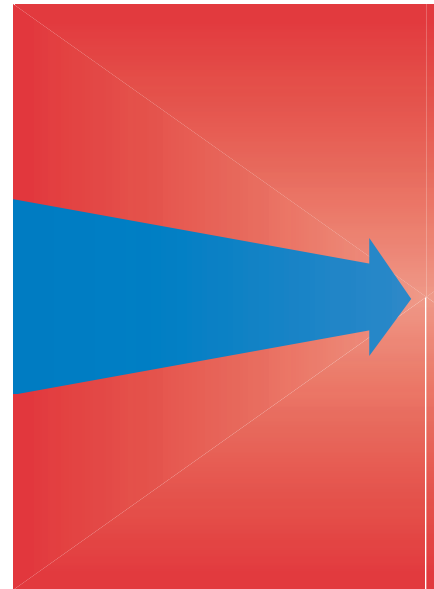


Foresight

Making the future work for you

Healthcare and Ageing Population Panels



JOINT TASKFORCE ON OLDER PEOPLE

What is Foresight?

Foresight is about being ready for the future. No one can predict the future. What we can do is look ahead and think about what might happen so that we can begin to prepare for it.

The future is shaped by the decisions we make today. If we wait for the future to happen to us the UK will miss out on opportunities for wealth creation and a better quality of life. The UK's Foresight programme is about making sure that we are ready for what lies ahead.

Foresight brings together the voices of business, government, the science base and others to identify the threats and opportunities that we are likely to face over the next ten to twenty years. In doing so, Foresight aims to bring about a culture of change in the way business, academia and government relate to each other and to the future.

The programme was launched in 1993 following the white paper on science, engineering and technology, *Realising our Potential*. It has a panel-based structure and operates on a five-year cycle. The current round of Foresight began in April 1999.

Work is being taken forward through three thematic and ten sectoral panels, each looking at the future for a particular area. All panels have been asked to consider the implications of their findings for education, skills and training and sustainable development.

Foresight panels

Thematic panels: Ageing Population, Crime Prevention and Manufacturing 2020.

Sectoral panels: Built Environment & Transport, Chemicals, Defence, Aerospace & Systems, Energy & Natural Environment, Financial Services, Food Chain & Crops for Industry, Healthcare, Information, Communications & Media, Materials, Retail & Consumer Services.

A further industry-led panel is looking at Marine issues and there is a task force addressing the impact of E-commerce on business processes and supply chains.

All Panels publishing their emerging thoughts for consultation. Most consultations will close by the end of September. Panels will publish their first full reports in late November 2000.

For further information on the Foresight programme, panels' emerging findings and Foresight news and events, please visit the Foresight website on www.foresight.gov.uk or fax us on 020 7215 6753.

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1 Introduction

Traditionally “old age” has referred to ages of 65 years and above and been associated with negative stereotypes of frailty, ill health, and social and economic dependency. This is changing. Life expectancy has increased, and mortality and morbidity at all ages have declined. The heterogeneity of older people - always present - is now more obvious as their numbers have increased. Older people are individuals, not only because of the uniqueness of personal circumstances but also because of intrinsic variability in the ageing process itself. The new older cohorts are different from their predecessors. Those who will attain “old age” during the next 20 years will have lived most of their lives in an era of antibiotics, vaccines, a comprehensive National Health Service, and fast-changing social attitudes. Their needs and healthcare expectations will be different.

In looking forward 20 years, the ‘Older People’ Task Force took particular account of the diversity (see Box 1) and polarisation which exists. Current trends are such that social and economic inequalities could become starker, despite recent initiatives to tackle social exclusion. As the value of the state pension and income support declines relative to earnings (including income from investments and earnings-related pensions), the material circumstances of older people living on different income sources are likely to diverge.

Box 1 - The Diversity of Older People

Older people are not a homogeneous group. Like the rest of the population there are differences in:

- ▶ gender (with a greater proportion of women in older age groups)
- ▶ ‘race’ and ethnicity
- ▶ socio-economic group/social class (with major effects on health and life expectancy)
- ▶ income/pensions (older women are particularly likely to be poor)
- ▶ regional/local cultures
- ▶ household and/or family structure

A person’s health in old age is influenced, but not necessarily determined, by earlier life experiences. Illness and disability in older people correlate with socio-economic status as measured in mid-life or early retirement. Beneficial circumstances in later life augment earlier advantages, whereas adverse later circumstances worsen disadvantage. However, these trends can be modified. Among disadvantaged older people, especially the oldest age groups, health and social services can play an important role in improving quality of life and alleviating health inequalities.

The Task Force began its work by identifying drivers of change in older people's circumstances and experiences, including:

- ▶ **advances in technology that can help preserve independence;**
- ▶ **advances in the biomedical sciences;**
- ▶ **increased access to information, education, knowledge and power in decision making;**
- ▶ **social, political and economic trends;**
- ▶ **the organisation, and funding and delivery of social and health care services.**

Hypothetical case studies were used to explore the impact of these drivers on the health and health care of older people living in different circumstances. Best-case and worst-case scenarios were reviewed in order to identify dangers, needs and opportunities. From these, the Task Force drew its recommendations.

The Task Force was conscious that certain values would inform its work and that these should be explicit rather than implicit. It therefore sought to identify them by discussion. Agreed values included the importance of recognising:

- ▶ **the potential positive social and economic contributions of older people**
- ▶ **older people's reasonable expectations of a publicly funded and adequately resourced system of care**
- ▶ **the contribution and hidden costs of 'informal care', much of which is provided by older people for older people, both within family networks and within the community**
- ▶ **the differential experience of older people in diverse groups within society and the profound impact of direct and indirect discrimination**
- ▶ **the need to maximise older people's autonomy, dignity and independence, and to minimise the occurrence and impact of disability and handicap.**

2 Needs

Population ageing is expected to lead to a higher need for expenditure on health and social care. Calculating the health and social care costs of an ageing population presents methodological challenges. Estimates of future needs depend on expected trends in the pattern of diseases and disabilities of the older population.

In the UK, temporal changes in cause-specific mortality at older ages are relatively well described, except for the oldest age groups (80+). Far less is known about the incidence and prevalence of a wide range of non-fatal conditions or the extent to which these may be changing. Many of these conditions are associated with high levels of health service costs (e.g. diabetes, cataract), poor quality of life (e.g. stroke, heart failure), and loss of independence (e.g. osteoarthritis, dementia). Information for planning future services requires estimates of trends in disabilities such as hearing loss, problems with mobility, and cognitive difficulties. Routine surveys of the population provide some data on self-reported disabilities or difficulties in carrying out everyday tasks but there are considerable limitations in the use of such data for informing policy.

Cardiovascular diseases (CVD) will remain an important cause of mortality and morbidity for at least some decades and will continue to show marked differentials between socio-economic groups. Current declines may be slowed or arrested through unfavourable trends in risk factors such as obesity and smoking. Older people will expect to have equitable access to new health technologies as well as to rehabilitative services and pharmacological treatments following myocardial infarction and stroke. Advances from human genome research may lead to more targeted treatments but a substantial fraction of older people will be on drug treatment for high blood pressure, heart failure, angina and other manifestations of CVD.

Cancer will become relatively more important as a cause of mortality and morbidity in old age. For most common cancers of old age there is, at present, little indication of a downward trend in mortality. Lung cancer rates have increased dramatically in recent cohorts of older women and this trend is likely to continue unless there are major reductions in the prevalence of smoking. There will be an increased need for all cancer services including investigation, treatment and terminal care. Advances in identifying early disease markers and genetic susceptibility make it likely that more targeted cancer screening programmes (e.g. colorectal, prostate) will be introduced.

Degenerative diseases of late onset will become commoner as a result of the increased numbers of the very old (the over 80s are the fastest growing age group). Age-related macular degeneration, the most important and at present irremediable cause of adult blindness in the UK, is predicted to increase 50% in the next 25 years while cataract surgery will continue to be a major health service cost. Possible benefits on the incidence of these diseases through adoption of healthier diets are likely to be offset by adverse trends in smoking. Considerable recent investment in dementia research will lead to new

therapeutics to arrest the rate of cognitive loss but there is as yet little evidence for a changed incidence.

Musculo-skeletal disorders contribute to major losses in mobility, independence in performance of activities of daily living and is a major cause for pain for many elderly people. Osteoporosis is responsible for hip and wrist fractures, spinal deformity and vertebral fractures particularly in post-menopausal women. Osteoarthritis results in degeneration of the articular surfaces of the hips, knees and spine. Shoulder pain due to a variety of degenerative changes is also common in old age. Problems with bony and soft tissues of the feet are common causes of pain, immobility and chronic wounds, which not infrequently progress to the extent that amputation is required.

Psychological problems, such as depression, are expected to increase but will show social variation. Demographic trends (e.g. divorce and geographical mobility) may lead to greater numbers of older people lacking a close confidante.

Age-related disabilities, such as hearing impairment, general cognitive decline, declines in muscle strength and stamina, and incontinence are expected to increase in prevalence, although the more optimistic scenarios suggest that disability will be postponed to later ages. The extents to which these disabilities may be influenced by environmental and genetic factors or by interventions to reduce the rate of decline are largely unknown although some encouraging results have been shown from physical activity programmes in older people. As people age they become more vulnerable to external risks and the consequences are more serious than at younger ages, for example falls are more likely to occur in older people and to lead to serious outcomes such as death and fractures. Current secular trends in hip fractures showing an increased incidence may be attenuated in future cohorts as a result of HRT use, safer home environments, and better understanding of risk factors and control strategies.

Long-term care presents a major need of older people that has particularly serious implications for the provision of social and healthcare support. The major issues concerning long-term care of older people were addressed by a Royal Commission, the major recommendations of which addressed how the costs of long-term care should be met and that the Government should establish a body that will monitor longitudinal trends, including demography and spending, ensure transparency and accountability in the system, represent interests of consumers, encourage innovation, keep under review the market for residential care and nursing care, and set national benchmarks, now and in the future. In July 2000 the Government published its NHS Plan and, as part of that Plan, its response to the report of the Royal Commission on Long-Term Care. The Plan undertakes to increase expenditure on new health and social care services for older people, including intermediate care services designed to ensure that older people are encouraged or enabled to remain independent for as long as possible. The Government has accepted most of the Royal Commission's recommendations except that the NHS Plan will make nursing care free in all settings including nursing homes, instead of the Royal Commission's approach of making all personal care free to individuals, subject to an assessment of need."

Emerging needs of older cohorts include the health impacts of climate change, stratospheric ozone depletion, and globalisation. Older people, especially in poor housing, will be vulnerable to the expected scenarios of climate change in the UK (thermal extremes, increased flooding and gales). Stratospheric ozone depletion and increased ambient ultra-violet radiation (UVR) along with secular trends in sun seeking behaviours are likely to lead to increased skin cancers (including basal cell carcinoma (BCC)), cataracts and immune-related diseases. Climate change along with increased population mobility may lead to the introduction of new infectious diseases, rapid spread of flu and other respiratory infections which older people are least likely to withstand (antibiotic resistance and greater susceptibility).

3 Dangers

DANGERS TO THE PERSON

The future holds clear dangers for older people both as individuals (from the morbidity and disability associated with ageing) and as significant consumers of health and social services (from inadequacies in provision).

Loss of independence. An important factor in the loss of a person's capacity to live independently is failure to prevent premature onset of chronic illness and disability. This commonly arises through missed opportunities for early diagnosis, which might have led to proper management of risk factors through medical and/or social intervention, including the use of new technologies, suitable housing, transport schemes, and community care services.

Reduced quality of life. A major threat to older people is failure to respond effectively, or in a timely manner, to the chronic diseases of old age. Societal trends may also lead to increasing isolation, especially for those living in socially deprived areas. The interaction of morbidity and social isolation will together result in increased proportions of older people becoming a preventable 'burden' to themselves and to society as a whole.

DANGERS FOR THE HEALTH CARE SYSTEM

Shortage of health professionals. There is a large cohort of non-UK medical, and to a lesser extent dental, practitioners who are rapidly approaching retirement age and who currently provide a substantial proportion of the community-based health care, particularly in socially deprived communities. The loss of this cohort will result in a dearth of practitioners with sufficient skills and motivation to work in difficult community settings.

Lack of access and quality of care. Shortage of health professionals and ageist societal attitudes may together impair access to timely and appropriate health care, particularly from primary and community-based services. Hospital services will also be vulnerable if insufficient account is taken of the increasing needs of older people and of possibilities of effective treatments to sustain independence and quality of life. Over-stretching of facilities for older people will have negative implications for staff recruitment, morale, and the quality and effectiveness of care.

Poor co-ordination of services. Older people are particularly vulnerable to problems caused by poor co-ordination of services, e.g. for follow-up care following hospital discharge. This reflects the current divide between health and social care and is likely to result in lack of effectiveness and greater overall cost.

Non-participation of elderly people. Ensuring the effectiveness and appropriateness of services in relation to a diverse population requires greater participation and empowerment of older people in determining priorities, with opportunities for consumer feedback and monitoring of service delivery. Failure to take proper account of individual preferences will result in diminished cost-effectiveness, e.g. through non-compliance or inappropriate provision.

DANGERS FOR SOCIETY

Societal trends including:

- ▶ increased family dispersion
- ▶ increasing divorce rates
- ▶ decline of neighbourhood shops and banks
- ▶ lack of public transport
- ▶ fear of crime

can have particularly severe effects on older people, contributing to social isolation and increasing the risk of entering the downward spiral into dependency and ill health.

A large proportion of older people live in a state of chronic financial hardship, being reliant on state benefits and having often experienced long periods of widowhood or unemployment. This group is characterised by having the highest levels of illness and disability but less access to facilities and services, with implications for increasing disadvantage and reducing quality of life. Advances in technology (including developments in telecare) offer considerable benefits for older people, but in the absence of specific policy to support making them widely available, may exclude the more economically and educationally disadvantaged.

4 Opportunities

Life expectancy is greater than ever before. The extra years of life represent a unique opportunity for individuals and society to enjoy to the full. Notwithstanding the deleterious impacts of the ageing process on many aspects of health, evidence is accruing that the period of disability and seriously impaired quality of life in advanced old age can be compressed. In other words, although the proportion of older people will increase, the healthcare 'burden' of dependency can, with careful planning and appropriate investment, be reduced. Older people have an important role to play in finding solutions to some of the challenges that can be foreseen.

Information technology. Continuing developments in IT are likely to produce the greatest single change in society within the next 20 years. The benefits to older people from IT access to family and friends (e.g. via videolink), 'smart' monitoring and telecare systems, entertainment and shopping will do much to counteract limitations on mobility. With appropriate involvement of the growing market of older users, intelligent interfaces will reduce the skills needed to access these facilities and may help to overcome sensory and even cognitive impairments. Access-for-all will be the key to success and a window of opportunity exists to maximise effectiveness of healthcare-related services for older people that may be delivered through IT. The current adverse trend towards increased polarisation could be significantly countered if all households are fitted with the means to receive IT services.

Attention should be given to adopting an 'industry standard' IT connection to be installed in every home, analogous to the provision of other essential services (e.g. gas, water, electricity).

Materials and devices. Opportunities to extend independence in old age through the use of advanced materials and technologies are substantial. However, implementation is often constrained by restrictions on health and social care budgets. The costs of providing advanced devices such as lightweight, electrically powered wheelchairs which maximise the older person's independence and quality of life will often be small in comparison with the costs of coping with secondary health problems that follow from isolation and high-level dependency. New absorbent materials are making a substantial impact on the common problem of urinary incontinence, which causes much anxiety, isolation, and depression in older people. Other approaches, including artificial sphincters, may offer very effective solutions in the next 20 years for older people with certain forms of incontinence. Advanced monitoring systems can help to ensure safe independent living, and advanced cueing systems can assist cognitively-impaired older people who may become confused when performing routine tasks.

The evaluation of new technologies to address healthcare needs of older people should explicitly take account of indirect savings as well as direct costs.

Biomedical research. Major opportunities are emerging for the development and implementation of new diagnostics, treatments to relieve symptoms and, most excitingly, prevention of some of the diseases of ageing, such as dementias, depression, stroke, heart failure, cancer, diabetes and osteoarthritis. Greater understanding of the ageing process is enabling the development of nutrition-and lifestyle-based approaches to the long-term maintenance of health, including the development of novel 'functional foods' (e.g. foods rich in antioxidants or those targetted at reducing risk of specific age-related conditions). Human genome research will provide insights into the genetic contribution to ageing and age-related disease conditions, and will enable the identification of at-risk sub-groups who might benefit particularly from specific interventions. Also biomedical research into basic biology will have an impact on the understanding of disorders of the elderly. All of these approaches need to be combined with epidemiological research to establish baseline data and demonstrate efficacy of interventions. We should not underestimate the amount of multidisciplinary research that needs to be done to understand the complexity of the ageing process.

The EQUAL initiative, which was instigated after the previous round of Foresight and which resulted in significant new programmes of research in ageing, should be repeated on an expanded basis in order to build a sustainable, internationally competitive UK research base.

Lifestyle and nutrition. Health in old age is a product of lifetime experiences, with many age-related diseases and disabilities being the result of earlier exposure to risk factors. Research and health promotion linked to the early-life determinants of good health, including oral health, in old age is thus of key importance. Remarkably little is yet known about optimum diets and nutritional indices in very old people or about how to overcome barriers to healthy eating and adoption of regular exercise. Health promotion activities should target the most disadvantaged groups in the community, since these are the groups in which adverse effects are most prevalent.

Lifestyle and nutrition research and health promotion initiatives need to be targeted in particular at the current generations of younger and middle-aged people, in order to increase the health expectancy of future cohorts of older people.

Living environment (housing, transport, crime, air quality). Sub-standard housing is a particular health risk for older people, while the home environment may be hazardous, for example, due to poor lighting or uneven surfaces. The opportunities to improve the living environment include provision of purpose built housing, improvement to existing housing, aids and adaptations, provision of help with household tasks, care and repair. Buildings that are designed from the outset to be accessible or adaptable to a range of levels of disability provide the opportunity to remain long-term in the same home, which is strongly preferred by the great majority of older people. The outdoor environment also contributes to the ability of older people to continue living in the neighbourhood of their choice. Lighting, pavements, road crossings, the availability of public transport and its accessibility to people with impairments, air quality (for the breathing-impaired), the perception of personal safety, and the proximity of shops and social facilities all contribute to creating a favorable living environment.

Demographic change should be reflected by ensuring that local authority planning rules and guidelines provide positive reinforcement of the specific needs for an 'older person-friendly' environment.

Integration of health and social services. Crucial services for older people include those that (i) reduce the impact of disabilities (hearing and vision aids, walking and bathing aids); (ii) enable independent living (e.g. home cleaning, shopping, bathing and provision of meals); (iii) provide medical or nursing care (e.g. community nursing services, incontinence services, chiropody). Older people in poor general health, the housebound, and those who are economically and socially disadvantaged are more likely to experience tooth loss, caries and periodontal disease and require affordable dental services. Although providing support to enable life at home is the main goal of service provision for older people in the community, there will be a proportion of older people with serious disabilities who require long term residential or nursing care. The need for long-term care will be in inverse proportion to the levels of formal and informal service provision (kin, community and voluntary sector) available in the community. Although some older people will have adequate financial resources to purchase services, others will remain reliant on families and public sector provision. It is likely that there will be considerable expansion and diversification of the private sector market including disability aids and home services.

The principle of joined up government provides an opportunity, recognised in the Government NHS Plan, for developing effective co-ordination of the work of the Health and Social Services departments. A seamless service provision and the removal of duplication and barriers to the effective delivery of care are expected to increase effectiveness and reduce overall costs. The adoption of a common budget and a ministerial team specifically charged with addressing the needs of older people would significantly further this aim. This development should include the introduction and longitudinal evaluation of different models of care, which must have the flexibility as well as complexity to respond to the multiple and diverse needs of older people."

Finance and productivity. Financial security in old age has a major bearing on health and healthcare. People entering the workforce can now expect to live for at least twenty years after retirement. The probability of their requiring long-term care is currently about one in four. Under these circumstances, there is a strong case for people who can afford to do so to be encouraged to make financial provision for their own old age. At the same time, the number of healthy, active older people will continue to rise rapidly. There is a huge potential for such people to contribute to the economy - whether directly in paid employment or indirectly in unpaid work. As active lifespans continue to increase, there seems no reason to insist on retirement for all at sixty or sixty-five. There is an opportunity now to encourage, more effectively than at present, current generations of younger people to make appropriate plans for their old age, supplemented by support for those who are unemployed. On the other hand, Government needs to accept that it has a contract with the current generation of older people, who have been making provision through their earnings-related contributions, which they were promised would provide care for them in their old age.

The balance between personal and Government provision for future healthcare needs of older people requires ongoing review. Such review will not only monitor the effectiveness of proposals in the Government NHS Plan, including those which respond to the recommendations of the recent Royal Commission on Long-Term Care, but will also take account of broader aspects of finance and productivity of older people."

Social participation/intergenerational exchange. The increased participation of older people in determining priorities for health and social care can be achieved by building on recent policies to elicit the views of local communities regarding needs and priorities and to involve patients in discussions and decisions regarding their own care. Many older people have considerable skills, motivation and experience to have a greater say in the provision of services, for which they will then have some ownership and responsibility. Particular attention should be paid to seeking the views and participation of ethnic minorities, many of which are now long-established and form an important element of the ageing population. Attention should also be paid to seeking the views of those in areas of the greatest social deprivation, where the challenges faced by older people may be very different from the average.

Planning should be by, as well as, for older people, taking full account of diversity.

Education, leisure and learning. Older people can benefit from increased opportunities for continuing education and learning and from leisure opportunities providing physical and mental stimulus. These have enormous potential to contribute to the maintenance of physical and psychological health and quality of life.

The planning of new facilities for education, leisure and learning should explicitly address the needs of older people.

Investment in healthy ageing. The level of resource is the most significant factor influencing the quality of the health services. This, in turn, impacts greatly upon the quality of life of the older person and, by affecting the diagnosis and treatment of disease in earlier life, upon the morbidity of the older population. There is a great opportunity to have a major positive impact upon the quality of the health services, and their cost-effectiveness, by investing in healthy ageing. This is possible, in part, because of the current favourable economic climate. More significantly, the appreciation that nearly all of our neighbours in Western Europe spend a significantly higher fraction of their national wealth on health and, in return, receive a much better and more efficient service is creating an awareness of the need to commit a higher fraction of GDP on our national investment in health.

UK investment in healthy ageing as a percentage of GDP should, as a minimum, be increased to match the EU average.

5 Recommendations

Continuing demographic change with sustained growth in life expectancy is a certainty. In the view of the Task Force, we are at a turning point where the extra years of life can, through positive action and investment, become an asset of enormous value and potential which will properly reflect the successes of the past that have made longer lives possible. Failure to act or inappropriate and inadequate action runs the risk of bringing to reality the much-feared social, economic and personal 'burden' of an ageing population in which the extra years are of low quality.

OUR RECOMMENDATIONS ARE:

- ▶ **Attention should be given to adopting an 'industry standard' IT connection to be installed in every home, analogous to the provision of other essential services (e.g. gas, water, electricity).**
- ▶ **The evaluation of new technologies to address healthcare needs of older people should explicitly take account of indirect savings as well as direct costs.**
- ▶ **The EQUAL initiative, which was instigated after the previous round of Foresight and which resulted in significant new programmes of research in ageing, should be repeated on an expanded basis in order to build a sustainable, internationally competitive UK research base.**
- ▶ **Lifestyle and nutrition research and health promotion initiatives need to be targeted in particular at the current generations of younger and middle-aged people, in order to increase the health expectancy of future cohorts of older people.**

- ▶ Demographic change should be reflected by ensuring that local authority planning rules and guidelines provide positive reinforcement of the specific needs for an 'older person-friendly' environment.
- ▶ Co-ordination of the work of the Health and Social Services departments should be effected, with a common budget and a ministerial team specifically charged with addressing the needs of older people, in order to remove duplication and barriers to the successful delivery of care, increase efficiency and reduce overall costs. This development should include the introduction and longitudinal evaluation of different models of care, which must have the flexibility as well as complexity to respond to the multiple needs of older people.
- ▶ The balance between personal and Government provision for future healthcare needs of older people requires ongoing review. Such review will not only monitor the effectiveness of proposals in the Government NHS Plan, including those which respond to the recommendations of the recent Royal Commission on Long-Term Care, but will also take account of broader aspects of finance and productivity of older people.
- ▶ Planning of health and social care should be by, as well as, for older people, taking full account of diversity.
- ▶ The planning of new facilities for education, leisure and learning should explicitly address the needs of older people.
- ▶ UK investment in healthy ageing as a percentage of GDP should, as a minimum, be increased to the EU average.

Taskforce Membership

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Responses are welcome and should be directed to either of the Panel Secretariats in the first instance:

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Please note that your response to this consultation exercise may be made publicly available in whole or in part at the Department's discretion. If you do not wish all or part of your response (including your identity) to be made public, you must state in the response which parts you wish us to keep confidential. Where confidentiality is not requested, responses may be made available to any enquirer, including enquirers outside the UK, or published by any means, including on the Internet.

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