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?

 Medicine, Barts and the London School of Medicine Queen Mary's University of London) The biology of fertility – what we 5 12 re f 0.851 0now a226

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

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 – ex[ected 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 recive 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

and weaknesses

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

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 in-migration

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 impro

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.

7

x4rdiot-0.0096   -0.6

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 comon 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 develoipments, 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.

- 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

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-

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

ting issues

inland and
le in costal
aphical scale
65 & over
ristchurch,
utput Areas
raphical area
uth Coast is
s with high
have lower

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 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