PREFACE

As I write this, I am in my seventh decade, having worked as a teacher, researcher and doctor in Hong Kong since 1977. My family emigrated to London in 1960, where I attended secondary school and university, subsequently working in various specialties in London hospitals. My personal experience of ageing covers my experience with my family in the UK, as well as my husband's family in Hong Kong. My work experience covers a period working part time in the private sector in general practice, and then for many years in the public hospital sector, setting up the geriatric service in the New Territories East Cluster in 1985 after joining the newly established Department of Medicine of The Chinese University of Hong Kong. At that time, academics led the service development, teaching and research in hospitals run by the Hospital Authority. I remember the profile of patients in the medical wards were very different: there were very few people aged 60 and above. A patient with a diagnosis of dementia created so much excitement that the newly established specialty of Psychogeriatrics immediately

took the patient over to their wards. Practically everyone could walk to the toilet and eat by themselves. By the time I retired from regular hospital work approximately 30 years later, the majority of patients in medical wards were aged 80 to 100 and could not or were not allowed to get to the toilet. Use of restraints was common in the name of safety, as were incontinence pads. During wintertime, most of the patients admitted from Residential Care Homes for the Elderly (RCHEs) were bedridden, and sometimes up to one third of inpatients were demented. The care they required was no different to those of the paediatric wards: many relatives or domestic helpers came to help with feeding, washing, and other aspects of personal care. In coping with the increasing demands of dependent older people, there was increasing focus on duration of stay as a performance measure, giving rise to a 'revolving door' phenomenon.

We had a great team for care of the elderly in the New Territories East Cluster: we initiated many initiatives such as restraint reduction, falls prevention, use of technology and robots to aid rehabilitation, telemedicine to support residential care homes in the 1990s, and establishing liaison with many community NGOs. Yet we could not keep pace with demand, and the gap and dilemma of meeting the needs of such patients and what could actually be done rapidly widened.

In my personal life, both sets of family developed various age-related problems, requiring navigating though different health and social care systems, as well as social and psychological support. I approach these problems from a professional perspective, but have gradually realized how inadequate this is, in spite of the

fact that geriatric medicine is supposed to provide holistic care covering not just physical health (how various body systems malfunction), but also functional (capabilities in independent living), social, psychological, and nutritional domains. I like to think that all this effort and experience is not in vain. Working in a predominantly institutional environment narrows one's view on ageing and makes it very negative. In reality, people use hospital services in the last years of life, and the change in hospital service profile is a result of increasing life expectancy to approaching 100. The health discourse has been dominated by the Hospital Authority services; yet with population ageing, it is increasingly necessary to design or build on existing community services, using an integrated approach to cover both social and health needs to tackle various problems before people end up in hospitals, and also to support them after discharge, in the inexorable journey towards end of life. We are far from doing this; yet if we ignore or fail to understand the full spectrum of consequences of population ageing, public health expenditures will increase, while unmet needs will also continue to increase.

The United Nations has declared 2020–2030 to be a decade of healthy ageing, with many countries supporting this aspiration. Currently many indicators of health ageing and service models are being promoted. In many ways this approach covering the whole life course is a very positive aspect to tackling ageing. Central to this approach is the concept of empowerment. People need to understand how ageing affects their brain function, as well as physical capabilities, and not view ageing through the black and white lens of whether you have a disease or not. There

is no drug that prevents these changes; however, there are many things one can do individually, and collectively as a society, that can contribute to delaying dependency for as long as possible. This book talks about some of these aspects, emphasizing that in the last analysis, we need to take charge of our own ageing.

The contents cover the current concept of healthy ageing, whether we are achieving healthy ageing in Hong Kong or not, the importance of social determinants of healthy ageing and social justice, and what we can do better, as well as what other countries are doing. My personal views may be unfamiliar to many people, yet I have found more resonance from many ordinary older people I talk to, as well as from dialogue with international communities. It is in the spirit of stimulating a change in paradigm of how we view ageing that this book is written. I believe that changes in mindset may be achieved by more and more people expressing what they need and grouping together to create a society that is truly age-friendly and that allows older adults to function in a meaningful way, whatever chronic diseases or disabilities that they may suffer from. Our future is in our own hands.