# Abstract

**Background**

All-cause age-specific mortality risks have been falling in England & Wales for more than a century. The period 2008-2015 has seen both a global recession, and an ‘austerity’ agenda of reduced investment in public services.

**Aim**

To produce estimated age-specific mortality risks over the period 2010 to 2015 based on previous trends, and compare actual against projected numbers of deaths by various ages to produce estimates of total excess deaths up to age 89 years each year from 2010 to 2015.

**Methods**

Office for National Statistics data on population counts and death counts at each age in single years were used to construct projections of mortality risk against year based on the trend from 1990 to 2010. The models were used to estimate the mortality risks that would be expected if mortality trends prior to the austerity period had continued. The number of deaths at each age in each year from 2011 to 2015 were estimated given population counts in each year, and compared with observed number of deaths in each year.

**Results**

A total of almost 32,000 more deaths up to the age of 89 years occurred between 2010 and 2015 than would have been expected from the model specification. Trends towards excess elderly deaths increased sharply after 2011, with 42,018 more deaths than expected occurring between 2012 and 2015.

**Discussion**

Falling levels of investment in social and health care services in England & Wales since 2010 may be responsible for mortality rates at older ages either increasing or falling more slowly than would have been expected if previous improvements had continued. Mortality for males was improving rapidly before 2010 so had that trend continued many more older men would have been alive by 2015. The actual rise in mortality was greater for older women.

# Introduction

## Austerity and elderly mortality

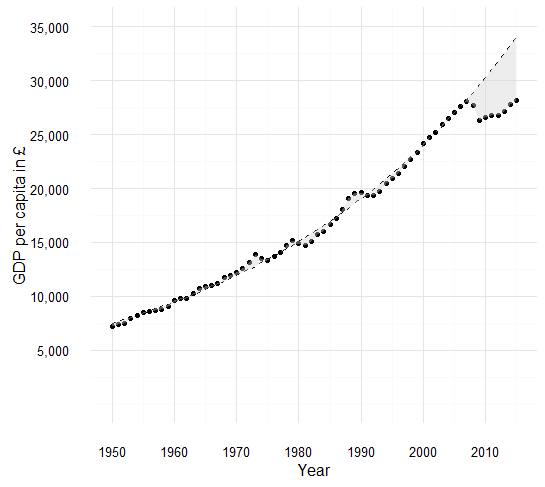
Recently, there has been growing evidence of the possible effects of austerity on elderly mortality within the UK. One study exploring the correlation between falls in Pension Credit and social care budgets in the UK, and changes in mortality rates in pensioners aged 85 years and older, found that each 1% fall in social care spending was associated with a statistically significant 0.08% rise in elderly mortality, with similar but weaker rises in persons aged 75 to 84 years. [5] Thes focus on elderly mortality was prompted by a 2014 *New Statesman* article commenting on provisional estimates by Public Health England, leaked in the online Health Services Journal in 2014, of deaths amongst over 75s in England, suggesting increased mortality in both 2012 and 2013. [6]

A 2015 Public Health England report considered three possible explanations for the trends: influenza, cold weather, and statistical artefact. [7] If either influenza or cold weather were the main causes of these rises then the following would be expected: firstly, that the mortality rate rises would be spatially patterned, and secondly that the rises would be a ‘blip’ associated with particular years rather than a trend. Preliminary analysis has found no evidence of spatial patterning. [5,8,9] Artefactual explanations could relate to aggregation biases caused by inadequately controlling for changes in age-composition within an age group such as those witnessed in a recent high profile case of rising middle aged mortality rates in the US. [10–12] However, this cannot explain similar changes in multiple population age strata, such as multiple five or ten year age groups, occurring over the same time period, which have recently been identified in English population records. [5,8] The scope for such biases also reduce as more age-disaggregated data are used. [12] Similar patterns of rising mortality rates were observed in the most recent mid-year estimates [14], and the consistency of these patterns point towards austerity as opposed the other findings.

## Slower improvements are still falls against expectations

The fact that death rates in some elderly age groups have risen in recent years should be of great concern as the tendency and expectation for many decades has been for the risk of death at most ages, especially older ages, to decline. Reasons for the previous declines are multifactorial and include both specific medical innovations, and broader improvements in living conditions such as improved housing and sanitation. [15,16] Only a severe and prolonged shock and assault to the factors which contribute to such steady improvements could alter these long-term dynamics[17–19]. Figure 1 shows how per capita GDP (not inflation adjusted) increased between 1950 and 2008 in England & Wales, using annual estimates from ONS. [20] The line shows the trend against time to 2008 inclusive, which is then extrapolated to 2015. Between 1950-2008, the statistical fit of this trend line is extremely high (R2 = 0.98) but after 2008 the shaded region, showing the difference between actual and projected per capita GDP, has grown ever larger. In 2009 the gap amounted to £6,800 per person; by 2015 it had grown to more than £13,400 per person. Before 2008, all previous recessions had been followed by one or more years of catch-up growth in per capita GDP. Nothing similar occurred after 2008, instead per capita GDP in 2015 has barely recovered to pre-GFC levels. Although similar down shift in economic growth occurred in many rich countries, the disparity between actual and projected levels in the UK are especially severe. Furthermore many other rich countries increased public spending as a proportion of GDP to protect their populations. In the UK the government after 2010 cut public spending as a proportion of GDP even as GDP itself fell.

Figure Per capita GDP against trend, 1950 to 2015;



**Notes**: **Data Sources: (A) ONS; HMD**

# Methods

## Data

Mid-year population estimates and registered deaths in England & Wales, for each year from 1990 to 2014, were downloaded from the ONS website. [27] These data are presented for each age in single years up to 104 years, though mid-year population counts are estimated for ages 90 and above [28] Mid-year population estimates and registered deaths for 2015 were released on 23 June 2016 for England & Wales. These are disaggregated by age in single years up to the age of 89 years rather than 104 years. [14]

## Modelling strategy

The precise details of the modelling strategy are detailed in the appendix, which also includes a sensitivity analysis[[1]](#footnote-1).

Our approach is to estimate models which formalise intuitions developed through visual inspection of shaded contour plots of the type shown in Figure 2. These suggest to us that there have been long-term trends towards reduced 12 month mortality risks throughout much of later life. It is also well known that mortality risk rises log-linearly with each additional year of life throughout much of adulthood. [39] We therefore estimate separate linear regression models for each sex and for each age in single years, using ONS data over the period 1990 to 2010, from birth (‘0 years’) to 89 years of age; a total of 190 separate linear regression models were produced. The start period of 1990 was used because we expected the assumption of a linear trend would be reasonable over this period, whereas it may be more nonlinear and complex over a much longer period of time. (A sensitivity analysis was also performed to see whether results were similar if a nonlinear trend specification were used.)

Within each of these models the response variable is the log mortality rate for a particular age and sex, and in a particular year. Predictor variables include an intercept at the start of the time series, a linear trend term with year, and separate intercepts and trend terms for both the years of New Labour government (1997-2010), and for the peak years of the GFC (2008-2009).

We then estimated the predicted age and sex specific mortality rates between 2010 and 2015 under the assumption that the New Labour terms (intercept and trend with year) continued. The actual population counts for each age and sex, for each year from 2011 to 2015, are then applied in order to produce counterfactual estimates of the numbers of deaths that would be ‘expected’ at each age and for each sex for each of these years. These counterfactual age and sex-specific death counts are then compared, for each year, with the actual numbers of deaths to produce the ‘excess’ number of deaths during the austerity period

To show the age distribution of the differences between actual and expected levels in each year from 2011 to 2015, graphs are produced showing the summed differences in total deaths by different ages in each of these years. For example, the value on the vertical axis when the horizontal axis is age 50 shows the sum of differences between actual and expected deaths in that year from birth up to age 50, the value at age 60 is the sum of differences from birth to age 60, and so on. This means that the summed differences up to certain ages can be negative if there are fewer than expected deaths at some ages.

## Results

## Model projections

Figure 2 shows the mortality rates projected at different ages in single years, had trends in age specific mortality rate reduction observed during the period 1997 to 2010 continued in the years 2011 to 2015 inclusive, for ages 60 to 85 years. Each point is a data point, the line shows the best fit of the trend, and the band shows the 95% credible interval around this line. The top row shows the mortality trends on the log scale and the bottom on the identity scale.

It is clear from the figure that during the period 1997 to 2010 there was a steady fall in age specific mortality risk on the log scale, steeper than in the period 1990 to 1997 for older ages in particular. After 2010 mortality rates at specific ages tended to move towards the top of the credible interval band, moving above these bands for most of the ages plotted by 2015. On the log scale it appears higher-than-projected mortality rates after 2010 are statistically significant at ages 70 and 75 years, with a greater deviation between actual and projected mortality rates for males than females. The identity scale helps raise the important distinction between statistical and substantive significance, however, with the borderline statistically significant ‘excess’ mortality at age 90 in 2015 implying a much greater additional mortality risk than the clearly statistically significant ‘excess’ mortality age ages 60 or 70.

Figure 2 Model projections and actual mortality risks age ages 60 to 85 years. (A) log10 mortality; (B) absolute mortality

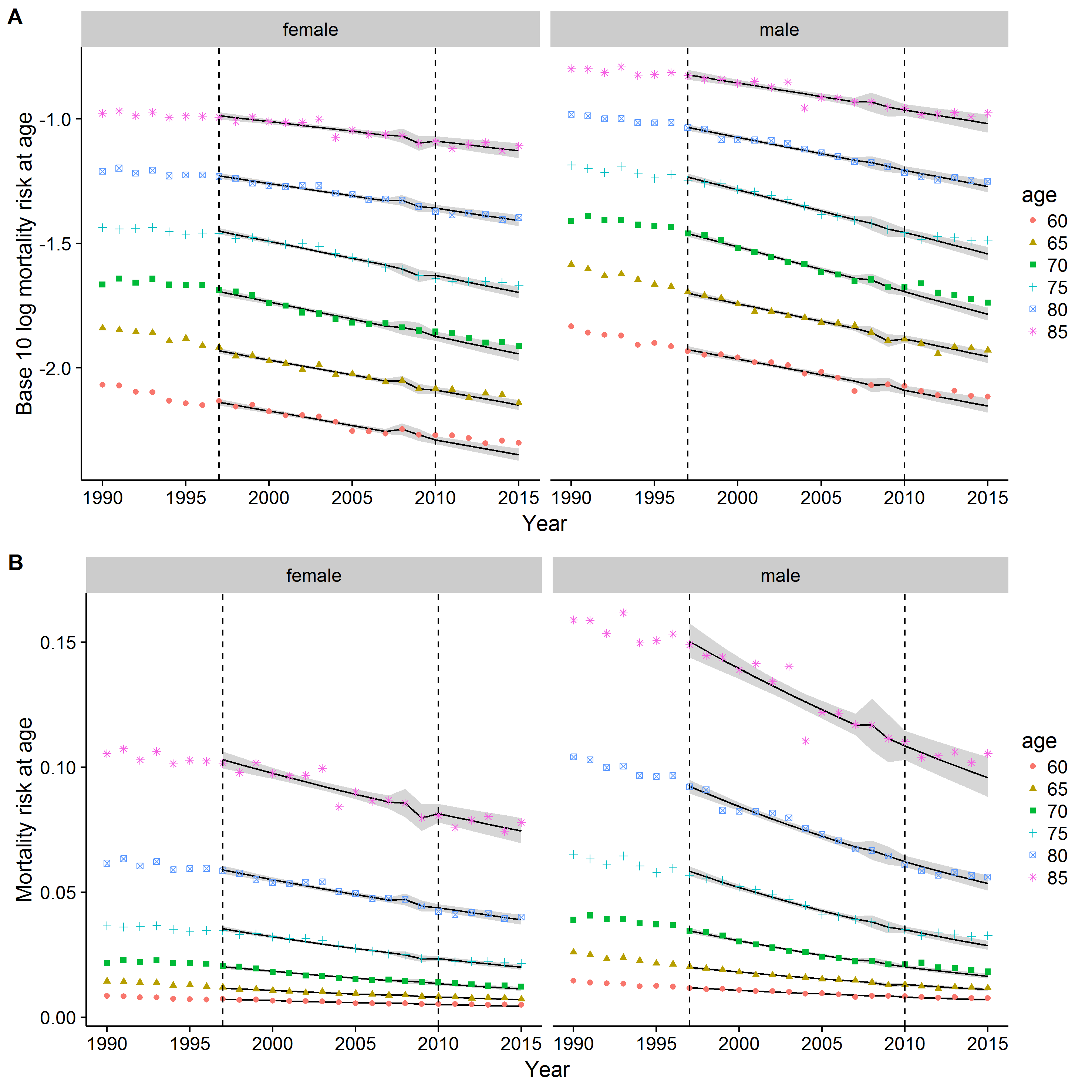


Figure S\_01 in the appendix shows equivalent projected and actual mortality rates in infancy, and at ages 15, 25, 35 and 45 years. In this figure it is clear that mortality rates in infancy fell rapidly between 1990 (in fact since the 1960s) and 1992, steadily but more slowly during the new Labour period, then slightly faster than the New Labour projection after 2010. Mortality rates for males aged 35 also fell after 2010 below the projected range. At other ages actual rates were largely as expected from the model. The projected and actual mortality risks at all ages in single years are used in the projection of total estimated excess deaths, below.

## Total Estimated Excess Deaths, 2010-2015

Figure 4 shows the total ‘excess’ deaths in each year from 2010 to 2015, between birth and the age indicated on the horizontal axis, if the New Labour trends and intercepts were projected forwards and applied to age-specific population counts in each year. A vertical dashed line is added at age 65 years, because it seems to mark an important turning point in the excess deaths. For each year from 2010 to 2015, there has been fewer deaths than expected between birth and the start of retirement age, but an increasing number of excess deaths after retirement age, such that by age 89 there were many more deaths than expected in total. These differences and worsening tendencies become evident from 2012 onwards, and have been getting worse in each subsequent year; 2015 saw a greater number of total excess deaths than the years 2012 to 2014 combined.

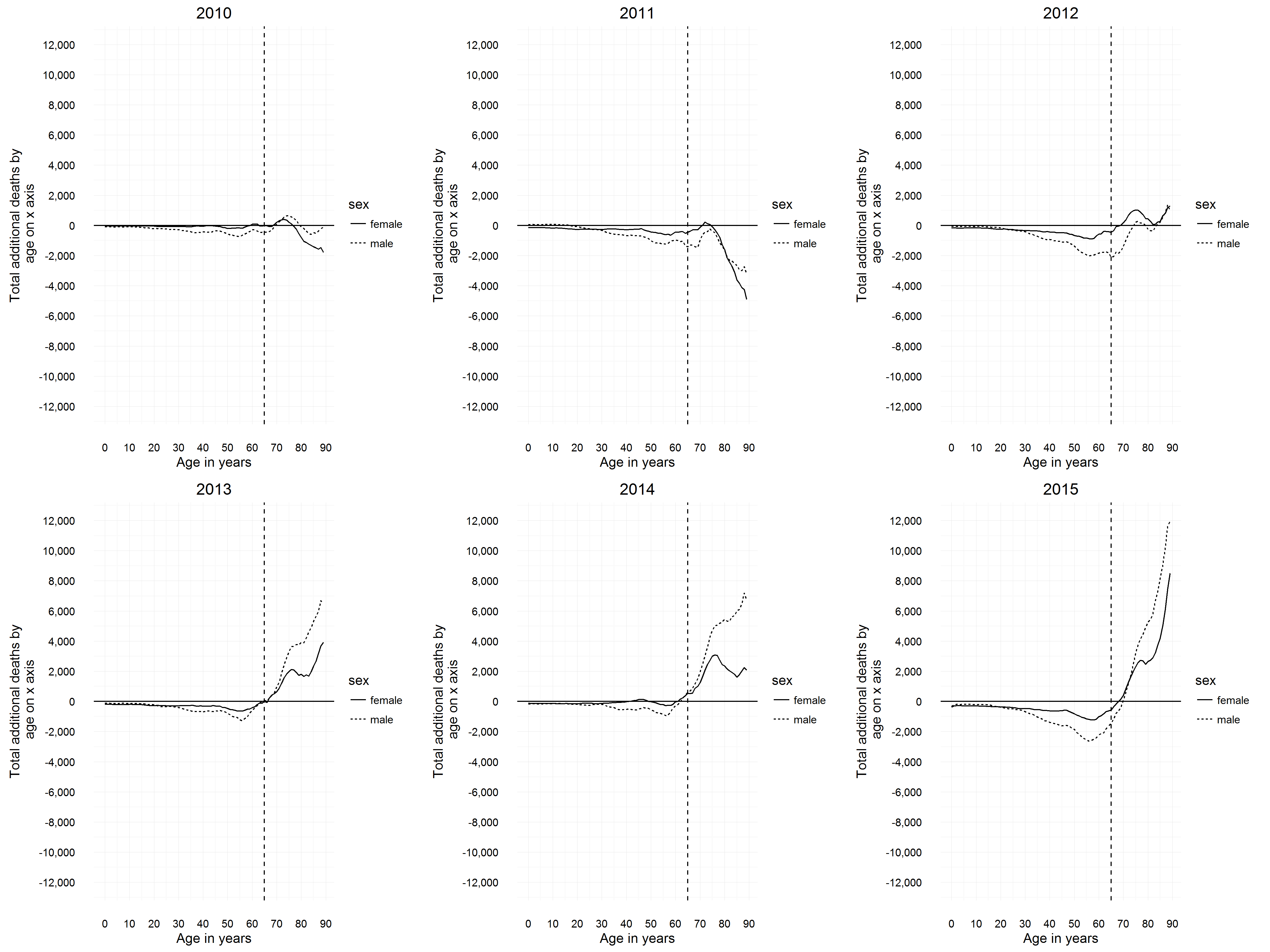
Results from the model are summarised in table 1 and table 2. Table 1 shows the ‘excess’ deaths by the ages of 50, 70 and 89 years for each year from 2010 to 2015, with positive excesses highlighted in bold. Table 2 further summarises these results to show the combined excess deaths either over the period 2010 to 2015, or the period 2012 to 2015. The models project 2,303 fewer deaths than observed in 2012, 10,430 fewer deaths in 2013, 8,820 fewer deaths in 2014, and 20,465 fewer deaths in 2015. In total, there were 31,973 more deaths than projected between 2010 and 2015, and 42,018 more deaths than projected between 2012 and 2015.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Year** | **Age** | **Males** |  |  |  |  |  | **Females** | |  |  |  |  | **Combined** | | |  |  |  |
| 2010 | 50 | -554 | ( | 19,094 | - | 19,648 | ) | -206 | ( | 11,786 | - | 11,992 | ) | -760 | ( | 30,880 | - | 31,640 | ) |
|  | 70 | **111** | ( | 75,811 | - | 75,700 | ) | **210** | ( | 49,994 | - | 49,784 | ) | **321** | ( | 125,805 | - | 125,484 | ) |
|  | 89 | -113 | ( | 212,724 | - | 212,837 | ) | -1,795 | ( | 192,910 | - | 194,705 | ) | -1,908 | ( | 405,634 | - | 407,542 | ) |
| 2011 | 50 | -998 | ( | 18,455 | - | 19,453 | ) | -423 | ( | 11,460 | - | 11,883 | ) | -1,421 | ( | 29,915 | - | 31,336 | ) |
|  | 70 | -950 | ( | 74,013 | - | 74,963 | ) | -110 | ( | 49,391 | - | 49,501 | ) | -1,060 | ( | 123,404 | - | 124,464 | ) |
|  | 89 | -3,235 | ( | 207,606 | - | 210,841 | ) | -4,902 | ( | 185,925 | - | 190,827 | ) | -8,137 | ( | 393,531 | - | 401,668 | ) |
| 2012 | 50 | -1,366 | ( | 17,817 | - | 19,183 | ) | -658 | ( | 11,097 | - | 11,755 | ) | -2,024 | ( | 28,914 | - | 30,938 | ) |
|  | 70 | -1,392 | ( | 73,161 | - | 74,553 | ) | **170** | ( | 49,648 | - | 49,478 | ) | -1,222 | ( | 122,809 | - | 124,031 | ) |
|  | 89 | **1,002** | ( | 209,909 | - | 208,907 | ) | **1,301** | ( | 189,135 | - | 187,834 | ) | **2,303** | ( | 399,044 | - | 396,741 | ) |
| 2013 | 50 | -786 | ( | 18,025 | - | 18,811 | ) | -465 | ( | 11,062 | - | 11,527 | ) | -1,251 | ( | 29,087 | - | 30,338 | ) |
|  | 70 | **973** | ( | 74,741 | - | 73,768 | ) | **652** | ( | 49,853 | - | 49,201 | ) | **1,625** | ( | 124,594 | - | 122,969 | ) |
|  | 89 | **6,505** | ( | 213,466 | - | 206,961 | ) | **3,925** | ( | 189,046 | - | 185,121 | ) | **10,430** | ( | 402,512 | - | 392,082 | ) |
| 2014 | 50 | -546 | ( | 17,908 | - | 18,454 | ) | -15 | ( | 11,291 | - | 11,306 | ) | -561 | ( | 29,199 | - | 29,760 | ) |
|  | 70 | **1,963** | ( | 74,625 | - | 72,662 | ) | **1,257** | ( | 49,967 | - | 48,710 | ) | **3,220** | ( | 124,592 | - | 121,372 | ) |
|  | 89 | **6,741** | ( | 212,499 | - | 205,758 | ) | **2,079** | ( | 185,505 | - | 183,426 | ) | **8,820** | ( | 398,004 | - | 389,184 | ) |
| 2015 | 50 | -1,845 | ( | 16,288 | - | 18,133 | ) | -816 | ( | 10,279 | - | 11,095 | ) | -2,661 | ( | 26,567 | - | 29,228 | ) |
|  | 70 | **82** | ( | 71,541 | - | 71,459 | ) | **392** | ( | 48,525 | - | 48,133 | ) | **474** | ( | 120,066 | - | 119,592 | ) |
|  | 89 | **11,952** | ( | 215,870 | - | 203,918 | ) | **8,513** | ( | 189,683 | - | 181,170 | ) | **20,465** | ( | 405,553 | - | 385,088 | ) |

Table 1: ‘Excess’ Deaths (Observed – Projected) by ages 50, 70 and 89 years for each year in the period 2010-2015.

|  |  |  |  |
| --- | --- | --- | --- |
| **Period** | **Males** | **Females** | **Combined** |
| 2010-2015 | 22,852 | 9,121 | 31,973 |
| 2012-2015 | 26,200 | 15,818 | 42,018 |

Table 2: Total ‘Excess’ deaths by age 89 years over the period 2010-2015 and 2012-2015



# Discussion

Our results demonstrate that since 2010, mortality rates for England and Wales have increased in comparison to longer term trends prior to the period of austerity. These increases have been particularly high among the elderly, with mortality rates for some younger ages continuing to fall. We estimate around 32,000 more deaths than projected since 2010, and over 42,000 more deaths than projected since 2012.

These estimates should be considered conservative for two reasons. Firstly, these only cover deaths up to the age of 89 years. Estimates of death and population counts above the age of 89 years are available for 2010 to 2014, but not in the 2015 release. Accumulated excess deaths above the age of 89 are even higher. Secondly, our model specification produced relatively conservative estimates of total additional deaths. A slightly more complex model specification, which allowed for nonlinear trends in rates of mortality risk improvement at various ages, produced even higher estimates of total ‘excess’ mortality, with around 60,000 additional deaths estimated between 2010 and 2015, and around 65,000 additional deaths between 2012 and 2015. Although this alternative model specification had slightly better penalised model fit at many ages than our standard model specification, there were few substantive differences, with both specifications indicating 2012 as a turning point in mortality trends.

Our findings appear consistent with what might be expected from a period that has seen the longest decline in long-term economic growth rate, and longest period of lack of investment in healthcare and associated social care services since World War 2 [refs]. This is both in terms of much increased and increasing levels of excess deaths amongst the elderly, but paradoxically also with somewhat reduced levels of deaths within working ages, in particular for males (detailed in the appendix). It is known that mortality rates tend to fall for people of working age during recessions, in part because the costs of risky behaviours rise [4,12,45]. Changes in these drivers of acute causes of mortality tend to react quickly to ‘environmental stimulus’. All-cause mortality among the elderly is more likely to be influenced by changes to the funding and functioning of social care and healthcare which may take longer to materialise.

Increasing elder death rates are ‘canaries in a coal-mine’, indicating an underlying decline in population health, wellbeing, and quality of life. For example, since the Coalition government introduced annual measurements of subjective wellbeing in 2010, there has been declining wellbeing for most age groups in each successive year. [46–48] The combined effects of the GFC followed by the Coalition’s Austerity experiment appear to be resulting in wider impacts on the population that may contribute to deteriorating health and wellbeing at both the short- and long-term including not just the rising elderly mortality reported here, but also increasing suicides rates [ref] and decreasing mental health [ref].

Though the working age working poor (and their children) experienced some of the most overtly adverse changes to social security provision in the UK, leading for instance to an explosion since 2010 in food bank use, [50–52] it is within the sick and frail that cuts to the quality of social and healthcare services appear to be a matter of life or death, indeed tens of thousands of excess deaths. This is despite, on paper, pensioners being one of the most generously treated demographic groups by consecutive UK governments, including the Coalition Government’s commitment in 2011 to a ‘Triple Lock’ to uprate the Basic State Pension such that its value will not decline in relative terms over time. [53] Although such commitments to maintaining the relative value of pensions benefit the elderly who are still in good health, with ageing comes frailty and expensive-to-treat multi-morbidity. It is once health deteriorates to a point where pensioners become dependent on state social care and health care to survive from year to year and month to month that they become exposed to a system undergoing both rapid reinvention and disruption, and increasing financial pressures and constraints. [54]

The longer-term consequences of austerity may take decades to become apparent. Long-term demographic records show that especially severe environmental change can cause lower cognitive functioning, increased morbidity, and an increased mortality risk to be carried by exposed populations throughout their lives; to an extent that the 1918 Influenza pandemic was still felt years after it, by increasing age-specific mortality risks for decades following. [24,55–57] Evidence of more subtle cohort effects associated with shifts in labour market conditions have been identified for specific types of mortality. Research exploring patterns in Scottish alcohol mortality and suicide trends has, for example, indicated there may be cohort effects associated with the years in which people first enter the formal labour market, with higher rates of suicide and alcohol-related deaths amongst males, in particular, who started their work life after the start of ‘neoliberal’ labour market reforms in the early 1980s, compared with cohorts who first started work in the 1970s and before. [58–60]

## Limitations

Population estimates for ages over 90 years are not routinely available disaggregated by age in single years as part of standard UK population estimates, and are estimated by the ONS. Given that our results indicate that much of the additional burden of excess mortality has been at some of the oldest ages, we considered it important to produce estimates of total excess deaths which include ages up to 95 years, despite these limitations. Effective measurement and dissemination of age-disaggregated population and death counts at and above the age of 90 years should be a national record keeping priority.

As has been noted many times, “all models are wrong, but some are useful”. [62] Our models are ‘wrong’ in the sense that they apply projected mortality rates to observed population counts for a number of consecutive years, and of course different mortality rates at any particular age would affect the number of people alive and thus exposed to the mortality rate of people one year older in the following year. However, we believe our approach is appropriate for aggregate quantification of harms or benefits, because otherwise sufficiently large premature mortality could give the impression that deleterious trends are actually positive. For example, if there were a sudden rise in deaths due to cardiovascular events occurring in populations in their late sixties there may then be a fall in deaths due to cancer amongst people in their seventies a few years later, but this would not be evidence of improvements in cancer treatment and care. For similar reasons, we have not altered the population sizes exposed to age-specific mortality risks in each of the years, only the degree of risks such populations are exposed to at each age.

The issue of how to accurately estimate the counterfactual is intrinsic to quantifying the consequences of different actions or clusters of actions. In our study consequences are measured as excess deaths, and the cluster of actions that are thought to have caused these deaths are known as ‘austerity’. Alternative, and arguably more sophisticated, statistical modelling strategies could be applied, and the actuarial estimates of excess deaths produced would change. However the sensitivity analysis included in our appendix suggests that, if anything more sophisticated models produce less conservative results.

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# Appendices

## Appendix A: Supplementary figures

The following figure shows the projected and observed mortality risk in infancy (age 0), 15, 25, 35 and 45 years.

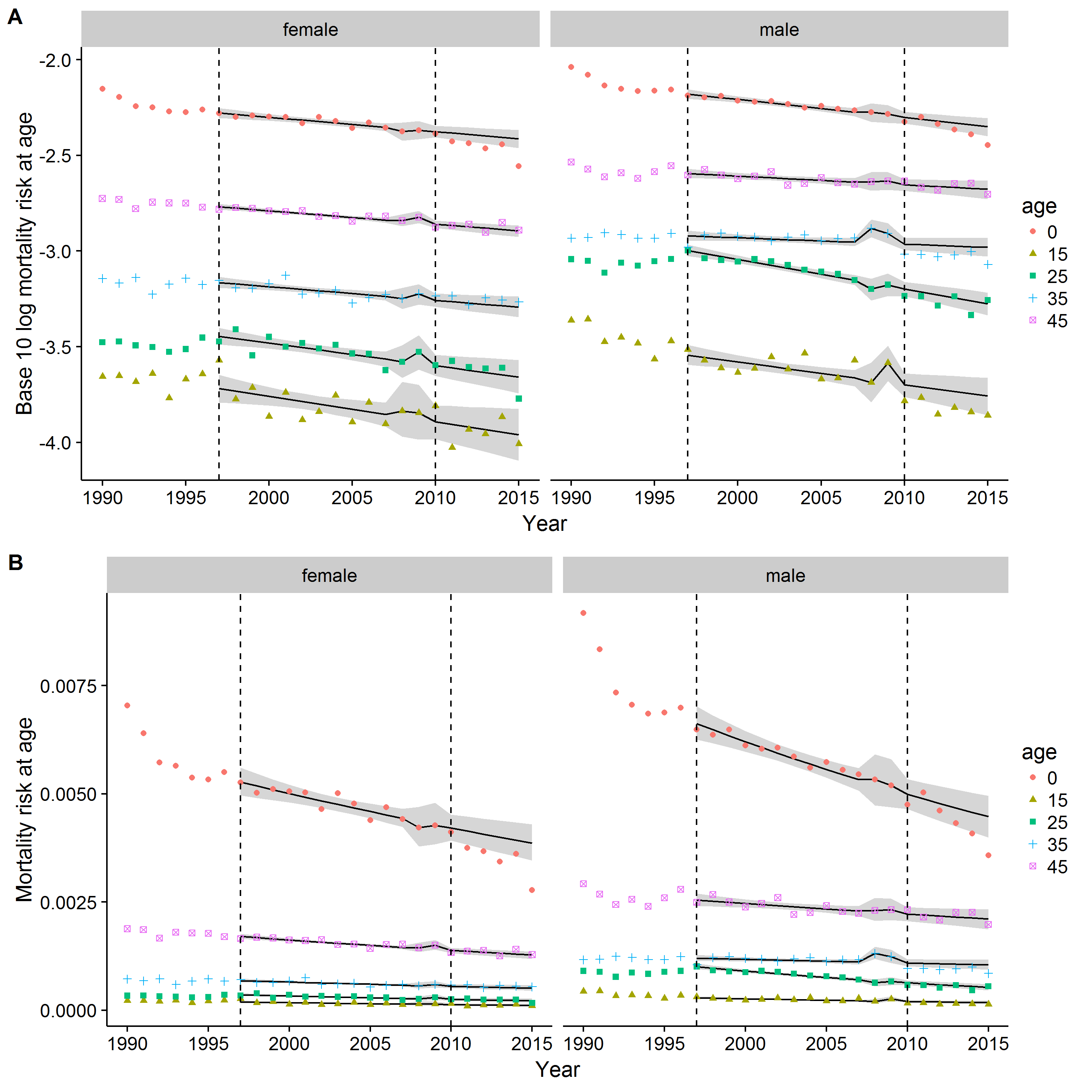


Figure 3 Figure S1

## Appendix B: Modelling approach

### Model

For each sex, and for each age in single years, a, from birth to 95 years old, a separate linear regression model was fit with the following specification:

|  |  |
| --- | --- |
|  | (1) |

Where is the mortality rate (death count divided by population count) in year t, at age a, and for sex s; t is year; L is a dummy variable indicating the years, 1997 to 2010, in which New Labour were in government; R is a dummy variable indicating 2008 and 2009, the years in which the UK economy entered a recession as a result of the GFC, and is an error term. The R term is included to capture any additional short-term changes in mortality rates to be captured in a separate term rather than influence the coefficients including New Labour years, and . The use of interaction terms Lt and Rt allowed for the gradients of change in log mortality rates over time to be different over the New Labour and GFC recession periods.

The above model specification was fit to ONS data for each year from 1990 to 2010 inclusive. Redefining , projected log mortality rates were calculated for years 2011 to 2015 inclusive by setting t to these year values and L to 1, i.e.

|  |  |
| --- | --- |
|  | (2) |

Predicted numbers of deaths at each age, for each sex, and in each year from 2011 to 2015 were therefore calculated by multiplying the relevant age-year-sex specific population counts by the requisite projected mortality rates, i.e.

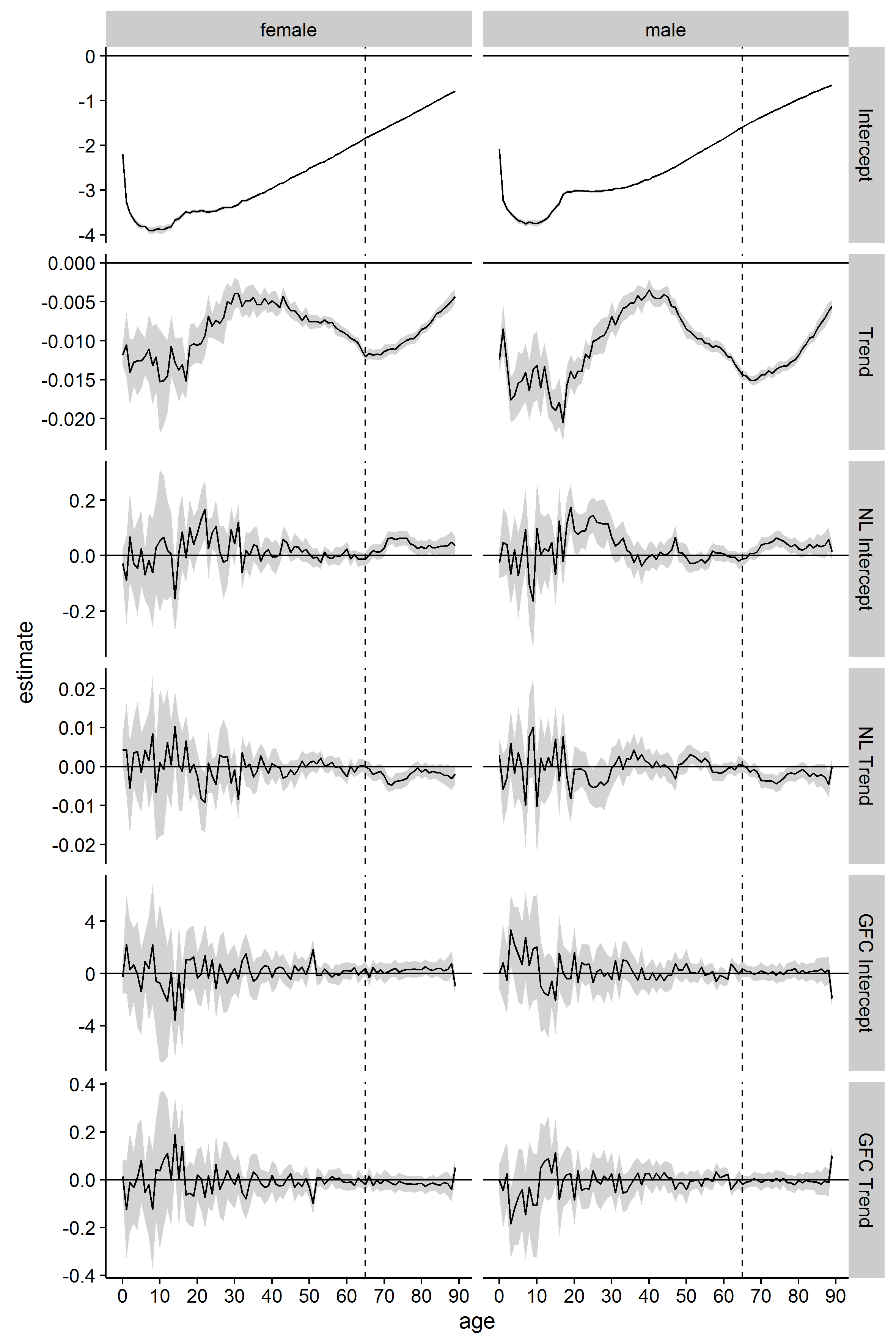
|  |  |
| --- | --- |
| or equivalently | (3) |

Where is the projected mortality rate rather than log rate.

The age-sex specific differences in deaths are therefore , and the total difference in deaths by age A, shown in figures xxx, is .

### Summary of regression coefficients for different ages in standard model

The following figure shows the regression coefficients for each of the age-specific models produced. The bands show 1.96 standard deviations above and below the central parameter estimates indicated by the line. GFC: Global Financial Crisis; NL: New Labour.

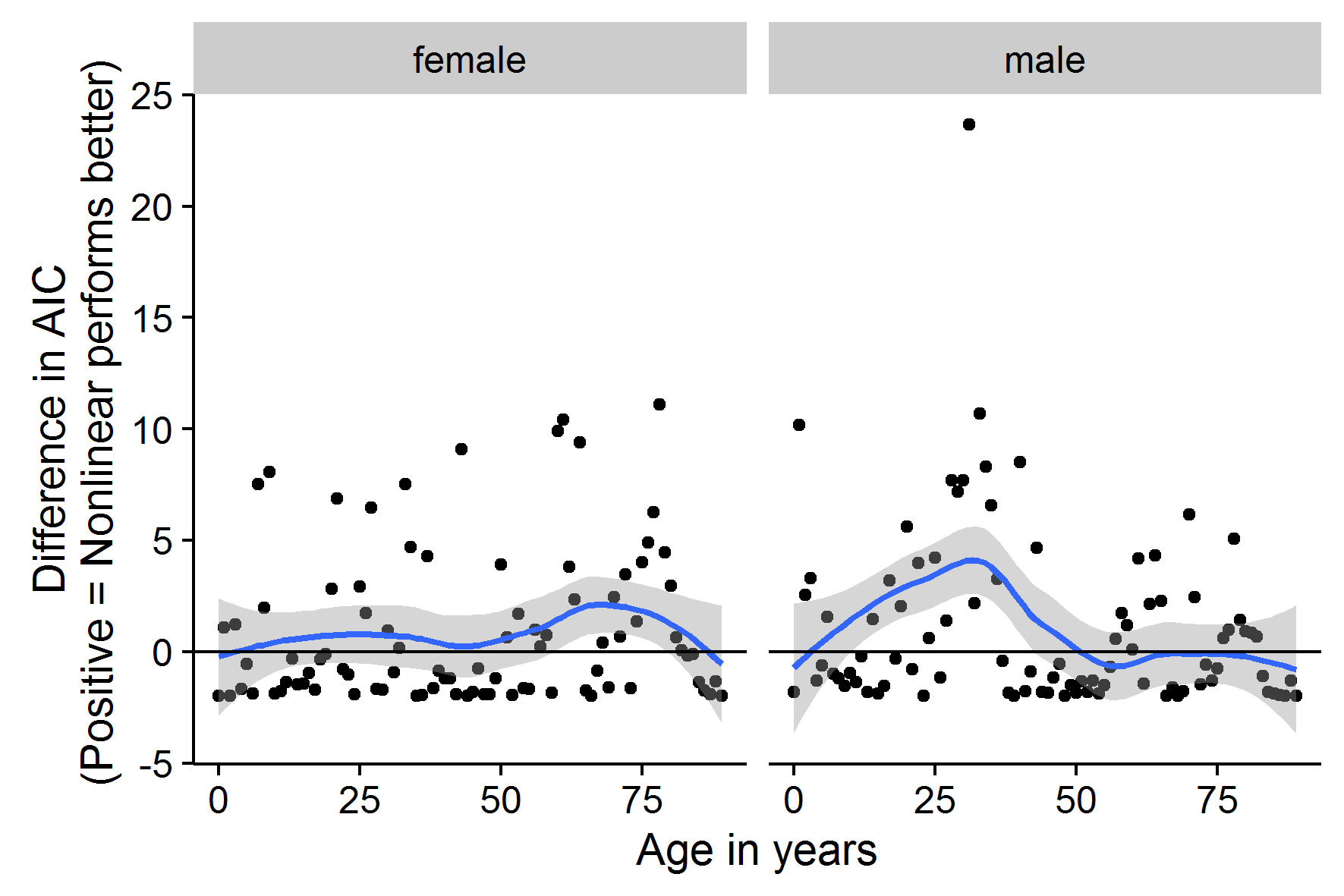


## Alternative Model specification

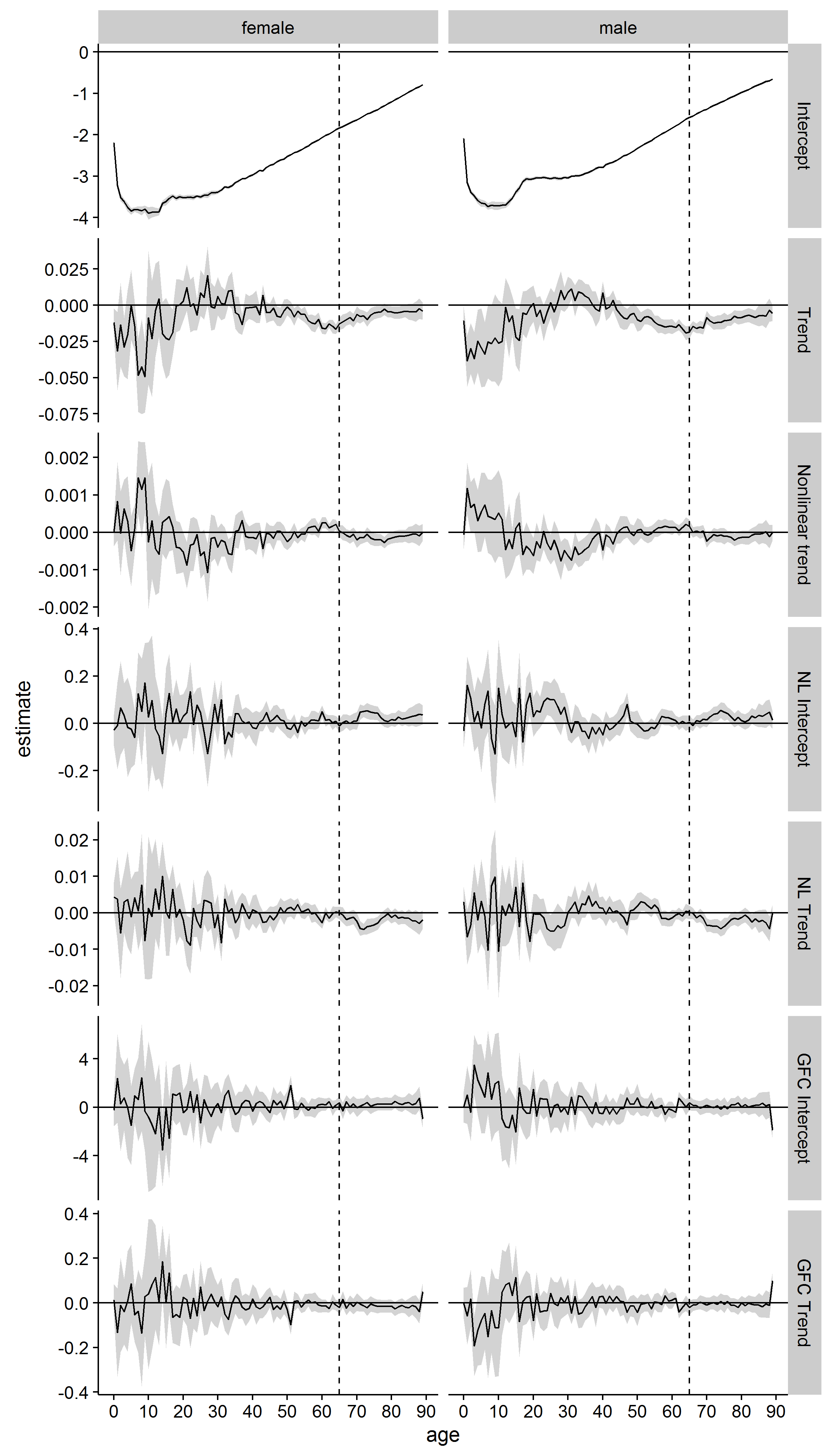
The alternative model specification includes an additional nonlinear term on year since 1990, i.e.

|  |  |
| --- | --- |
|  | (1) |

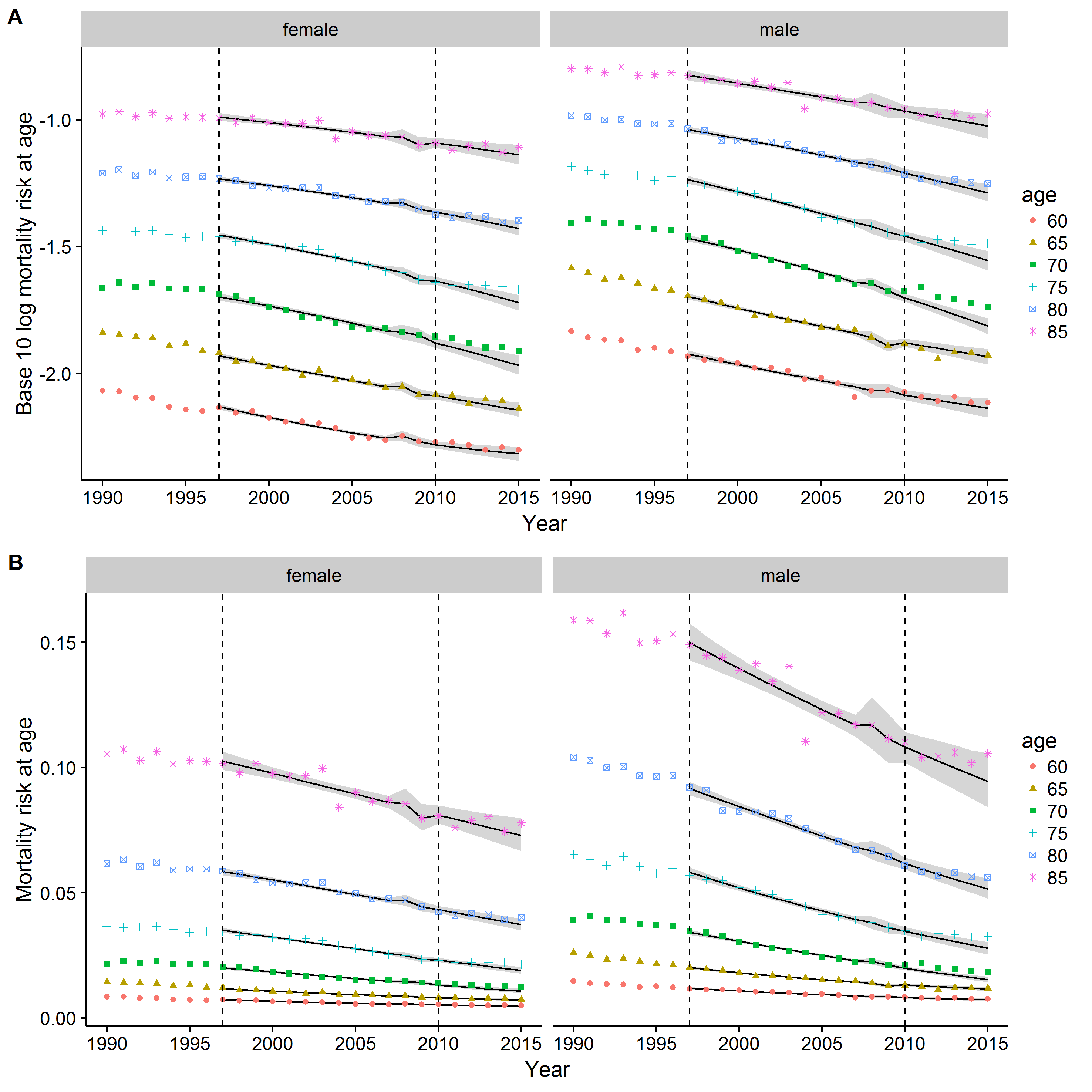
Note: There were too few observations to include interaction terms between and New Labour or the GFC.

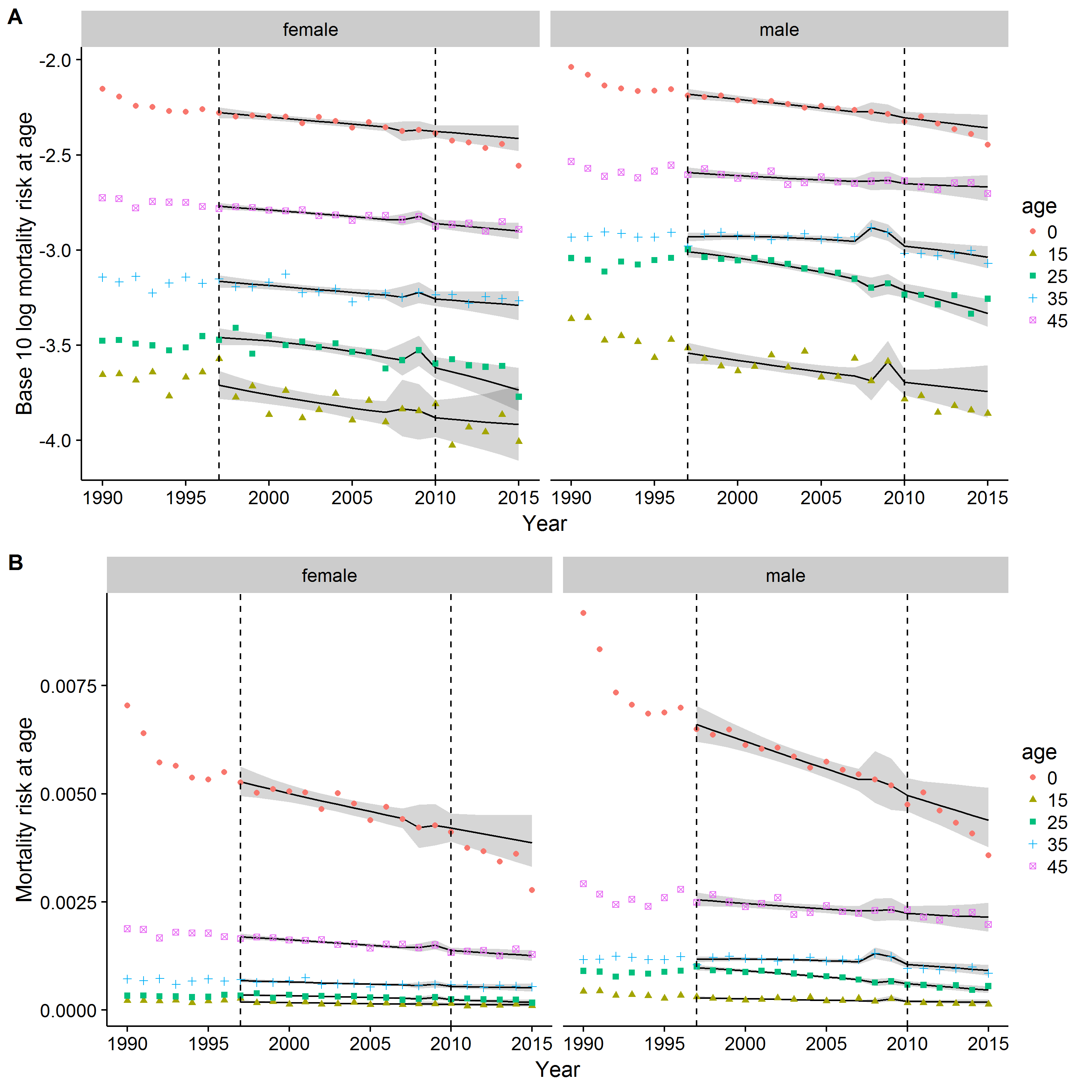
The figure below shows difference in AIC between the standard linear model and the alternative nonlinear model. A nonlinear smoother is added to show this relationship with age. Overall both models have similar performance in terms of fit to the data, although there is an indication of a nonlinear trend for males in young adulthood. 

The figure below shows the coefficients of each of the age-specific models using this alternative model specification. The new trend is labelled ‘Nonlinear trend’, and is statistically significant for males in young adulthood, as implied by the AIC comparison above.



The following two figures show projected against actual mortality rates at older ages, and at younger ages. These figures suggest the non-linear model specification appears to have a slightly better fit to the data, but substantively the patterns are very similar:





The following figure shows the accumulated ‘excess’ mortality using this latter model specification. Substantively, these results are very similar to those in the main model specification, though with a smaller difference between actual and projected in 2010 and 2011, and an even faster acceleration of excess mortality in later years.

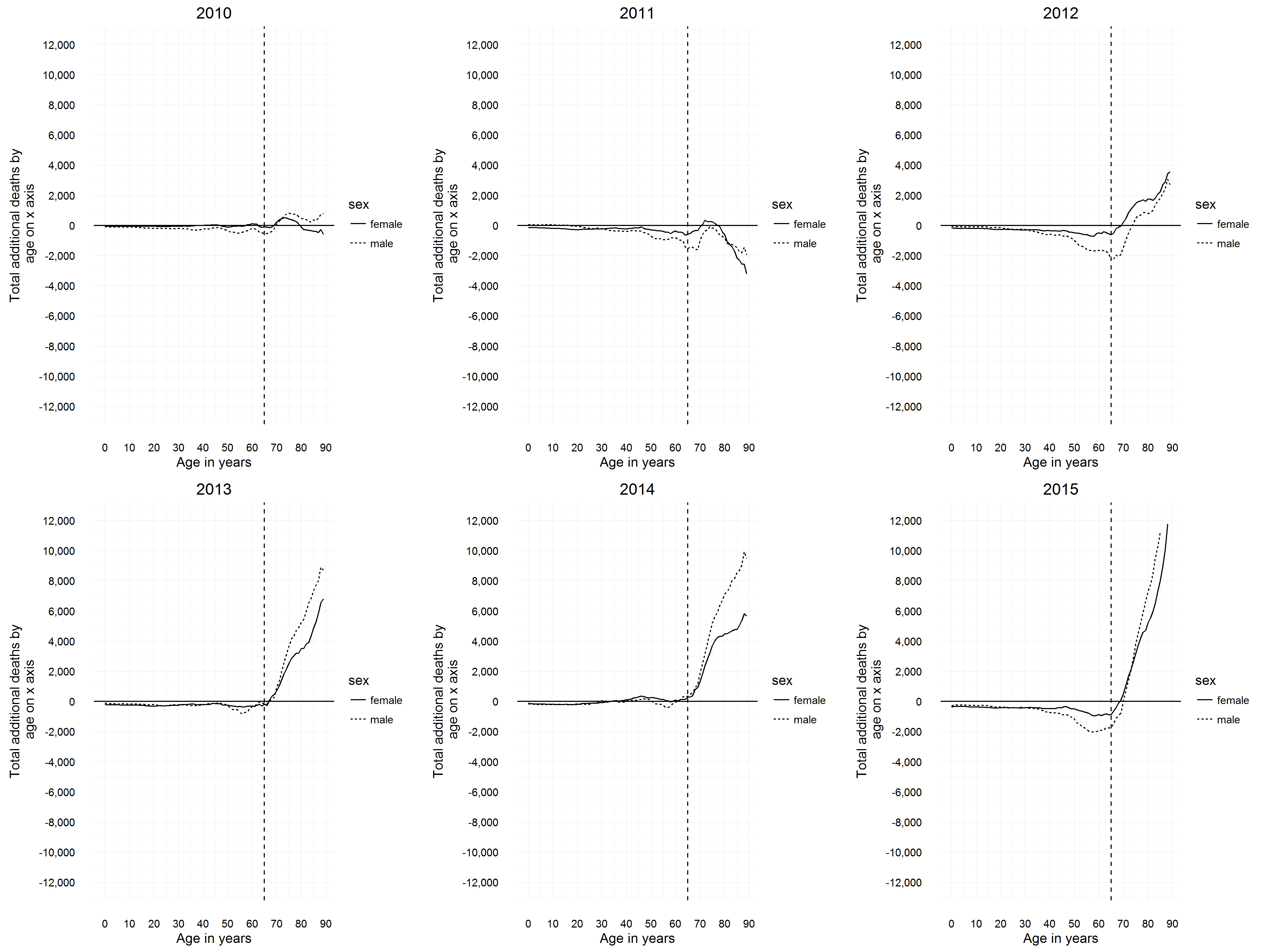


Table S1 summarises the above figure, showing the total excess deaths in each year by ages 50, 70 and 89. Table S2 further summarises these figures, showing the total number of ‘excess’ deaths between the period 2010-2015 and 2012-2015. These suggest there were fewer ‘negative excess’ deaths by age 89 in 2010 and 2011, suggesting a better model fit over this period, and predicts a higher excess death total than the standard model, with 60,073 more deaths than projected between 2010 and 2015, and 65,043 more deaths than projected between 2012 and 2015.

|  |  |  |  |
| --- | --- | --- | --- |
| **Period** | **Males** | **Females** | **Combined** |
| 2010-2015 | 35,032 | 25,041 | 60,073 |
| 2012-2015 | 36,188 | 28,855 | 65,043 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Year** | **Age** | **Males** |  |  |  |  |  | **Females** | |  |  |  |  | **Combined** | | |  |  |  |
| 2010 | 50 | -347 | ( | 19,094 | - | 19,441 | ) | -112 | ( | 11,786 | - | 11,898 | ) | -459 | ( | 30,880 | - | 31,339 | ) |
|  | 70 | **87** | ( | 75,811 | - | 75,724 | ) | **219** | ( | 49,994 | - | 49,775 | ) | **306** | ( | 125,805 | - | 125,499 | ) |
|  | 89 | **799** | ( | 212,724 | - | 211,925 | ) | -600 | ( | 192,910 | - | 193,510 | ) | **199** | ( | 405,634 | - | 405,435 | ) |
| 2011 | 50 | -703 | ( | 18,455 | - | 19,158 | ) | -290 | ( | 11,460 | - | 11,750 | ) | -993 | ( | 29,915 | - | 30,908 | ) |
|  | 70 | -1,007 | ( | 74,013 | - | 75,020 | ) | -102 | ( | 49,391 | - | 49,493 | ) | -1,109 | ( | 123,404 | - | 124,513 | ) |
|  | 89 | -1,955 | ( | 207,606 | - | 209,561 | ) | -3,214 | ( | 185,925 | - | 189,139 | ) | -5,169 | ( | 393,531 | - | 398,700 | ) |
| 2012 | 50 | -981 | ( | 17,817 | - | 18,798 | ) | -481 | ( | 11,097 | - | 11,578 | ) | -1,462 | ( | 28,914 | - | 30,376 | ) |
|  | 70 | -1,470 | ( | 73,161 | - | 74,631 | ) | **204** | ( | 49,648 | - | 49,444 | ) | -1,266 | ( | 122,809 | - | 124,075 | ) |
|  | 89 | **2,706** | ( | 209,909 | - | 207,203 | ) | **3,560** | ( | 189,135 | - | 185,575 | ) | **6,266** | ( | 399,044 | - | 392,778 | ) |
| 2013 | 50 | -304 | ( | 18,025 | - | 18,329 | ) | -244 | ( | 11,062 | - | 11,306 | ) | -548 | ( | 29,087 | - | 29,635 | ) |
|  | 70 | **907** | ( | 74,741 | - | 73,834 | ) | **713** | ( | 49,853 | - | 49,140 | ) | **1,620** | ( | 124,594 | - | 122,974 | ) |
|  | 89 | **8,714** | ( | 213,466 | - | 204,752 | ) | **6,810** | ( | 189,046 | - | 182,236 | ) | **15,524** | ( | 402,512 | - | 386,988 | ) |
| 2014 | 50 | **40** | ( | 17,908 | - | 17,868 | ) | **254** | ( | 11,291 | - | 11,037 | ) | **294** | ( | 29,199 | - | 28,905 | ) |
|  | 70 | **1,894** | ( | 74,625 | - | 72,731 | ) | **1,348** | ( | 49,967 | - | 48,619 | ) | **3,242** | ( | 124,592 | - | 121,350 | ) |
|  | 89 | **9,495** | ( | 212,499 | - | 203,004 | ) | **5,666** | ( | 185,505 | - | 179,839 | ) | **15,161** | ( | 398,004 | - | 382,843 | ) |
| 2015 | 50 | -1,149 | ( | 16,288 | - | 17,437 | ) | -503 | ( | 10,279 | - | 10,782 | ) | -1,652 | ( | 26,567 | - | 28,219 | ) |
|  | 70 | -3 | ( | 71,541 | - | 71,544 | ) | **508** | ( | 48,525 | - | 48,017 | ) | **505** | ( | 120,066 | - | 119,561 | ) |
|  | 89 | **15,273** | ( | 215,870 | - | 200,597 | ) | **12,819** | ( | 189,683 | - | 176,864 | ) | **28,092** | ( | 405,553 | - | 377,461 | ) |

1. ## A structural sensitivity analysis with a non-linear specification of the trend in age specific mortality rates over time and a probabilistic sensitivity analysis, using a quasi-Bayesian statistical simulation approach are presented in the appendix.

   [↑](#footnote-ref-1)