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CHAPTER 4:

Adding Years to Life, and Life to Later Years

As life expectancies lengthen, so do years of potentially healthy and productive life. The key word is “healthy”. So far, although women live longer than men, approaches to health policy often start from the false assumption that after menopause the concerns of women and men converge. This chapter concentrates on health issues especially concerning women, on the understanding that women’s health issues in later life have not had their due share of attention.



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Women live longer than men, and average more years of ill health late in life. Older women’s health reflects inadequate access to basic services, food and nutrition throughout their lives, and the hardships of their childbearing years — including births too early or too closely spaced, poor nutrition and anaemia.

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The ICPD on Ageing and Older Persons

The ICPD Programme of Action notes (in paragraph 6.16) that the world is experiencing “record increases in the proportion and number of elderly persons”, including the very elderly, and a “steady increase of older age groups . . . in relation to the working-age population”.

Stressing that “elderly people constitute a valuable . . . component of a society’s human resources”, the programme calls on governments to:

- ◆ help elderly people to be more self-reliant and attain a higher quality of life;
- ◆ enable them “to work and live independently in their own communities as long as possible or as desired”, making full use of their skills and abilities;
- ◆ recognize and encourage the contributions elderly people make to families and society as volunteers and caregivers;
- ◆ improve health care and health policies that address the needs of the elderly (8.7);
- ◆ develop old-age economic and social security systems that ensure equity and solidarity between and within generations, paying special attention to women’s needs;
- ◆ encourage multigenerational families and help families take better care of elders (5.11, 6.18);
- ◆ eliminate all forms of violence and discrimination against elderly people;
- ◆ raise awareness on and encourage debates about population ageing (11.16).

The Platform for Action of the Fourth World Conference on Women (Beijing, 1995) amplified these recommendations, emphasizing the conditions of older women living in poverty (paragraphs 52, 58 and 101).

The health of women

Women generally live longer than men, but they can also expect more years of ill-health late in life. Women’s health, especially that of older women, is closely tied to discrimination and poverty. Women have unequal and inadequate access to basic services, food and nutrition. In many poor households and communities, women work harder than men but eat less.

Polluted water affects women’s health more than men’s because they are more frequently in contact with it. Other environmental hazards, including lifelong exposure to pesticides and indoor air pollution from smoky kitchens, also threaten women’s health. Many older women suffer from chronic health problems caused by years of neglect, discrimination and the hardships of their childbearing years (see the discussion of gender differences in health indicators, below). Biological factors that lead to higher disease and disability in women can be exacerbated by this lifelong discriminatory treatment.

Healthy Ageing through the Life Cycle

As life expectancy increases, the important causes of death and ill-health change. Complications of pregnancy and delivery and infectious diseases of childhood have a much greater impact in societies with high mortality. The reproductive health and choices of women significantly affect their life prospects and those of their children. The age of the mother, care during gestation and delivery and the spacing of births have an important influence on infant and childhood mortality and morbidity. Breastfeeding is good for the infant and reduces a mother’s risk of breast cancer.

Later health problems can begin from conditions prior to birth. Malnutrition of the mother during gestation and of the infant once born creates a predisposition to a number of chronic diseases in adulthood. Diabetes is related to the level of depletion of the mother’s body during pregnancy, often the result of multiple and closely-spaced births. A woman whose weight was low at birth and in early years can experience foetal growth dysfunction during her own pregnancies, causing injuries to a variety of foetal organs as nutritional resources are diverted to the development of the brain and heart. Foetal malnutrition can contribute to risks of cardiovascular disease and pulmonary and liver diseases through adulthood.¹

Menarche dramatically changes women’s roles, self-image and prospects and marks an important social transition in many societies. Social pressures may foster marriage and pregnancy soon after menarche, which is not only risky in itself but has implications for health in later life (see Chapter 2).

Delaying the first pregnancy beyond adolescence is unequivocally a health benefit. However, women who have their first pregnancy after their mid-20s run increased risk of breast and uterine cancers in later life. Spacing births, especially in a context of comprehensive reproductive health care, offers additional health benefits for both mothers and children.

Menopause: A social and biological transition

The average age at which women reach menopause is very similar throughout the world, within about a year of 50. Individual women reach the end of their reproductive years at different times depending on their health status, social circumstances and reproductive history. Research by WHO’s Human Reproduction Programme suggests that menopause is earlier among women

who have never had children, who smoke or who have lived in poverty.

Leaving the reproductive years marks an important change for women, even more so where their value is defined primarily by their reproductive roles. Some societies provide new opportunities and status within the family for a woman at this time, if her reproductive history has satisfied norms; in others, the transition further reduces her social position. In some societies, women may exercise more power in the household as mothers-in-law and grandmothers than they did as younger women, and they may accumulate other resources. The gaining of new authority encourages perpetuation of the pattern, including opposing the empowerment of younger women. In many societies, however, control of resources and decision-making power is constrained throughout life, and older women can be especially dependent on others.

Increased research attention is being given to the physical effects of changing hormonal levels at the cessation of menses. These include increased risk of heart disease, osteoporosis (excessive bone tissue loss), and an acceleration of the changes in skin, muscles and other tissues associated with ageing. Women with osteoporosis are more likely to fracture bones; 80 per cent of hip fractures at older ages are in women. Risks of reproductive tract infections increase due to the drying and thinning of vaginal walls. Psychological changes include a loss of sexual appetite and pleasure, mood swings and depression, which may also be influenced by changing social identities and self-perception.

In industrial countries most women reach menopause in generally good health. Women in developed countries have increasingly adopted hormone replacement therapy as a means to reduce present discomfort and later risks to health, and to restore sexual drive and pleasure.² The trade-offs between reduced long-term risk of heart disease and osteoporosis and smaller increased risks of breast or endometrial cancer are actively debated. The efficacy of other changes in regimen, nutrition or activity need to be considered. Some oppose this therapy because of ambivalence about women's sexual pleasure after the reproductive years (if not earlier). More open and informed public discussion will help to dispel myths about women's sexuality. Long-term longitudinal studies will eventually help to clarify the health risks and advantages of different approaches.

In many countries menopause is simply not given priority as a reproductive health issue by health service providers, though this is changing. Some developing countries, such as Chile, have already initiated pro-

grammes to incorporate menopausal information and services in their health systems. As older populations grow larger more attention can be expected.

Late childbearing and onset of menopause have been found in some studies to be associated with longevity. This apparent relationship is probably not causal but spurious: women who are ageing at a slower rate than others remain fecund longer. Many other studies show the damaging effect on women's health of continuing pregnancies into later life.³

Extending health

Studies of the duration of expectancy of healthy life are not generally available for most developing countries. Preliminary data from a growing number of countries do allow some tentative conclusions about the current situation and trends. Women live longer than men in most countries, and life expectancy differentials at older ages are also large. After 65, however, women can expect to spend a smaller proportion of their lives in good health than men.⁴

Longer life does not necessarily mean more years of inactive, impaired or disabled life. As life expectancy has increased, so have the years of healthy and active life. In developed countries (where the data are better) these increases have been dramatic even in short periods of time. Chronic conditions like arthritis can increase with age but need not impair normal activities or lead to disability.

Recent research suggests that chronic disability has declined in recent years in developed countries. The national long-term care surveys conducted in the United States⁵ have investigated rates of disability (see box) among persons over the age of 65. These surveys have shown dramatic changes in disability within the past decade and a half. Four rounds of data (1982, 1984, 1989 and 1994) have already been collected and analysed. The disability rate declined by 1.3 per cent *per year* between 1982 and 1994.⁶

These declining disability rates reduced by 1.2 million the expected disabilities in people age 65 and over. Similarly in Canada in 1978 an estimated 40 per cent of persons over 65 had functional disabilities; by 1991 this had declined to 25 per cent. In France, life expectancy without disability increased by 1.3 years for males and 2.3 years for females between 1981 and 1991. The increase in life expectancy without disabilities for females exceeded the total increase in life expectancy (1.8 years) during that time period. Such differences can lead to very significant differences over time in the



numbers of seniors with disabilities and lead to dramatic savings in the cost of long-term health care. These changes can also affect the prospects for longer and more enjoyable lives.

A variety of disabilities increase with age but are not caused by age. While disability becomes an increasing concern at the oldest ages, it should not overwhelm policy concern. Prevention or early correction of conditions which contribute to later disability will improve overall health and life potential and satisfaction.

Old age is associated with changes in skin tone, muscle firmness, the integrity of connective tissue, inflammatory disease, bone loss and resulting visible signs of ageing. With improvements in healthy ageing, however, their onset has been further and further postponed. A 50-year-old depicted by an artist in Renaissance Europe looks more like a 70-year-old today. In many developing countries, a similar extension is starting to emerge.

Research has plotted characteristic curves of performance for a wide range of conditions. Most older people remain mentally acute until very late in life. Some loss of short-term memory (for example, for newly heard names and information) and forget-

fulness become more common in the 50s and 60s, but such losses are generally quite gradual and can often be reversed with mental exercise. Physical dexterity and strength often decline earlier and more quickly than mental skills, though at different rates, and have probably been declining at slower rates in healthier and longer-lived populations. They too can be retained longer with exercise. On the other hand, lack of confidence and growing anxiety can accelerate the effects of ageing.

Loss of mental function in old age derives from a variety of underlying conditions, such as the after-effects of strokes and other cardio-pulmonary conditions and the development of Alzheimer's disease. The incidence of such loss is very similar in a wide variety of settings, and increases from about 3 per cent at age 60-65 to nearly 30 per cent by age 80.⁷

Recent substantial changes in healthy life expectancy can be ascribed to a better overall quality of life — clean water, better sanitation and adequate nutrition. More people have access to health services and education. Medical services and techniques and disease-fighting drugs have improved. There is much discussion about the contribution of different factors,⁸ even in more developed regions where extended lifespans are no longer a new phenomenon.

The cumulative burden of disease in adulthood affects an individual's health at older ages. One factor which certainly has significance for today's developing countries is that better health in childhood has been shown to improve adult health.⁹

In addition to nutritional deficits, the impact of infectious diseases, and childhood and environmental hazards, there are long-term consequences of congenital and perinatal infections by sexually transmitted diseases. For example, syphilis contributes to blindness, deafness, paralysis and bone disease, and gonorrhoea to blindness. Among conditions arising in the reproductive years, human papilloma virus, a sexually transmitted disease, has been implicated as a cause of cervical cancer.¹⁰

Among the important diseases which contribute to preventable early morbidity and mortality at older ages are cardiovascular disease (including strokes and heart attacks), osteoporosis and malignancies. Risks can be reduced by following nutritious and low-fat diets, exercising, avoiding tobacco, alcohol and habit-forming drugs, and minimizing exposure to environmental hazards. Trends in the incidence of breast and lung cancer and strokes have been positive in more developed countries but have been mixed in developing regions.¹¹

BOX 21

Can Disability Be Measured Cross-culturally?

Researchers in developed countries have devised instruments for measuring the degree to which older persons lose their capacity for independent and effective living as the result of ageing, disease or other medical, social or economic changes. Two instruments have been widely used and adapted to cross-cultural studies. Self-reports of capacity monitor basic activities in daily life (ADL). Self-reports concerning performance of instrumental activities in managing daily life (IADL) relate to such tasks as meal preparation, money management, collecting daily needs (or shopping) and use of transportation.

Routine tasks differ according to the infrastructure and level of development of the society. Fetching water or fuel can be important components of everyday life, but are understandably not included in surveys in countries with plentiful water, gas and electricity. Similarly, ramps, chair lifts, advanced furniture and implement design, lighting systems, medical prostheses and better health habits will broaden the range of activities for people with the same levels of physical disability. Some standardization to allow cross-national comparisons will greatly increase understanding and improve our ability to develop appropriate interventions to assist individuals and families in coping with ageing.

Extending Life

Scientists differ in their assessments of life expectancy beyond the levels current in today's industrial countries. Long-term projections by the United Nations¹² are extending the upper age range for life expectancies to 87.5 for men and 92.5 for women in Northern America, Europe and Oceania but not before 2150. Outside these areas, long-term projections assume an increase to nearly 82 years for men and over 86 years for women, 21-22 years over current levels. But these projections depend on consistent long-term improvements in living conditions.

Some optimists believe that life expectancies can be increased to 150 years or more. The lifespan of mice has been extended by up to a third by feeding them 20 per cent or less of their normal caloric input with a nutritionally adequate diet. Concentrating on specific factors in diet rather than quantity, researchers find that diets low in saturated animal fats and high in vegetables, fruits and grains can extend healthy life expectancy by reducing the risk of death from hypertension, heart attack and certain cancers.¹³ Certain drugs and vitamins E and C reduce the number of free radicals in the blood. These compounds are generated by normal metabolism, and their accumulation is believed to be an important factor in cellular changes associated with ageing. Other optimists point to fundamental research in the process of cellular ageing that suggests that pharmacological manipulation of enzymes or direct genetic interventions might slow or reverse the effects of ageing.

In countries with the most advanced biomedical capabilities, research along these and other lines will attract funding as populations age. As with other areas of medicine, extending the findings to poorer people and countries will be a challenge.

Pessimists believe that inherent limits to life are programmed into our genetic heritage. Some theorists suggest that there is a limit to the number of times that cells can divide without damage or loss of genetic information (though recent research has demonstrated that this number might be much higher than previously thought). Others suggest that there are no evolutionary advantages to extending life beyond the reproductive years (see box). All cultural traditions have recognized stages of the lifespan and accepted "natural" limits to longevity. Centenarians are found everywhere, but everywhere they are recognized as unusual. Pessimists are quick to point out that different diets may offer protection from specific health risks, but diets promising longevity or immortality are found only in the imagination.

BOX 22

Longevity and Reproduction: Evolutionary Perspectives

The dominant paradigm of biological thought recognizes adaptive evolution (punctuated periodically by rapid environmental or biological change) as the principal mechanism shaping the form and function of organisms over time, including people.¹⁴ If the main determinant of evolutionary advantage is reproductive success, there would be little apparent reason for prolonging life much beyond the reproductive years.

However, reproductive success is tied not only to the birth of children but to their survival. There is speculation that active life beyond the reproductive years allows support for the children of one's own offspring. Such support can ensure the survival of descendants and allow one's own children greater freedom for exploration and development. Grandparenthood and the multigenerational family may be a particularly human evolutionary technique.

Pessimists have also pointed out that social turmoil, emerging diseases, drug resistance or environmental disaster could result in a reversal of the trend to longer lifespans. The demographic impact of AIDS in sub-Saharan Africa and higher mortality in the Russian Federation show there can be at least short-term reversals of generally positive trends.

Whatever future discoveries suggest about the limits to longevity, the implications of any advances in expectation of life and health will be defined by the social accommodations which result. The duration and meaning of different spans of life will take on new meanings.

The methodology for large-scale surveys to monitor trends in healthy life expectation is gradually being acquired by developing countries. Success depends on the capacities of statistical monitoring services and the priority accorded to older populations.

Implications of an older world

Changes in age structure will strain medical systems in much of the world. Many of the poorer developing countries will find themselves with growing populations of older people while they are still struggling to protect the health of younger age groups. To prevent a high incidence of poor health among older people in the future, these countries need to improve health and nutritional information and access to basic health services, including reproductive health, for all age groups, now.



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The health demands of older populations will force policy makers to balance the relative costs and benefits of interventions in favour of different population groups¹⁵ and to rationalize decisions about which of these efforts to support. They will need better understanding of the contribution to overall well-being made by services which

improve health at various ages, and especially the health of the elderly.

The burden of disease and causes of mortality will shift to older ages over the next several decades as a result of changes in the age-sex structure of the population, overall changes in levels of mortality and morbidity over the entire life course and changes in the distribution of deaths within age-sex groups.²¹

There will be a continued decrease in mortality from infectious diseases, particularly those of childhood, assuming continued national and international efforts to eliminate them. Deaths from cancers, which occur at older ages, are expected to increase in all regions, though less rapidly in countries with economies in transition, where they are already a large fraction of rates in more developed countries, and in sub-Saharan Africa where populations are youngest. In Asia, deaths from cancers are expected to pass deaths from infectious diseases by around 2015. The changes in the age pattern of deaths (see Chapter 1) and the causes of death constitute the epidemiological transition which is under way at differing paces throughout the world.

Death rates from circulatory diseases are projected to increase in aggregate. Increases are expected to be modest in the Arab States and to trend slowly downward in sub-Saharan Africa. Increases in the more developed countries are projected to continue.²²

As discussed above, the projected trends in death rates have different components. Nearly two thirds of the decline in deaths from infectious diseases in developing countries is expected to result from interventions to combat infection: less than 18 per cent from changes in age structure. In contrast, deaths from circulatory causes are expected to increase from under 19 per cent to over 35 per cent of all deaths. Nearly a third of the increase will result from changes in age structure, and about 45 per cent from increases in the proportions of death within age groups as more people adopt habits like smoking and dietary changes that increase the risks.

Changing population structures will contribute to the shift from infectious to non-communicable and chronic diseases, but this does not justify extensive reorientation of publicly-funded health services, especially in developing countries. Poorer and less healthy people of all ages suffer more from infectious diseases; they also need advice, information and preventive care to avoid degenerative and other diseases in later life.

It is important not to lose sight of the urgent need to improve services for these

BOX 23

The United Nations on Ageing

In 1982, The World Assembly on Ageing adopted the Vienna International Plan of Action on Ageing.¹⁶ The plan outlined the challenges and opportunities for development posed by increasing numbers and proportions of older people. Recommendations addressed:

- ◆ health and nutrition — emphasizing prevention of disabilities and diseases;
- ◆ social participation — encouraging promotion of volunteer activities, part-time work and mutual self-help among the elderly, particularly women, and overcoming negative stereotypes and other barriers;
- ◆ economic security — recommending social security, benefits in kind, employment opportunities, and direct assistance to families, where appropriate;
- ◆ housing, the environment, consumer protection, research and education.

In 1991 the UN General Assembly agreed on a set of principles¹⁷ which state, among other things, that older persons should:

- ◆ have access to adequate food, water, shelter, clothing, social and legal services, and health care, through the provision of income, family and community support, and self-help;
- ◆ have the opportunity to work and access to training, and participate in deciding when and at what pace they will retire;
- ◆ live in environments that are safe and adaptable to changing capacities;
- ◆ help formulate and implement policies affecting their well-being, share their knowledge with younger generations, volunteer in community service that matches their skills and interests, and form associations;
- ◆ have access to appropriate institutional care, and when residing in any care facility, to enjoy respect for their dignity, beliefs, privacy and right to make decisions about their care;
- ◆ live in dignity and security, free of exploitation and physical or mental abuse, and be treated fairly regardless of age, gender, race or ethnicity, disability or economic status.

The International Year of Older Persons in 1999 will promote these principles. "Towards a society for all ages" is the theme. United Nations bodies and voluntary organizations will undertake expert group meetings and public events to promote age-integration and counter social exclusion.¹⁸ On 1 October 1999, the World Health Organization, local governments and NGOs are organizing intergenerational walks in Auckland, Sydney, Tokyo, Shanghai, Bangkok, Geneva, London, Rio, New York and Vancouver, to emphasize that older people can, through healthy lifestyles, remain as active as people of any age.

In addition, the General Assembly has adopted eight global Targets on Ageing for the Year 2001¹⁹ to promote an age-integrated society that encourages the talents and participation of older persons while meeting their care needs.²⁰

groups, which include disproportionate numbers of women and rural populations, as well as older people. Investment in treatment of diseases affecting older ages benefits disproportionately the better off and healthier segments of the population. The ultimate aim is to reduce health disparities and ensure quality health care for all.

Monitoring Health Status through the Life Cycle

Various indicators have been developed to monitor the health and well-being of people through their life cycle. Different concepts of health are captured in different measurement approaches.²³ The general concept of life expectancy is adjusted to indicate expectation (objective or subjective) of healthy years of life. Health planners also use very particular measures to project service requirements related to the absence of specific diseases (e.g., osteoporosis-free life expectancy), disabilities, handicaps or impairments (e.g., dementia-free life expectancy). Clients' self-ratings of health at different ages can be an effective indicator of their prospects for an active and healthy life even without clinical information. Negative reports can direct policy makers to neglected subgroups and to the underlying health and social conditions.

Gender differences in health indicators

Women's health needs, apart from those affecting reproductive health, have often been given lower priority than those of men, particularly in developing country settings. Gender-disaggregated health statistics on the elderly are similarly rare, on the assumption that the health needs of the elderly somehow merge after menopause.²⁴

Biological susceptibility to various conditions differs between the sexes; monitoring of differences in incidence can better direct preventive efforts. "Gender-disaggregated, gender-sensitive and gender-specific indicators in non-reproductive areas of health"²⁵ would enhance understanding of gender-specific health patterns, lifestyles, occupation-related illnesses, ethnic/class/geographic variations, and availability of health care.

Gender-differentiated indicators should also be developed to monitor other areas, such as access to education and training, credit and employment. Such measures would reflect changes in opportunities through the life cycle and in social situations over time.

Some important issues affecting older women's health:

- ◆ Women beyond reproductive age usually have less regular contact with health services²⁶ in many countries. Detection of conditions like breast and cervical cancer may be severely delayed.
- ◆ Little is known about gender-specific measures and health care approaches for mental health and physical disabilities among older women. Service provision for mental illness in older women, especially depression and dementia, needs attention.
- ◆ Prevention of chronic disabling conditions suffered by older women, such as arthritis, osteoporosis and incontinence, should be directed at younger age-groups as information about causes, precursors and populations at risk become known.
- ◆ Promotion of healthy behaviours, including the prevention of smoking and substance abuse, often begun in adolescence, and the adoption of regular exercise could significantly lower morbidity and mortality risks at all ages.
- ◆ Although women's life expectancy has increased,²⁷ lifetime morbidity and low social status severely compromise the health status of older women.²⁸ Data are needed on the health of women working in dangerous conditions, especially in the informal economy; on domestic violence; on the domestic workload; and on body image problems that result in morbidity. For example, loss of weight among older women in Papua New Guinea is seen as "normal"²⁹ and thinness in old age is seen as aesthetically pleasing.³⁰ Similarly, studies in Egypt found that many reproductive health pathologies are perceived as "normal".³¹ In other settings, obesity is seen as pleasing though it increases health risks dramatically.

In addition, various conditions related to women's reproductive health have implications for later life:³²

- ◆ Anaemia is a contributing factor in over 20 per cent of all post-partum maternal deaths in Asia.
- ◆ 60 per cent of women of childbearing age in South Asia are underweight, stunted by inadequate nutrition during their own childhood. In Southeast Asia, the proportion of underweight women is 45 per cent. Obstructed labour is more likely among such women.

Statistics on the health of older women are rare.



- ◆ Improving the Vitamin A status of pregnant women whose intake of the vitamin is low reduces maternal mortality and morbidity. In a recent trial in Nepal, *low-dose* vitamin A supplementation reduced maternal mortality by 44 per cent.
- ◆ Zinc deficiency, widespread among women in developing countries, is associated with long labour, which increases the risk of death, and with mental development disabilities.
- ◆ Iodine deficiency in women increases the risk of still births and miscarriages. In highly iodine-deficient areas there may be increased maternal mortality and morbidity through severe hypothyroidism. Other health benefits to iodine programmes are being actively researched.
- ◆ Folate deficiency, which induces neural-tube birth defects if it is present during the first month of pregnancy, may represent a risk for maternal morbidity and mortality and increase the risk of low birth weight.
- ◆ Chronic degenerative diseases such as heart disease may be associated with poverty, particularly in early life and during foetal development, and with exposure to harmful substances. Low-birth-weight babies not born prematurely have a higher incidence of hypertension later in life than those with a normal birth weight. Low birth weight has also been correlated with glucose intolerance in childhood and diabetes in later life.³³

Longitudinal studies would detail information on health conditions, constraints, needs and experience of women as they age. They could also reveal the effectiveness of lifestyle changes and other preventive interventions.

Data needs for studies of ageing

Understanding the effects of ageing for individuals and the societies they live in calls for research in a variety of areas and disciplines, from medicine to economics, and close study of the relationships between them. Several major research programmes are under way in developed countries and, increasingly, in developing countries, some of the most valuable being multidisciplinary and longitudinal studies.

The dynamics of relationships in families are an important component of this research. Research designs have been developed for: the examination of economic and

social situations of older persons; exchanges and interactions within and between families; quality of life and health; retirement preparation and adaptation; and the impact of widowhood and other dimensions of social experience.

Survey work in reproductive health has moved to include both spouses as respondents and has begun to take into account the social context of reproductive behaviours. In a similar way, and more than in many other areas of social science research, the value of information collection over time from a number of members of social networks (including families) is becoming increasingly appreciated. Research to discover determinants of health, activity and well-being in old age could direct appropriate interventions.

Among the many important social science research programmes under way are: REVES (International Research Network for Interpretation of Observed Values of Healthy Life Expectancy); German Socio-Economic Panel; Asset and Health Dynamics Among the Oldest Old (AHEAD); the Longitudinal Study of Ageing (LSOA) and Supplements on Ageing (SOA I & SOA II); the National Long Term Care Survey (NLTCS); Luxembourg Income Study (LIS); the Health and Retirement Study (HRS); the Panel Study of Income Dynamics (PSID); and Rapid Demographic Change and the Welfare of the Elderly.

Such research is expensive, and costs are increased by mobility among people surveyed. Policy makers should give careful attention to the prioritization of research questions to ensure that survey design and data are carefully focused and policy-relevant. A balance is needed between attention to high-priority target groups (the poor, women and rural populations) and a more general understanding of society as a whole.

More and broader studies relating to older populations are being carried out in developing countries. A compilation of studies early in the decade identified a variety of studies but only small numbers devoted to any single topic.³⁴

UNFPA supports policy research and information dissemination in the area of ageing. It has been instrumental in funding the compilation and dissemination of census micro-data in Europe (including Eastern Europe). It has given interregional support to the International Institute on Ageing, which helps meet the training needs of developing countries and acts as a bridge between developed and developing countries by promoting technical cooperation and skills exchange and providing advisory services.