inactivity and self employment are closely linked with poor pension provision.)
- Location. (Where people from different ethnic minorities live because this will give us an idea about where services for these groups will be most needed.)

As people get older, their health may decline. The Census asked people to rate their own health and, although it used a very simple question, this question has been a good predictor of how often people will use medical services. The Census asked: “Over the last twelve months, would you say your health, on the whole has been: good? Fairly good? Or not good?” People from most ethnic minority backgrounds are more likely to say their health is not good. They were also more likely to have some long term illness or disability which restricts their daily activities. As this population ages therefore, they are likely to need a greater amount of medical resources than the general population.

Some ethnic minority groups are much less likely to indulge in poor health behaviours than their white counterparts. People from an Asian background – especially women- are much less likely to drink above the recommended daily alcohol guidelines than those in the general population.

The picture for cigarette smoking amongst people from ethnic minority groups was very different than for drinking. Both

Bangladeshi and Black Caribbean men were more likely to smoke than men in the general population. Women from all ethnic minority groups were less likely to smoke than women in the general population. Although very few Bangladeshi women smoked cigarettes, a relatively large proportion (26%) chewed tobacco. This method of using tobacco was also popular among Bangladeshi men (19%) but they tended to use it in conjunction with cigarettes.

People aged over 60 from the white British group are very likely to be living on their own or with their partner whereas this is much less likely to be the case for people from an Asian background – especially Pakistanis and Bangladeshis. In fact older people from these groups are much more likely to be living with some kind of extended family. All of this is likely to have an affect on future care arrangements.

People from non-White ethnic groups are less likely to actually be in the labour market than people from White backgrounds. Economic inactivity rates are particularly high for the Pakistani and Bangladeshi groups. Notably 78% of Bangladeshi women are economically inactive compared to just 26% of White women. Similarly people from non-white backgrounds are more likely to be unemployed – again Pakistanis and Bangladeshis are the most likely to suffer from this problem. Bangladeshi men had the highest unemployment rate in Great Britain at 20 per cent - four times that for white British or white Irish men.

There are also higher levels of self-employment for Asians. Around one fifth of Pakistani (22%) and Chinese (19%) people in employment in Great Britain were self-employed. This compared with around one in ten white British people. Again self-employed people are less likely to have good pension provision because they may not have occupational pensions.

Over half of all non-whites in the UK live in London or the South East, with major population centres such as the West Midlands accounting for a large part of the rest. As with other differentials in health and employment status, the distribution of the ethnic population will have implications for the successful planning of future provision of public services.

Tony Warnes, University of Sheffield discussed *International migration and older populations*.

Key points

- Older migrants are likely experience varying degrees of disadvantage to native older people, based on disruption to their kin networks, their eligibility to welfare and other support based on citizenship, as well as their likely ignorance of services and discrimination against them from institutions supplying services.
- Patterns of economic migration since the 1950s are creating a large elderly expatriate population in Europe’s largest industrial nations. This group has many different nationalities and often widely varying circumstances.
- However, other older working migrants who return home to their native country after working and those who migrate to live close to their descendant relatives are less well

documented than other older migrant groups described above.

- There is a considerable data gap for older migrants. Many of them to fall between the gaps of national population registers due to factors such as multiple residencies.

An older migrant is very likely to differ from a resident, older native in several ways, since their civil status, socio-economic circumstances and state welfare entitlements and receipts are influenced by having been an international migrant.

Diversity

There are two widely recognised groups of older migrants in Europe,

- working-age migrants who have aged; and
- older people or retirees who migrate when they (or their partners) stop work.

Large scale international labour migrations from 1950s took large numbers of people from southern Europe to northern Europe, and from North Africa, the Caribbean, the Indian sub-continent, Turkey, the Middle East and Indonesia to Europe. This is now leading to rapid increases of ethnic minority and expatriate older populations in many parts of Europe. This is most typically found in large cities of northwest Europe and former mining and industrial areas, e.g. the Ruhr, and heavy industrial and textile manufacturing areas.

The changing population of Europe

The total population of Europe in 1998 was around 810 million. The recorded foreign population was 21 million, some 2.6 per cent of the total. Most of these immigrants were found in West European countries. The largest concentrations were in Luxembourg (35%) and Switzerland (19%), as compared to 9% in Austria, Belgium and Germany.

The largest foreign national groups have continued to be from the traditional labour recruitment countries of southern Europe, which are Italy, Portugal, Spain, Greece and Turkey. In the EU and EFTA as opposed to Europe in total, there were 19.8 million foreigners in 1998, of whom 12.9 million (65%) were Europeans living abroad in other European countries. There were 3.1 million Africans and 2.2 million Asians. As far as their distribution around the continent, Germany dominates as a destination for non-EU member state foreign nationals.

Other older migrants

If the two groups of older migrants described above have been widely recognised – by researchers, the media, and as ‘special needs’ groups among health and social service providers – other older migrants in Europe have considerably less research, practice or policy attention. They are:

- Working-age migrants who ‘return’ when they cease work; and
- Older people or retirees who migrate to live proximate to (and a few with) their descendent relatives

The first group are return labour migrants, as from northern Europe to, for example, Andalusia and southern Italy, or from Great Britain to Ireland. The largest unrecognised group among British older migrants (and most likely the Germans and Dutch) are, however, neither return labour migrants nor taking homes in the most visible sunbelt resorts or coastal strips.

Of the more than 820,000 UK state pensioners who receive their

pensions overseas, nearly a quarter are in Australia and nearly two-thirds in that country and the United States, the Irish Republic and Canada.

Data deficiencies

There are many reasons why data on older migrants may have inconsistencies. For many, a ‘single permanent place of residence’ does not apply. There is also a lack of clear boundaries between permanent and seasonal residence abroad, and ‘residential tourists’. Residential behaviour oscillates from year to year, depending on a whole variety of factors, including finance, weather, health and developments in the family back home. This can result in a complex usage patterns among older migrants with multiple residences.

Such widely varying behaviour creates data deficiencies in compiling information on the behaviour and constitution of the older migrant population. There is very weak recording of cross-boundary movers, and considerable evasion and misrepresentation of actual residential habits. Also, continuous population registers rarely allow household characteristics to be described and never compile information on social networks. As regards the age structure of migrants, there is a chronic lack of data across Europe.

Data needs: the way forward

The number of older migrants is increasing due to a number of factors. The advanced economic development in restricted areas of the world has increased spatial differentials in wages along a north-south / first world-third world divide. Other factors augmenting these are cheaper air transport, cheaper and better telecommunications and mass media spreading information about differential standards of living. The rise in older migrants from the UK moving abroad can be seen in the growth in pensions being claimed overseas.

Interestingly, a look at the ages at which British migrants decided to settle in four different areas of Southern Europe reveals the retirement lifestyles, or at least later life choices, to be the dominant factor for residency there.

Conclusion

We must address the following data issues:

- identify social and welfare-entitlement circumstances of migrant, non-native and ethnic minority groups
- using a biographical or life course approach, we need to identify causes of disadvantage and exclusion in relation to economic and family-support contributions
- identify extent to which unmet needs are the consequence of deficiencies (or cultural insensitivity) or service and benefits provision; and
- establish the preferences and wants of minority groups

Therefore,

- We must do more to combat social exclusion and disadvantage among minority *and migrant* groups
- We must be more assertive in drawing connections between ‘free-movement’ labour market policies (which encourage immigration), and a state’s responsibilities for these people when they reach old age

- We must identify and challenge the structured and inherited disadvantages of non-native older people.

A national perspective was dealt with by Stamatis Kalogirou, London School of Hygiene and Tropical Medicine who talked about the *Geographical distribution of older and younger people*.

Key points

- Ratios of older to younger people show a wide variation across the geography of England and Wales, and has implications to economic and social support structures
- The spatial distribution of those aged 65 and over as well as those over 80 and over shows a coastline-inner country divide between old and young. The South coast is the most favourable area for those aged 65 and over
- In most rural areas the proportion of those aged 65+ or 80+ is high
- Areas with high proportions of non-white population, such as London, have lower proportions of older people
- The proportions of people 65+ with bad health is particularly high in certain parts of London (e.g. east); and
- Different censuses use different geographies, creating issues around future data policy needs.

There is a clear young/old divide between coastal and inland and urban areas, with much higher proportions of older people in coastal areas (which become more extreme, the finer the geographical scale employed). At local authority level, the proportion aged 65 & over ranges from 9% (in Newham, London) to 30% (Christchurch, Dorset), and for Output Areas the range is 0 – 57%. (Output Areas are postcodes groups – this was the smallest size geographical area aggregated data available for the 2001 census.) The South Coast is the most favoured area for those aged 65 and over. Areas with high proportions of non-white population, such as London, have lower proportions of older people.

The parent support ratio provides an indication of support availability for those aged 80 years old and over (who are in need of care) by those who are aged 50 – 59 (likely age group for their children). The higher the parent support ratio is the greater the potential availability of economic and social support for the older old is.

The spatial patterns of the parent support ratio suggest that there is high availability of potential supporters and care givers for the old in local authorities located at the coast, mainly at the south coast of England. In most of the inland within England and Wales, the availability of potential intergenerational support from those 50-59 to those 80 and over is rather low.

Migration is generally low for ages above 50. There are several types of movers: retirement, support movers (near children and to homes). Fewer people in the age range are job seekers.

In areas with high proportions of non-white, professionals and recent migrants there is a high turn over effect (mainly observed in London). In-migration ranges from 0.52% (Sheffield) to 5.80% (City of London). Out-migration ranges from 0.87% (Rhondda, Cynon,

Taff – S. Wales) to 4.56% (City of London). Net-migration ranges from -2.11% (Wandsworth, London) to 2.11% (North Kesteven, Lincolnshire)

Migration figures raise several issues in terms of data availability. The UK Census is, understandably, relatively good at identifying those who have come to live in London from the rest of the UK or abroad. It fails to provide much real data on those UK residents that have migrated abroad. Such information that there is usually relies on passenger surveys or pensions claims from abroad. As this is imperfect data it leaves large gaps in government information. Other people slip through the net too. EU passport holders may live and work in London without registering with the state. Conversely, figures in some of the more controversial groups such as asylum seekers are well documented.

In general the proportion of people with health problems increases with age. Some 48.5 % of Londoners aged 65 and over reported having limiting long-term illness. This ranges from 25.9 to 66.7% when it is looked at the ward level. It is above 60% in some wards in Newham and Hackney. It is below 40% in several wards in Bromley and Kensington & Chelsea. While inner city areas tend to have far fewer residents over 65 as a proportion of the local population, but their health, however, tends to be worse than average, especially in the more deprived inner city areas in the centre and East. This is a policy issue that points towards a great need for specific targeting of health resources to these areas. Micro-management of data could well be of great use here, a good example of when borough-level data becomes too generalised.

Conclusions

- Population structure changes hugely when looked at in different geographies, care must be taken when doing so
- The spatial clusters suggest regional and urban-rural divides
- London is a special case with a 50% increase of non-EU15 born residents over the last decade (1991-2001)
- Older people increased in inner London; however, they are smaller part of the total population at ward level
- The proportions of people 65+ with bad health is particularly high in certain parts of London (e.g. east)

There are several data issues:

- Different geographies between censuses make time analysis difficult
- Random data adjustments for confidentiality issues insert bias. The census information is available down to very small neighbourhoods. To prevent anyone abusing this information to access personal information, random data adjustments are introduced. This can be problematic unless managed correctly by users of the data.
- Data corrections/adjustments accounting for potential undercounts may be wrong

Jane Falkingham, University of Southampton and Maria Evandrou, King's College London of the ESRC SAGE Research Group on *How will tomorrow's elders differ from today's? Differentials in socio-economic characteristics between and within birth cohorts*.

Introduction

The presentation examined demographic change and trends in health and health risk behaviour in Britain in order to inform future projections, drawing out the implications of these trends for health and social care in later life over the next 30 years.

Older people are major consumers of health and social services. By 2030, it is estimated that people aged 65 and over are likely to account for a quarter of the British population, as the large post-war baby boom cohorts enter retirement. Although the numbers of older people in the next 30 years can be forecast with some degree of certainty, less attention has been paid to the likely health and socio-economic characteristics of future generations of elders, and how these may differ from previous cohorts of elderly persons. By looking back into the past and seeing how the experiences of the generations entering retirement over the next 30 years are likely to shape their future some insight may be gained. The experiences of two cohorts that are currently retired, i.e. those born in 1916-20 and 1931-35, are compared with those of two younger cohorts, taken to represent those entering retirement over the next 20-30 yrs, i.e. those born in the late 1940s and early 1960s.

Key findings suggest firstly that there will be a rise in solo living amongst elderly people. However this may not necessarily be accompanied by an increase in the availability of care from adult children, especially amongst the 1960s cohort. A fifth (20%) of women born in 1961 are likely to remain childless at age 45. Secondly, evidence on future health outcomes is mixed, and it is premature to assume that tomorrow's elders will be healthier than today's. Trends in smoking provide one indication that younger generations will be healthier in later life than current generations of older people. However, the proportion reporting limiting long-standing illness suggests the opposite; with younger cohorts reporting slightly higher levels than previous cohorts at the same age. Furthermore, the 1960s cohort has experienced higher levels of unemployment, and longer working weeks for those in work, at earlier stages in their life course than previous cohorts. Increased levels of work-related stress may manifest themselves in poorer health in older ages. Moreover, even if tomorrow's elders will, on average, be healthier than today's, action still needs to be taken to tackle the widening inequalities in health risk behaviour.

When making future projections and developing models, the research presented highlights that it is important to take into account the diversity of experiences both between and within cohorts. Continued investment in longitudinal data and high quality cross-sectional household survey data will facilitate this type of policy relevant research in the future.

Finally, there was a discussion, which included a Panel of demographers, and data/information providers and users, which comprised

Len Cook, National Statistician
Ian Diamond, Chief Executive ESRC
Professor Emily Grundy, LSHTM
Mr John Hollis, GLA

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