

AGING IN THE UNITED KINGDOM: A REVIEW OF DEMOGRAPHIC TRENDS, RECENT POLICY DEVELOPMENTS AND CARE PROVISION

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Although the UK's population is not predicted to grow very much in the future, the population structure is changing and there is a shift towards a much older age distribution. The characteristics of demographic aging in the UK include a marked reduction in fertility rates, increasing rates of life expectation at birth (ELB), increasing dependency ratios and variations in mortality and social class in old age. The UK's demographic context has important implications for aged care policy and planning. This paper documents the demographic trends, reviews recent major policy changes and their impact on care provision, and discusses some of the emerging implementation issues that challenge the potential of such policies to meet the needs of an aging population.

INTRODUCTION

The demographic context of aging in the United Kingdom is interesting and whilst the proportion of elderly people is currently relatively static, important future changes are on the horizon. The 1993 population of the UK was 58.2 million, an increase of just over 10% since 1961. The UK is often treated as being relatively homogeneous in demographic terms but its component countries, England, Wales, Scotland and Northern Ireland, do have somewhat different demographic profiles. There were spatial variations among the four countries but the largest increase of about 15% was in Northern Ireland, where birth rates have been consistently higher than in the rest of the UK and are likely to remain so for the foreseeable future. Most of the data used in this paper will refer to the UK unless otherwise noted. The future population size of the UK is not expected to grow very much and is likely to peak at about 62 million around the year

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2025. Thereafter, the population will begin to reduce and, indeed, the total population in seventy years' time is projected to be similar to that of today (around 57 million persons once again). The most important change will be a shift towards a much older age distribution within the population.

It is interesting that, as Thane (1989) notes, many researchers have regarded the aging population as a burden. It is possible that as she suggests, this pessimism may have been unwarranted. However, the existence of a burden will depend very much on the outcomes of policy initiatives such as care in the community and the various methods of financing future care. It will also depend on the willingness and ability of family and informal care to assist in future care and support. Whether they and the formal care providers can underwrite a sufficiently comprehensive system for elderly people in the UK in the future is still a matter of debate.

BIRTH/DEATH RATES AND FERTILITY CHANGES

Two major factors in the UK today affect population size and structure: decreased mortality and reducing fertility (Victor, 1991; Central Statistical Office, 1994). The most spectacular changes in mortality over the past century or so have involved reductions in infant mortality which has fallen from about 150 per 1000 live births in the mid-nineteenth century to a 1994 figure of 6.6. Crude death rates have also been falling and have converged for males and females (indeed, female CDRs now exceeding those of males due to the female population structure). CDRs in 1994 were around 11 per 1,000 and crude birth rates around 13 per 1,000. It is today only the slight excess of births over deaths that keep the UK's population growing at all and migration, previously a significant feature, currently has a negligible effect. By about 203, deaths are likely to outweigh births although future predictions of mortality and longevity are now recognized as somewhat speculative in view of recent general increase in life expectancy. In the future, changes in mortality are more likely to affect older than the youngest groups in which remarkable advances have already been achieved.

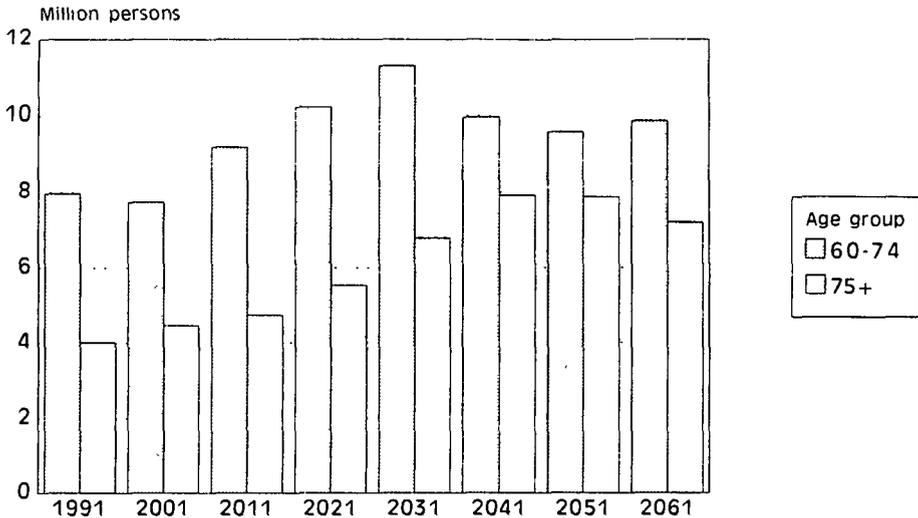
It is the marked reduction in fertility levels as much as any other feature of the population of the UK, many other countries in western Europe and now in the Asia-Pacific region, that have given rise to demographic aging of the population. Fertility rates (completed family size) in the UK have been below 'replacement level' fertility of 2.1 since the late 1940s with the exception of Northern Ireland where this was reached in the early-1970s. In the 1985-based national projections, the long-term average completed family size for the UK was assumed to be 2.0 children per woman. This has

subsequently been revised downwards to 1.9 children (OPCS, 1993) and was estimated to be 1.76 in 1993, although there was a minor upturn in 1990 caused by the generation born in the 1960s reaching their years of peak fertility. The general downward trend in total fertility rates has been accompanied by deferred childbearing and, in 1992 for the first time, women in their early 30s were more likely to have a child than those aged 20-24. This is an important social trend which has its explanations in changing family structures, aspirations, career options and choices. It has, however, very important implications for future family patterns and the potential of children to be involved with the care of elderly members. Fewer total children are being born to women and at later ages; women are living longer and there are likely to be fewer economically active persons in the workforce as a whole and fewer in any given family able to be involved with elder care. Therefore, dry demographic statistics assume major importance in terms of future economic, social and health policy and potential.

AN AGING NATION

Important changes are occurring in the older groups of the UK's aging population. In 1911, only about 5% of the population was aged 65 and over. By 1971, this proportion had reached about 13% and, in 1991, 15.7%. However, whilst the number of people of pensionable age (60+ for women; 65+ for men) is likely to have reached around 24% by 2051, this proportion will remain fairly static until after the turn of the century. Until about 2005, this number will increase only by about 2% per annum. The principal demographic feature of the elderly population over the next two decades is that the percentage of persons aged 65-79 will stay relatively static at just under 12% of the total population, whilst those age 80 and over will increase slightly from just under 4% to over 5% by 2021.

The relatively small growth in elderly proportions until about 2011 gives the UK a slight respite in which to acquire knowledge and formulate policies (Thane, 1989). Thereafter, there will be a gradual increase in all elderly groups until 2041 when those aged 65-79 will comprise about 17% of the population and those aged 80+ will comprise about 8% and increase to over 9% in the following decade (Figure 1). Looked at longer term, the number of persons aged over 75 is projected to more than double by 2051. However, the number of people aged ninety years and over will increase more than five fold! It is worth remembering that these people have already been born so the main speculation about numbers in the upper age groups

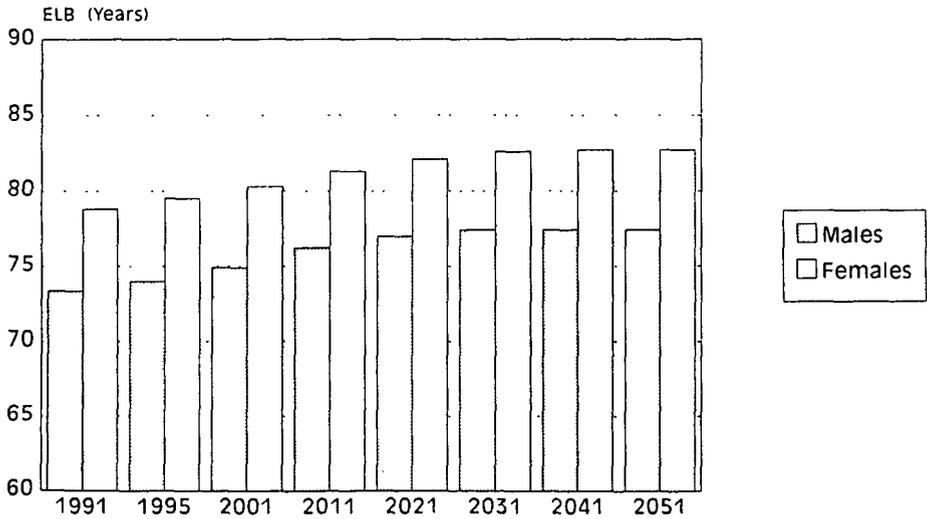


Source: based on data in OPCS (1993)

FIGURE 1. UNITED KINGDOM POPULATION PROJECTIONS, AGE GROUPS 60+ 1991 TO 2061

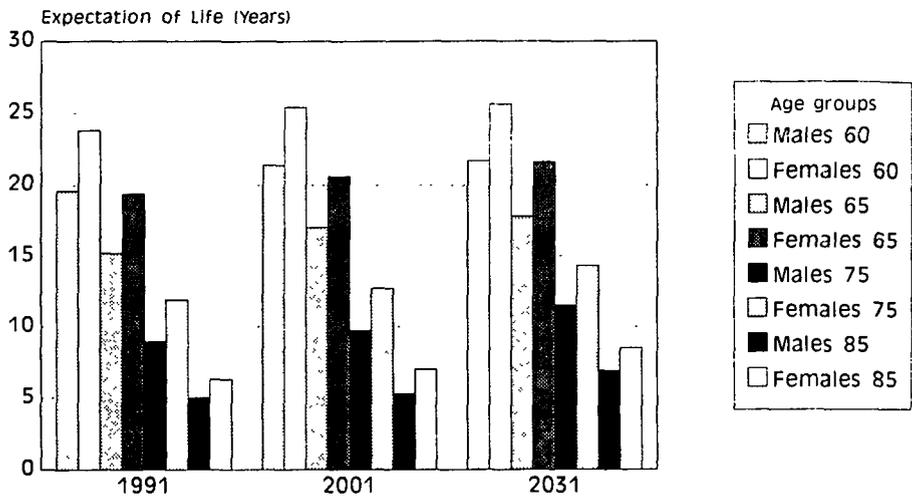
related to future longevity and reductions in mortality rates in the UK, by reductions in accidents and disease. As the Office of Population Censuses and Surveys (1993) notes, even in countries with the highest expectations of life, there is as yet little firm evidence of a slowing down in the rate of improvement to suggest that an upper limit is being approached. Therefore, users of elderly population projections for more than a decade or so in the future need to bear in mind that the range of possibilities is wide.

In general, therefore, to project future populations and expectation of life, various scenarios of mortality change are proposed. A medium projection is usually that which is quoted and often assumes that the century-long increase in longevity will cease after about forty years (or around 2030). Using such assumptions, Figure 2 shows projected Expectation of Life at Birth (ELB) up to 2051 and Figure 3 compares ELB by gender and age groups over 60. It can be seen that there has been a general steady increment in ELB up to 1991 and that the gap between female and male ELB has reduced from about 6.1 to 5.4 years. This difference is likely to reduce only slightly in the future so that the lifespan of women will continue to considerably outstrip that of males, which has various implications for social policy, housing and pension support for elderly females who might have substantial periods alone in later life. Over the next 50 years or so, ELB for women and men is likely to be increased by some 3.5 years to reach 77.4 and 82.7 years respectively. ELB in the UK today is in line with, or slightly



Source: based on data in OPCS (1993)

FIGURE 2. UNITED KINGDOM PROJECTED EXPECTATION OF LIFE AT BIRTH 1991-2 TO 2051-2



Source: based on data in OPCS (1993)

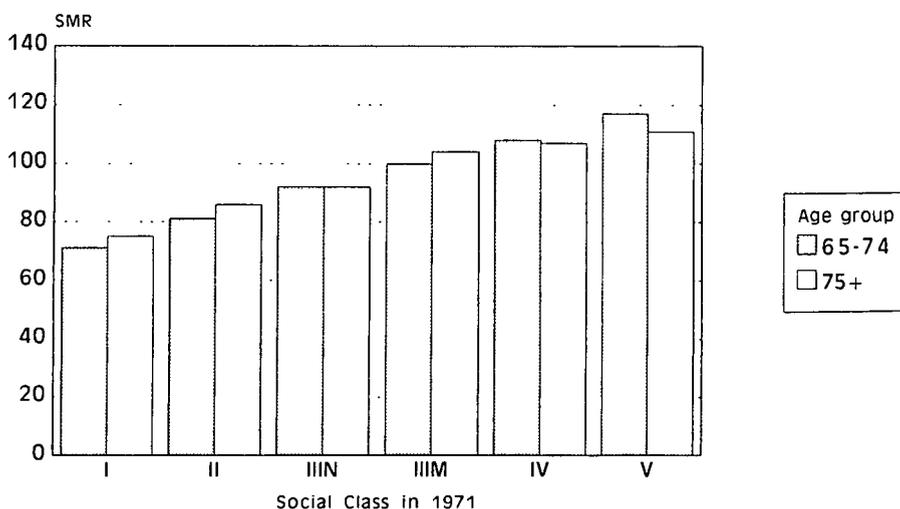
FIGURE 3. EXPECTATION OF LIFE FOR ELDERLY PERSONS UNITED KINGDOM 1991, 2001, 2031

below, those in other major Western European countries such as France and Germany, indicating some room for improvement. However, ELB in Europe as a whole is now beginning to be equalled by some countries in the Asia-Pacific region and overtaken by others such as Japan and Hong Kong (Bartlett and Phillips, 1995; Phillips and Bartlett, 1995).

The proportion of elderly people together with those aged under 16 (or another agreed year in a given country) are held to constitute the 'dependent population', a rough estimate of the population supported economically by the working age group. In the UK, the number of children under 16 has fallen (with the exception of a slight increase in the 1990s) and this group represents only 20% of the 1993 population, closing the gap with the 65+ group, which represents 15.8% of the population in the same year. The increased attention in the UK and elsewhere on the population over pensionable age concerns the increased share of pension, social and health care costs that will fall on national and personal budgets. As the baby boom generation reaches retirement age, it is estimated that the numbers over the current pensionable age will peak at around 17 million in 2036. Combined with the projected numbers of children, this gives a dependency ratio of 82 persons per 100 working age people by 2036. In 1993, this ratio was only 63 per 100. Whilst this increase in dependency ratios is not as high as in countries such as Japan, it is nevertheless in line with many other European countries and has important implications for the future funding and staffing of care for elderly people. In the UK, the total of 'dependent elderly people' (currently, men aged 65+ and women aged 60+) will outnumber those aged 16 or under at around the year 2011 and the total of elderly dependent population will increase for the subsequent twenty or more years.

HEALTH STATUS

A further policy-related point to be made concerns population aging as it relates to health status. The major causes of disability in old age are known to be related to the effects of cardiovascular and cerebrovascular disease, problems with vision and hearing, osteoarthritis, osteoporosis, incontinence, dementia and depression. However, it is difficult to assess the extent to which disability and dependence levels have changed as a result of increased longevity, as little adequate information on the real health status of the older population is available. The General Household Survey uses self-reported morbidity, which may reflect individuals' expectations about their own health and the services available, rather than absolute levels of morbidity (Medical Research Council, 1994). Any predictions about



Source: base on data in Population Trends, 80, 1995

FIGURE 4. MORTALITY BY SOCIAL CLASS, MALES AGED 65+ STANDARDISED MORTALITY RATIOS, UK, 1976-89

morbidity need to be interpreted with caution, however, as it has been suggested that the extent of disability in the future may not increase proportionately with age as expected (Jack, 1991). Nevertheless, it is known that the UK population varies in longevity and morbidity according to social factors, relating to occupation, education, housing and nutrition, amongst others.

It is also interesting to note that social class gradients in mortality persist into old age (Figure 4). To date, the higher social classes (professional and managerial groups in Social Classes I and II) have had lower Standardised Mortality Ratios (SMRs) than those groups in manual, semiskilled and unskilled occupations (Social Classes III, IV and V). These differentials reduce somewhat amongst older groups but still persist. For the 65-74 and 75+ age groups, SMRs range from about 70 to over 110 from Social Class I to V at least amongst older males (Harding, 1995). These findings suggest that policies to reduce inequalities and bolster the health of less advantaged social groups need to continue into old age even if, often, the damage to people's health might have occurred at an earlier age. The less advantaged might suffer greater disability and be less financially and personally equipped to deal with it.

POLICY CHANGES

The cost of providing health and social services to a growing elderly population has been central to the formulation and implementation of recent government policies. The White Paper *Caring for People* (Department of Health, 1989) was primarily aimed at those over retirement age and focused on six key objectives: values for money through a new funding structure; introduction of assessment of need and case management; promotion of an independent provider sector; promotion of domiciliary, day and respite care; more support for informal care; increased accountability of agencies. Matching services with users' needs is a key concept promoted by recent policy developments. The NHS and Community Care Act followed the White Paper in 1990, but its implementation was delayed for almost three years until April 1993. A whole new framework of services, which essentially separates the provision of services from their purchase, has been established. The responsibility for community care has been transferred to local authorities, changing their role to the management and regulation of care rather than its provision. This involves the assessment of individual need, the design of care arrangements and monitoring of their delivery.

These policy changes were intended to encourage new initiatives in community-based care and reduce the dependency on institutional care as a solution to the needs of the frail elderly. A major consideration, however, was the reduction of public expenditure in the form of social security payments to people in private and residential home care. The previously open-ended budget for those on income support had resulted in uncontrolled expenditure during the 1980s (Bartlett, 1987) and by 1993, the income support payments to people in private residential and nursing home care had reached £2.5 billion and were still increasing. Changes in funding arrangements have therefore been a major element in the community care reforms, with the transfer of the residential care portion of the social security board and lodging allowances to local authorities. Applicants that satisfy a means test and have their needs assessed may be supported in residential or nursing homes in the private or independent sector. Alternatively, packages of domiciliary care may be arranged.

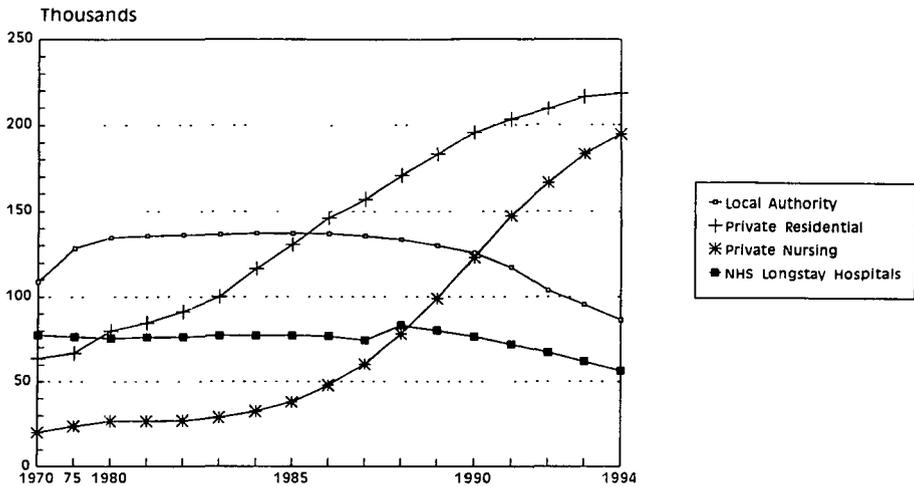
Various government guidance has been issued to promote the effective implementation of the NHS and community care reforms. Recent Department of Health (1995) guidance emphasizes the importance of collaboration between NHS and local authorities for arranging and funding services to meet peoples' needs for continuing care. Health Authorities are

required to review current arrangements for organizing and funding continuing health care and develop draft local policies and eligibility criteria for continuing health care by the end of September 1995, for implementation in April 1996. The guidance further notes that NHS continuing health care provision should not be reduced, or hospital discharge criteria altered, until policies and eligibility criteria are in place. Discharge from NHS inpatient care may be appropriate if a place in a residential or nursing home is arranged and funded by social services or the patient and his or her family, or a package of health and social care is offered to support a patient at home or in other accommodation.

There have been other important policy developments with implications for the delivery of aged care provision. In line with the current government's preference for deregulation, various directions have been issued for the private nursing and residential care home sector. Recent guidance from the Department of Health, directs health authorities to keep regulatory burdens on providers to "the minimum consistent with the need to ensure adequate protection for patients" and advises that "registration officers do not impose requirements beyond their statutory duties" (Department of Health, 1994a). Similar local authority guidance has also been issued for residential care homes to promote a reduction in paperwork and better distinction between basic standards and optional advice. The efficiency of the regulatory system has certainly been questioned and inconsistencies in inspection procedures and requirements across the country noted (Royal College of Nursing, 1994). A review of social services inspection is due to take place in 1995 at the same time as a review of the inspection of independent hospitals and nursing homes.

IMPLICATIONS FOR ORGANIZATION AND DELIVERY OF SERVICES

Major changes have occurred in the balance of long term care provision between the NHS, local authority and the independent residential and nursing home sector. Government policy prior to the 1990 community care reforms had clearly encouraged the growth of private nursing and residential care home provision and a reduction in long-stay NHS beds commenced in anticipation of the reforms. Figure 5 illustrates the general trend of contraction in public and NHS long-term places and expansion of private residential and nursing homes places. Of the total 556,000 places available across all sectors in 1994, the largest share (39%) was in the private and voluntary residential care sector, followed by 35% in the private and voluntary nursing home sector. Local authority residential home places



Source: based on data from Laing and Buisson

Note: Private sector includes Voluntary Places

Note: NHS Long Stay Places were redefined in 1988

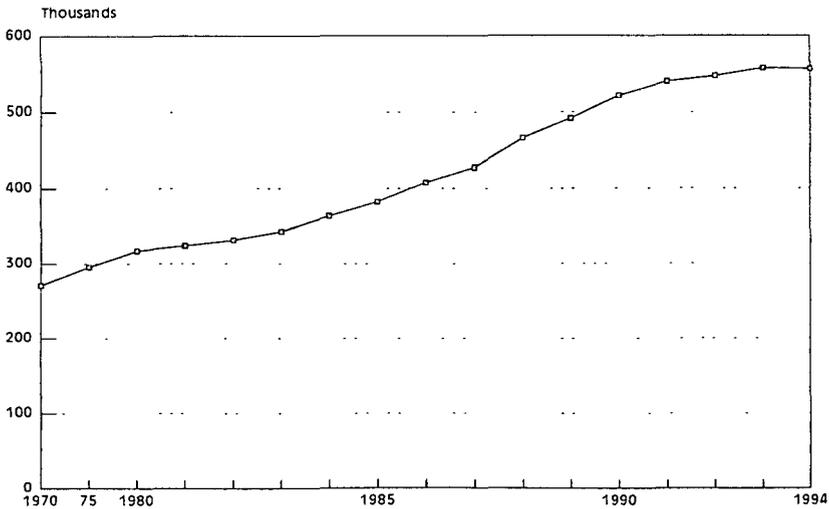
FIGURE 5. CARE OF ELDERLY AND PHYSICALLY HANDICAPPED PERSONS PLACES BY SECTOR, UNITED KINGDOM, 1970-1994

accounted for 16% of the total and NHS long stay hospitals just 10%.

The reduction in public residential home and NHS long-stay places commenced in the mid-1980s. Over a quarter of the NHS provision of 77,200 places in 1984 has been lost, resulting in a 1994 level of 55,600 places (Laing and Buisson, 1994). Patients no longer have the right to occupy indefinitely an NHS bed. Places in local authority residential care have fallen even more dramatically. A 37% reduction from 137,200 to 86,400 places occurred between 1984 and 1994 (Laing and Buisson, 1994).

On the other hand, places in private and voluntary nursing homes have been multiplying rapidly since 1970, when the figure was 20,300, to the 1994 level of 194,800; an increase of over 800%. While not as dramatic as the private nursing home sector, places in the private and voluntary residential care homes have tripled from the 1970 level of 63,800 to 218,200 in 1994 (Laing and Buisson, 1994).

The effects of changes in funding arrangements have been evident during the first year of the community care reforms (1993/94). The number of local authority supported residents in residential home care increased in England by 25% to 121,000 and support was also provided for 25,000 residents in nursing home care (Department of Health, 1994b). Clearly, and of the *White Paper's* objectives to further promote the independent sector is already



Source: based on data from Laing and Buisson

All Sectors = Local Authority, Private, Voluntary and NHS

**FIGURE 6. CARE PLACES FOR ELDERLY AND PHYSICALLY HANDICAPPED PERSONS
NUMBER OF PLACES, ALL SECTORS, UNITED KINGDOM, 1970-1994**

proving to be successful. However, while the total bed numbers across all sectors have more than doubled since 1970, the figure is no longer increasing. A slight drop actually occurred for the first time between 1993 and 1994 (Figure 6). Laing and Buisson (1994) suggest that 100,000 more places will be needed in nursing/residential care homes by the year 2000.

The decline in the number of NHS continuing care beds has various consequences, but of particular concern is the inequity of access to long-term care that is likely to result from geographical variations in this provision. It is believed that the establishment of locally based eligibility criteria by health authorities is likely to increase this inequity (RCN, 1995). Research has already identified that there are also wide geographical variations in private and public residential and nursing home provision (Larder, Day and Klein, 1986; Phillips and Vincent, 1988; Corden, 1992; Warnes, 1994). Although the recent guidance (Department of Health, 1994a) stresses the responsibility of the NHS to meet the needs of people who require continuing physical or medical health care, it is expected that this care may be in hospital or a nursing home.

IMPLEMENTATION ISSUES

The process of implementing recent policy reforms has already raised numerous issues about the organization and delivery of aged care services. The following discussion, however, only attempts to address some of the more pressing issues. First, there are implications arising from the introduction of assessment and care management. The policy guidance presented various models for assessment and care management, but local authorities have largely been left to devise their own process. A recent study of the implementation of community care reforms identified that local authorities experienced difficulties in designing assessment forms and distinguishing the levels of assessment (Lewis, Bernstock and Bovell, 1995). Inequity is an inevitable result of local authorities developing their own assessment procedures and criteria. Furthermore, as the assessment process and its outcome are largely under the control of professionals, the opportunity for consumers to exercise a real choice of care options is limited (Walker, 1993). In the case of private nursing home admissions, it is already known that the decision to select and enter a home is rarely made by the elderly clients themselves (Challis and Bartlett, 1987).

Second is the challenge of achieving joint planning and commissioning. Appropriate and efficient placement of older people in need of care is increasingly dependent upon the operation of a successful health/social care interface, for example joint purchasing strategies between health and social services and good information sharing across all services (Murphy, 1993). However, during 1993/94 a few difficulties were identified, for example, nursing home places could not be easily obtained by a few health authorities (Harrison, 1994). Although there are some example of effective joint planning (Broadhurst, Bradshaw & McIntyre, 1995), as yet there appears to be little incentive for this to occur on any great scale.

The third issue concerns the ability of the private nursing home sector to cope with the needs of the more dependent patients, formerly care for in long-term hospital beds. Although changes in funding arrangements may reduce the choice of private homes to reject the more dependent formerly cared for in long-term hospital beds, there is no guarantee that the private nursing home sector will be able to provide adequate care for the very dependent residents. Demographic data and health statistics point to the continued need for long-term hospital care until the private nursing home sector is sufficiently skilled to cope with severe disabilities. However, under the present system there is no incentive for the NHS to provide continuing

care. Health authorities can control expenditure by transferring patients to long-term care in the independent sector.

Fourth is the issue of regulating standards and quality of care in the independent sector. Standards in private and voluntary residential care and nursing homes have been legislated for over ten years by the Registered Homes Act 1984. Guidance on standards has been available through the code of practice for residential care (Centre for Policy on Ageing, 1994) and national guidelines for nursing homes (National Association of Health Authorities, 1985). Given the increasing reliance on the private sector to provide long-term care, the government's intention to deregulate independent nursing homes and hospitals is therefore of some concern. The quality of nursing care provided in some homes is still poor (Bartlett, 1993) and many homes are ill-equipped to care for very dependent older people, particularly those suffering from dementia.

CONCLUSIONS AND IMPLICATIONS FOR THE FUTURE

Despite recent policy developments, it still remains to be seen whether a sufficiently comprehensive system of support for elderly people in the UK can be developed. This review has highlighted some of the chief barriers to the smooth implementation of reform. The desired shift from institutional to community-based services for older people has not yet occurred. Ambiguities exist regarding policy implementation at a local level, particularly in relation to the utilization of NHS long-term beds. There are concerns that long-term beds and income support are being removed before effective alternatives are put in their place (Marks, 1994). Day and domiciliary packages are not abundant in the independent sector and cost ceilings placed on these packages may encourage social services departments to turn to residential and nursing home care as a cheaper alternative (Wistow, 1995). However, there are concerns about whether the independent sector is suitably qualified to meet the needs of the UK's increasing numbers of high dependency older people.

Considerable thought about the development of future models of care is still necessary to meet the challenge of an aging population in the UK. A new public/private partnership may be necessary to capitalise on existing provision and improve care (Bosanquet, 1995). A wider role of nursing and residential homes in providing day and domiciliary support may offer the support necessary for older people living in their own home or with care. The need to address the wider difficulties of the health and social care divide are fundamental to the future planning of aged care services in the

UK and will require major improvements in health and social care coordination at an organizational and practitioner level (Henwood, 1992).

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