

積極健康樂頤年的全球趨勢

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(以下譯文節錄自 Ms Hoskins 的發言)

1. 首先，人口老化是一個成功故事。它是 20 世紀最偉大的社會成就，亦是 21 世紀社會的最大挑戰。
2. 第一項挑戰是流行病類別的轉變。在 1990 年，世界上的疾病 49% 屬傳染病類。但在 2020 年時，只有 22% 屬傳染病，很大部份的死亡將會由非傳染疾病所致。
3. 另一項主要的挑戰是醫療護理費用的急速上升。人口老化很多時被指為醫療護理費用上升的原因，但研究顯示醫療護理費用上升的成因主要是：
 - (1) 低效率的服務模式。
 - (2) 醫療基建投資不得其所。
 - (3) 分擔費用的設計出錯，導致出現誤用或濫用的情況。
 - (4) 不恰當地使用高成本的科技。
4. 我們應該採取一種新思維，視年長人士為一個無年齡界限社會的一份子，能為社會發展作出積極貢獻及獲回饋。
5. 世界衛生組織就人口老化發表了一份政策文件：“Active Ageing : A Policy Framework”。「積極健康樂頤年」(Active Ageing) 的意思是在一個人的成長過程中加強「健康」、「參與」及「保障」，從而改善生活質素。「積極健康樂頤年」對個體或不同年齡組別皆宜。在世界衛生組織的典章之中，「健康」不單指體格上的健康，亦包括社交及心理健康；「參與」是指能夠維持自主；而「保障」則是指有需要的人士可以得到照顧。
6. 我們認為生活質素包括以下 5 個因素：
 - (1) 體格健康。
 - (2) 心理健康。
 - (3) 獨立自主。
 - (4) 人際關係。
 - (5) 外在生活環境。
7. 「積極健康樂頤年」成功與否在乎圍繞著個人、家庭及社會的眾多影響或決定性因素。最大的不良影響是吸煙，其次是痴肥及缺乏體力活動。外在生活環境對年長人士的獨立能力、自主能力及積極性有著很大的影響。

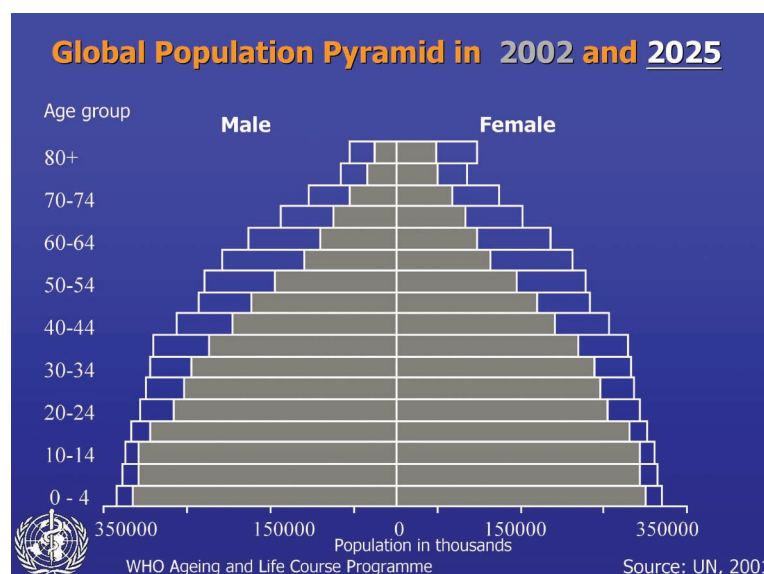
8. 防止年長人士摔倒是一項我們必須處理的急務。傳統觀點把這些傷勢視為「意外」而導致這課題長期受忽視。我們應了解意外不是無可避免的，意外是可以處理及防範的。
9. 我們亦需要為年長人士提供社會支援、防止他們受到暴力侵犯及虐待、與及可以獲得終身學習的機會。此外，亦需保障他們的生活和收入，使他們有機會繼續工作。
10. 在衛生和社會服務方面，我們建議一個涵蓋整個人生，並結合教育、預防疾病、醫療、復康以至長期護理，由年幼到年長的持續照顧模式。我們應特別著重從基層及社區角度推動健康服務，這是預防疾病及促進健康的第一度防線。我們應該為公眾健康從業員提供有關老人病及老年學的培訓，以及支援正式及非正式的護理照顧。
11. 「積極健康樂頤年」的三大支柱是：參與、健康及生活保障。協助年長人士保持健康及活力的措施是必要而不是奢侈品。

A Global Perspective on Active and Health Ageing: Current & Future Trends

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(The following are excerpts of Ms Hoskins' presentation)

1. Population ageing is one of humanity's greatest triumphs. As expressed by WHO's Director General, Gro Harlem Brundtland, "Population Ageing is first and foremost a success story for public health policies as well as social and economic development". Population ageing has thus been recognised as one of the greatest societal achievements in the 20th century.
2. Population ageing refers to a decline in the proportion of children and young people and an increase in the proportion of people aged 60 and over. As populations age, the triangular population pyramid of 2002 will be replaced with a more cylinder-like structure in 2025.



3. Until now, population ageing has been mostly associated with the more developed regions of the world. What is less known is the speed and significance of population ageing in the less developed regions where the vast majority of older persons are already living.

Proportions of population age 60+

	2002		2025
Italy	24.5	Japan	35.1
Japan	24.3	Italy	34.0
Germany	24.0	Germany	33.2
Greece	23.9	Greece	31.6
Spain	22.1	Spain	31.4

WHO Ageing and Life Course Programme

Absolute Numbers (millions) of Persons Above 60 Years of Age in Countries With About or More Than 100 Million Inhabitants (in 2002)

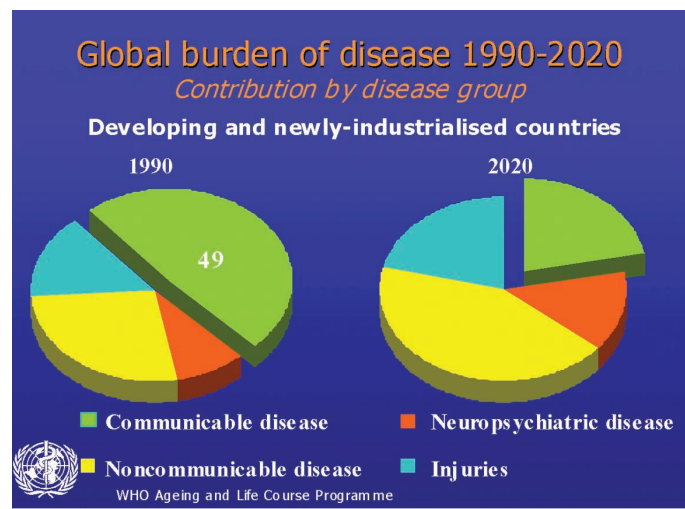
	2002		2025
China	134.2	China	287.5
India	81.0	India	168.5
Brazil	14.1	Brazil	33.4
Nigeria	5.7	Nigeria	11.4

WHO Ageing and Life Course Programme

- In 2002, over half of the world's older people lived in Asia. Asia's share of the world's oldest population will continue to grow the most and will be 59% of the global population 60 plus in 2025. At the same time, Europe's share as a proportion of the global older population will actually decrease the most over the next two decades (from 24% to 17%).
- Population ageing is a triumph, but also one of the greatest societal challenges for the 21st century.

Challenge Number One is "The epidemiological transition". As nations develop and industrialise, a shift in disease patterns occurs. Even as many developing and newly industrialised countries continue to struggle with some infectious diseases, they are faced with the rapid growth of non-communicable diseases (NCDs). This trend from communicable to non-communicable diseases will accelerate over the next two decades as shown in the figure below. In 1990, 51 percent of the global

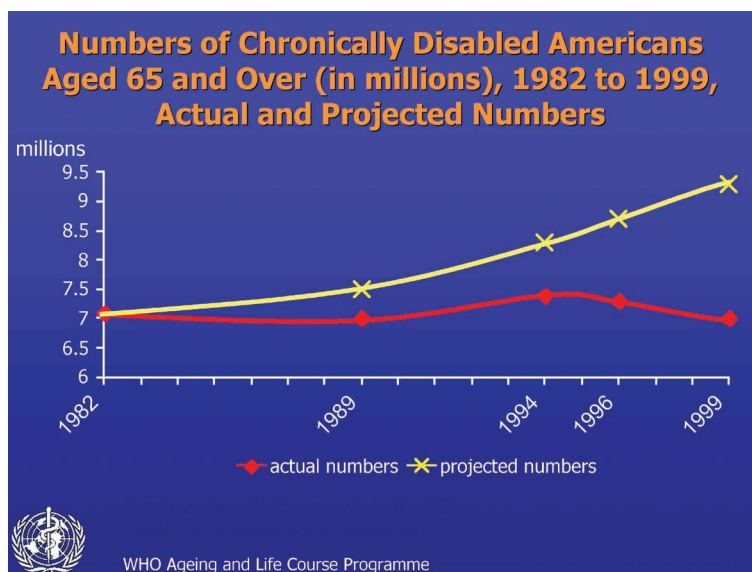
burden of disease in developing and newly industrialized countries was caused by NCDs, mental health disorders, and injuries. By 2020 the burden of these diseases will rise to approximately 78 percent with only 22% being due to infectious and communicable diseases.



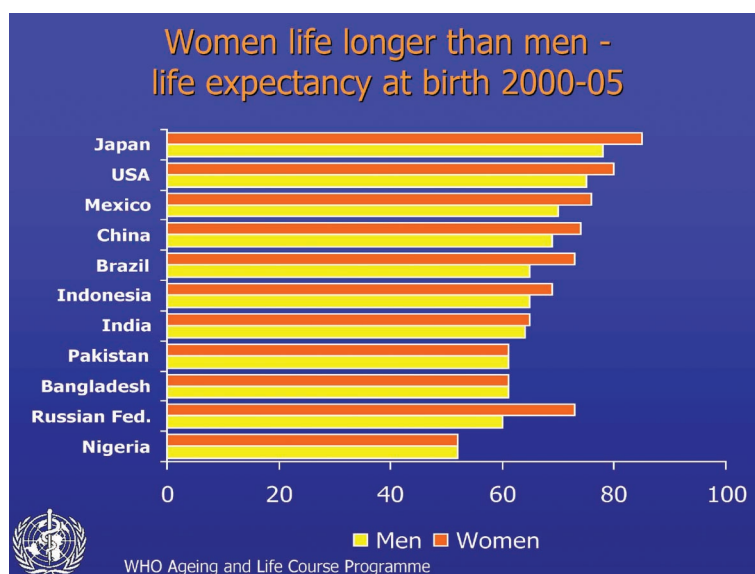
Chronic diseases share three features:

1. They grow with development: no nation will escape from this trend.
2. They challenge the health care system to move towards a comprehensive integrated system of care.
3. Their burden can be reduced if health systems change.

Challenge Number Two is the increased risk of disability. Many people develop disabilities later in life related to the onset of a chronic or degenerative disease. But the onset of disabilities associated with ageing and the onset of chronic diseases can be delayed or prevented altogether. For example, there has been a significant decline over the last 20 years in age-specific disability in the United States. The figure below shows the actual decline among older Americans between 1982 and 1999 compared to the projected number if rates of disability had remained stable over that time period. A similar trend has occurred in England and the Sweden. The adoption of healthy lifestyles is certainly a factor but more research is needed to provide the evidence.



Challenge Number Three is the “Feminization of Ageing”. In the vast majority of countries, women live longer than men. While women have a biological advantage in length of life, they are also more likely than men to experience discrimination and cumulative disadvantages in many parts of the world. Older women, particularly those living alone, are highly vulnerable to poverty and isolation. In addition, they often suffer from multiple health problems and disabilities.



Challenge Number Four is persistent inequalities between countries in terms of the distribution of wealth and access to resources. While the developed countries became rich and then they became old, the developing countries are rapidly ageing while their population still endures widespread conditions of poverty. Ageing should be addressed as part of the development agenda. Healthy older persons are a resource for their families, their communities and the economy. It is well known that socio-economic status and health are intimately related. With each step up the socio-economic ladder, people generally live longer healthier lives.

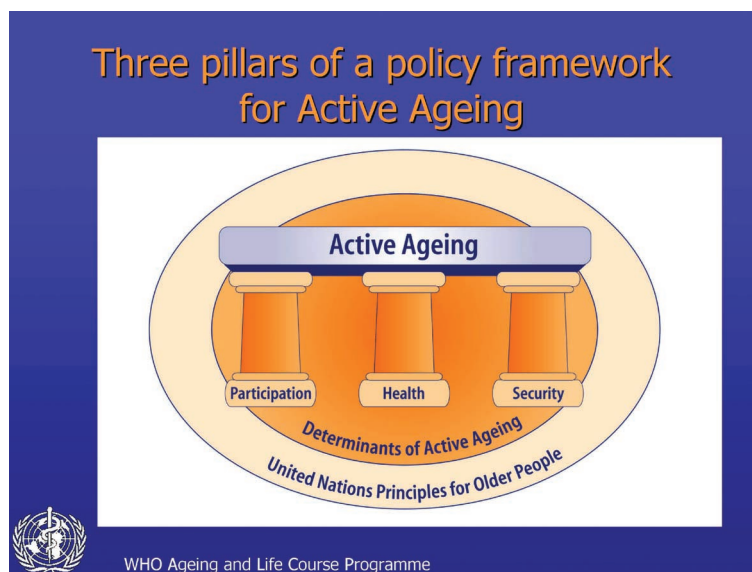
Challenge Number Five is the perception that population ageing drives up health care costs. However, studies in OECD countries have shown that escalating health care costs are more related to:

1. inefficiency in care delivery
2. wrong investments in infrastructure
3. wrong incentives for payment systems
4. inappropriate use of high-cost technologies

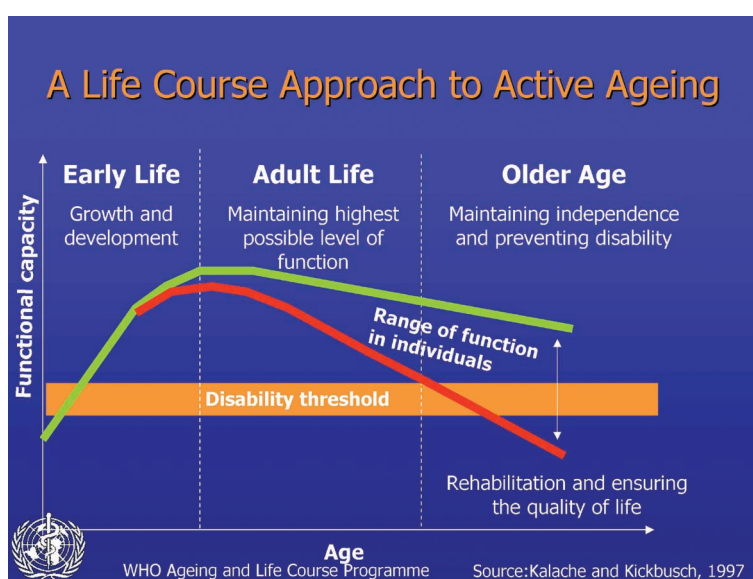
Therefore, population ageing per se is not likely to lead to health care cost "spiralling out of control."

6. Traditionally, old age has been associated with illness and dependency. But policies that are stuck in this outdated paradigm do not reflect reality. It is time for a new paradigm, one that views older people not as a drain on the economy but as active participants in an age-integrated society and as active contributors as well as beneficiaries of development.
7. In an increasingly interconnected world, failure to deal with the demographic imperative in a rational and positive way will have serious socio-economic and political consequences. To meet these challenges and as its contribution to the Second World Assembly on Ageing, WHO developed a Policy Framework on Active Ageing. Active Ageing is defined as the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age. Active ageing policies apply to both individuals and population groups. Action is necessary on the three basic pillars of Active Ageing: participation, health, and security. Health, according to the WHO Constitution, refers to physical as well as social and mental well-being. When the risk factors for chronic diseases and functional decline are kept low while the protective factors are kept high, people will enjoy health and both a better quantity and quality of life.

Participation requires multi-sectoral action and should lead to maintaining autonomy and independence for as long as possible. In the event that older people are not longer able to support and take care of themselves, they should be ensured of protection, dignity and care and enjoy security.

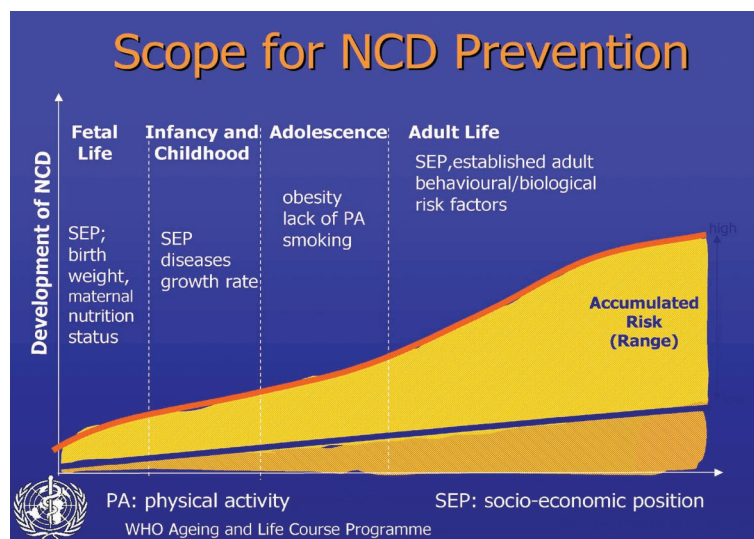


8. A life course perspective on ageing (see figure below) underpins all multi-sectoral actions on Active Ageing. Functional capacity (such as ventilatory capacity, muscular strength and cardiovascular output) increases in childhood and peaks in early adulthood, eventually followed by a decline. The rate of decline, however, is largely determined by factors related to adult lifestyle -- such as smoking, alcohol, levels of physical activity and nutrition -- as well as external and environmental factors. The gradient of decline may become so steep as to result in premature disability.

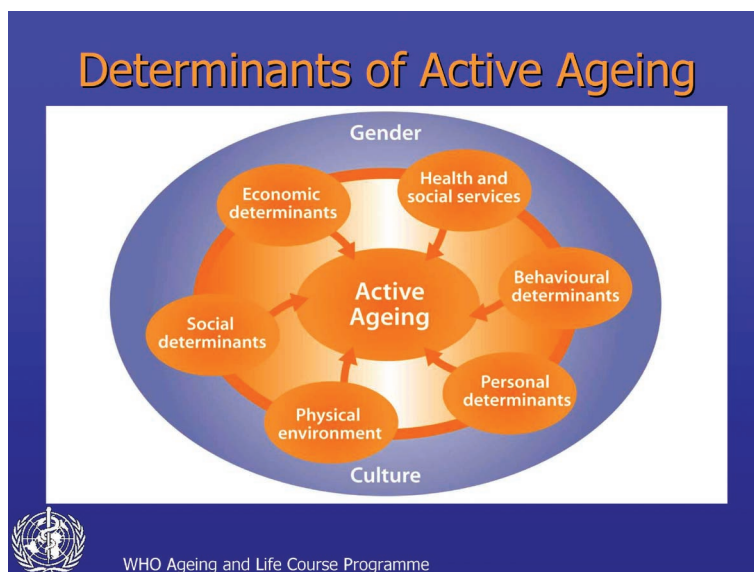


However, the acceleration in decline can be influenced and may be reversible at most ages through individual or public policy measures. It should be added that the disability threshold can be lowered through changes in the environment. This will decrease the number of disabled individuals in any given environment.

9. Another way of looking at the Life Course is to look at the scope for the prevention of non-communicable diseases (see figure below). By midlife and in the later years, non-communicable diseases are responsible for the vast majority of deaths and diseases. Research is increasingly showing that the origins of risk for chronic conditions begin in early childhood. This risk is subsequently shaped by factors, such as socio-economic status and behavioural factors which will put older individuals at greater risk of developing NCDs at older ages. But with appropriate life style changes, the accumulated risk can be lowered resulting in better health.

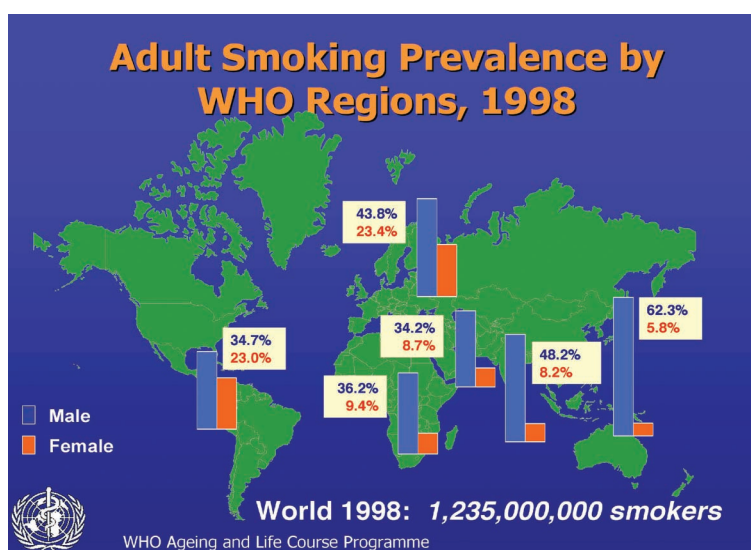


10. When developing the Policy Framework, we have chosen the term "Active Ageing" because it is more inclusive than "healthy ageing" as it recognises the multiple factors that affect how individuals and populations age. Active ageing depends on a variety of influences or "determinants" that surround individuals, families and nations. Understanding the evidence we have about these determinants helps us design policies and programmes that work.
11. The figure below shows a systematic outline of the "Determinants of Active Ageing", which operate throughout the life course:



(1) Behavioural Determinants.

The adoption of healthy lifestyles is important at all stages of the life course. Smoking is the most important modifiable risk factor for NCDs and a major preventable cause of death. The figure below "Adult Smoking Prevalence by WHO Regions, 1998" shows that the prevalence of smoking among males is very high, particularly in the Western Pacific Region, which includes China.



Diet and nutrition are of paramount importance. Excess energy intake greatly increases the risk for obesity, chronic diseases and disabilities as people grow older. Another behavioural risk factor is insufficient physical activity. WHO estimates that more than 65% of world population is insufficiently active. Insufficient physical activity contributes to many NCDs. The estimated impact is approximately 2 million annual deaths.

(2) Determinants related to physical environment

Physical environments that are age-friendly can make the difference between independence and dependence for all individuals but are of particular importance for those growing older. For example, older persons who live in unsafe environments or areas with multiple physical barriers are more prone to isolation, and increased mobility problems. One of the burning issues is how to prevent falls among older persons. The traditional view of injuries as “accidents” has resulted in historical neglect of this area of public health. We should recognize accidents do not just happen, they can be addressed and prevented.

(3) Determinants related to the social environment

Social support, freedom from violence and abuse, and access to life-long learning are key factors in the social environment that enhance health, participation and security as people age.

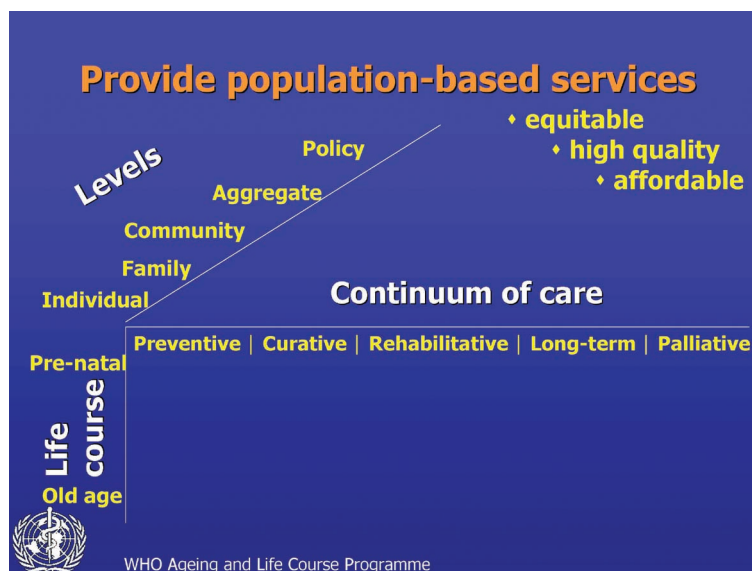
(4) Economic determinants

Three aspects of the economic environment have a particularly significant effect on active ageing: income security and access to work throughout the life course as well as social protection.

(5) Health and Social Services should be available throughout the life course. They need to be integrated, coordinated, cost-effective and based on the principle of universal access. We need a continuum of care from preventive, curative, rehabilitative, long-term to palliative. Services should be available at various levels from individual, family, community, to aggregate levels, such as work places, and they should be governed by sound public policy. We should in particular note the importance of community-based approaches to care. Community-based care is of paramount importance for managing disease and promoting well being. We should provide basic training in geriatrics and gerontology for community-based health care workers as well as practical support for formal and informal carers.

12. The policy framework on Active Ageing is guided by the United Nations Principles for Older People. These are to promote independence, participation, care, self-fulfilment and dignity for all older people. Moreover, policies should be based on an understanding of how the determinants of active ageing influence the way that individuals and populations age. The three basic policy objectives,

i.e. to encourage participation and thus prevent exclusion, to promote health, and to provide security, cannot be overemphasized.



13. The WHO policy framework complements the International Plan of Action on Ageing adopted in Madrid. It provides a roadmap for multi-sectoral policies and shares the same approaches: application of a life course approach with an emphasis on maintaining maximum functional capacity at older ages; identifying and acting upon the risk factors to active and healthy ageing; regarding ageing as a development issue; working towards health care policies that provide a continuum of care; and trying to ensure universal and equal access to health care services

14. Active Ageing Policies and Programmes aim to achieve the following results:

1. Fewer premature deaths in the highly productive stages of life
2. Fewer disabilities associated with chronic diseases in older age
3. More people enjoying a positive quality of life as they grow older
4. More people participating actively as they age in the social, cultural, economic and political aspects of society, in paid and unpaid roles and in domestic, family and community life
5. A side effect is lower costs related to medical treatment and care services

15. The time to plan and to act is now. With our planet ageing rapidly, measures to help older people remain healthy and active are a necessity, not a luxury.