《國文抄錄》

우리나라의 姓選好와 性比 不均衡에 관한 分析

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1950년대부터 많은 개발도상국가들은 家族計劃을 위주로 하는 人口抑制政策을 추진하여 왔다.

특히 家父長制度를 중심으로하는 동아시아 국가들에 있어서는 男兒選好觀이 출산력 저하나 피임실천율의 증대에 지대한 沮害要因으로 일관해 왔다. Sheps(1963)는 실증적으로 2명의 아들을 갖기 위해서는 약 3.9명 정도의 자녀를 두어야 한다는 연구결과를 제시한바 있다.

이와 같은 남아선호관의 여파에도 불구하고 韓國과 臺灣은 1980년대 중반에 이미 1.6명 수준의 저출산율을 이룩하였으며, 1970년대에 인구억제 정책을 시작한 中國도 2명 수준으로 저하되어 가족계획사업의 성공사례로 평가되어 왔다. 그러나 이들 국가들의 출산율은 지난 20-30년이라는 짧은 기간에 너무나 급진적으로 감소된 반면에 남아선호관의 상존으로 인한 性比(女子 100명당 남자수)의 不均衡을 초래하게 되었다. 한 예로 한국의 경우 1960년도만 해도 6명 이상의 자녀를 출산하는 과정에서 1-2명의 아들을 둘 수 있는 확률은 매우 높았으나, 최근에는 출산율이 2명 이하로 저하되어 아들을 둘 수 있는 확률은 과거보다 3-4배나 어려워졌기 때문에 人爲的인 방법으로 아들을 두는 부모의 수가 증가하고 있다. 中國은 1970년대 중반기부터 강력히 추진되어온 소위 "한자녀 갖기 운동"으로 인하여 女兒出産인 경우 영아살해 또는 出生의 미신고등 많은 사회적 물의를 야기하였고, 최근에는 초음파검사를 통한 선택적 人工姙娠中絶(胎兒가 女兒인 경우)의 경우가 급격히 증가하고 있다.

우리 나라의 성비는 출산율이 급격히 감소된 1980년대 중반기부터 급격히 증가되었다. 즉 인구전체에 대한 성비는 1980년의 103.9명에서 1985년에 110명으로 증가하였고, 1990년 116.9명으로 증가되었다. 성비는 자녀의 수가 적을수록 높아지는 추세이다. 1991년 조사에서 출산을 종료한 부인의 경우 1자녀의 성비는 무려 206명이나 되고 있다. 이와 같은 결과는 한자녀를 원하는 부인이 아들을 둔 경우 1자녀에서 斷産을 결심하기 때문인 것이다.

統計廳 자료에 의하면 성비는 무엇보다도 자녀의 出産順位와 밀접하다. 1991년 출생신고자료의 경우 첫아이의 출생시 성비는 106.1명이고, 둘째아이가 112.8명이나, 셋째아이는 184.7명으로 크게 증가하고 넷째 이상의 경우는 212.3명이나 된다. 동일한 出生順位라도 이미 두고 있는 자녀의 성에 따라서 많은 차이를 보인다. 1991년도 3번째 출산의 경우 딸만 2명을 두고 있는 경우가 136.3으로 아들만 2명 또는 아들과 딸을 각각 1명씩 두고 있는 경우에 비해 높은 性比를 보이고 있다. 자녀를 출산하는데 있어서 처음에는 아들을 기다리지만 딸의 수가 증가함에 따라 적극적으로 아들을 낳고자 하는 노력을 지속하게 됨을 알 수 있다. 이는 즉 姙娠한 자녀의 性이 딸로 판명되면 인공임신중

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절을 통해 임신을 종결시키고 있음을 의미한다.

최근 한국보건사회연구원에서 수행한 연구결과에 의하면 이미 출생한 자녀의 性構成은 임신결과를 결정하는 가장 중요한 변수로 부각되고 있다. 즉 姙娠이 인공임신중절로 歸着되는 確率은 부모가 이미 아들을 두고 있는 경우에 一貫性 있게 증가되고 있음을 보이고 있다. 따라서 남아선호관은 임신결과를 결정할뿐 아니라 선택적 인공임신중절에 의한 性比의 不均衡을 초래하는 주요 변수로써 浮刻되었다. 특히 피임실천이 普遍化되고 선택적 인공임신중절의 이용이 손쉬운 현대사회에 있어서는 남아선호관이 출산력 저하에 저해요인으로서가 아니라, 人爲的이던 自然的이던 간에 아들만 두면 斷産하는 現今의 出産風土下에서는 남아선호관이 오히려 출산력저하에 肯定的으로 작용하고 있다고 하겠다.

胎兒의 性 識別을 통한 선택적 인공임신중절의 件數는 1990년 한해에 약 20,000건 정도가 되고, 1986－1990년 사이에 총 80,000건으로 추정된다. 이 수치는 출생한 여아수의 5%에 해당한다. 현재 출생시 성비의 불균형은 年間 總出生數의 10% 미만에 불과한 3번째 이상의 출산에서 발생되고 있기 때문에 인구학적인 측면에서는 큰 문제는 아니다. 그러나 앞으로 출산율의 감소와 더불어 선택적 인공임신중절이 년간 출생수의 90%이상을 차지하고 있는 둘째, 첫째出産順位로 확산된다면 성비의 불균형은 급진적으로 가속화되어 전통적 結婚慣習의 崩壞등 인간의 生態界를 파괴하는 새로운 차원에서의 社會人口學的인 문제가 야기될 것이다.

結論的으로 性比의 不均衡을 초래하는 근본적인 원인은 우리 나라의 전통적 意識構造인 남아선호관의 常存과 최신의 醫療技術에 의한 선택적 인공임신중절에 기인된 것이기 때문에 이를 是正하기 위한 제반 社會制度的 支援施策은 지속적으로 강화되어야 할 것이다.

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A Revisit of Elderly Suicide in Hong Kong, 1983-1992

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Ⅰ. The Elderly suicide Phenomenon

Pareto has said that aging is an objective reality known to all, but whose beginning is impossible to pinpoint precisely (Baechler, 1979, p. 284). He was thinking not so much of the state of being old as of the process of growing old, The elderly encounter many stressful life events that are either absent or relatively uncommon to other age groups in society, They are relatively more socially isolated, physically ill, and likely to experience life's chief crisis : death of a spouse, In addition, financial hardship is widespread.

Elderly people have shown high suicide rates relative to other age groups throughout history (Lester, 1992). Hudson Bay Eskimos pitched themselves from cliffs when they could no longer negotiate the harsh physical conditions of the long winters, Aging Crow Indians dressed themselves in their finest clothes and single-handedly attacked their enemies in suicidal fashion. Aged Samoans were buried alive at their own request. Dying of natural causes in these cultures after a long, debilitation old age was considered a major embarrassment to the individual and his or her family (Bromberg and Cassel, 1983). Where old age is an honor and the highest prestige is accorded to old people, no one will kill himself because of depression (Levy, 1949, p. 806). Although longevity is not considered an embarrassment in the Chinese society today, the suicide rate among people over 65 remains the

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highest of any age group (Lester, 1992).

Basic contributions to the study of suicide were made by Freud (1917/1957) and Durkheim (1951). Freud covered the individual, interpersonal, and drive aspects, while Durkheim's demographic and social studies dealt with society and the suicide rate, especially the centrality of social integration or else alienation in the prevention or etiology of suicide. The most recent study of suicide in the elderly has been enriched by Miller (1979), whose scholarly survey was brought up to date by Osgood and McIntosh (1986). Both these volumes are required reading for every one interested in elderly suicide.

The reasons for suicide in the elderly are not as self-evident as they seem to some persons who attribute the event primarily or even solely to being old. Many of the elderly do, nevertheless, succumb to despair and suicide. Older persons are consistently the winners in the undesirable race to have the highest suicide rates, and there is evidence that the rate is increasion.

One key suicidogenic condition facing the elderly is serious physical illness. Strokes, heart attacks, bouts with cancer, and eventual death characterize the elderly cohort. Loss of mobility as a result of stroke contributes to social isolation, which in turn contributes to suicied. Self-esteem can be lost through disfigurement and increased isolation. Retirement, death of spouse, deaths of life-long friends, physical limitations to mobility, and fear of crime all contribute to greater isolation in later life.

Conwell et al. (1989) found that, with increasion age, suicides were more often widowed, more often living alone, more often reacting to physical illinss and loss, and less often intoxicated at the time of the act. Vogel and Wolfersdorf (1989) compared elderly and younger completed suicides among hospitalized psychiatric patients, The elderly suicides had more physical diseases, more delusional fears and auditory hallucinations, felt lonelier, had experienced more loss through death and had more interpersonal problems, The major features of the family at the time of a suicidal attempt are summarized by Richman (1991, p.162, Table2) into seven characteristics, Both demographic and family studies highlight the central significance of separation and loss, incomplete or failed mourning, role problems, and unresolved crises.

As we suggested before, elderly suicide rests on a foundation of pervasive despair, failure, and hopelessness, There are at least four major factors that have been shown to be related to elderly suicide. These are cumulative loss, alcohol and drug dependence, retirement with its financial and social concomitants, and social isolation resultion in loneliness (Stillion, McDowell and May, 1989, Ch.6). Shneidman (1991, pp.40-45) also identified ten psychological commonalities of elderly suicide. Recently, Richman (1991, p.156, Table 1) summarized twenty one major indices of suicidal potential in old age, derived from the social, biological, situational, and psychological conditions, at both conscious and unconscious, overt and covert levels.

Ⅱ. The Hong Kong Context

There has recently been a marked growth in the population of elderly people in Hong Kong's population (Census and Statistics Department, 1991, p.33). The present population of Hong

Kong is estimated to be approximately 5.90 million people (Government Information Services, 1993, p.381). The number of people age 60 and over was estimated to be 829, 100(13.9%) in mid-1993 and is expected to rise to 922,300 (14.9%) in mid-1997 (Census and Statistics Department, 1987, p.16). Increasing numbers of eldrely persons will results in a corresponding increase in the demand for a greater number, a greater variety and a longer duration of services for elderly people in the territory.

As in other Asian countries, the Chinese family in Hong Kong remains the most fundamental unit in society, It continues to perform many of its traditional functions such as rearing the young and caring for the old, although the extent of both has been lessened considerably by the processes of modernization and industrialization(Wong, 1975). The family in Hong Kong is undoubtedly very different from what it was 30 or 40 years ago when traditional Chinese or Confucian norms and values still prevailed (Ho. 1973). Present families are mostly of the nuclear type, and the tendency is for more and more children to live away from their elderly parents when they start their own families (Chow, 1983). The normative expectation of filial piety no longer can safeguard the surviving years of the elderly in Hong Kong. Not surprising that every week we read from local newspapers about incidents of elderly suicides this days (Carter, 1993, p.3).

In 1988, Kwan used a secondary data analysis approach to trace back all reported elderly suicide cases in Hong Kong from 1983 to 1986. The findings indicated that the suicide rate tended to rise with age for most of the four years studied(Kwan, 1988, p.252). Within this paper we will further examine the elderly suicide phenomenon by using data within the Hong Kong Government's Coroners Report from 1989 to 1992, also from annual reports of Samaritan Befrienders of Hong Kong from 1983 to 1988.

There were 503 female(45.1%) and 612 male (54.9%) suicides from 1989 to 1992. In all years studied, more elderly men committed suicide than female (see Table 1). Death by suicide was most striking in the old-old group (age 70+) as compared to the young-old group (age 60 to 69). The old-old group was responsible for more than 58% of all deaths (see Talbe 2).

In general, the suicide rate tended to rise with age for all the years studied, The greatest difference was between those aged 60-69 and people aged 70 and above (see Table 3). When we further classified suicides into old-old and young-old groups, data in Table 4 and 5 indicated that the increase was even more striking. Also it has been gradually increasing from 1983 onward to 1992 respectively. For example, the young-old suicide rate increased from 22.3 in 1983 to 26.7 in 1992, for the old-old suicide rate, it was increased from 38.1 in 1983 to 50.5 in 1992 respectively. Also, the sex-specific suicide rate presented in Table 6 indicated that the suicide rate among the female group tended to rise sinec 1990.

Ⅲ. Discussion

Most of the elderly in Hong Kong are now living in a world very differenht than the one in which they grow up. First of all, growing older increaese the probability of the development of

Table 1. Frequency Distribution of Victim (60+) by Sex

Sex	Year			
	1989	1990	1991	1992
	N (%)	N (%)	N (%)	N (%)
Male	147(53.8)	146(55.3)	157(56.1)	162(54.4)
Female	126(46.2)	118(44.7)	123(43.9)	136(45.6)
Total	273(100.0)	264(100.0)	280(100.0)	298(100.0)

Source : Hong Kong Coroners Report, Hong Kong : Government Printer, 1989 (p.16), 1990(p.16), 1991(p.17), 1992(p.14)

Table 2. Frequency Distribution of Victim Age Groups

Age Group	Year			
	1989	1990	1991	1992
	N (%)	N (%)	N (%)	N (%)
60-69	118(43.2)	107(40.5)	121(43.2)	120(40.3)
70-79	106(38.8)	101(38.3)	106(37.9)	103(34.6)
80+	49(18.0)	56(21.2)	53(18.9)	75(25.1)
Total	273(100.0)	264(100.0)	280(100.0)	298(100.0)

Source : Hong Kong Coroners Report, Hong Kong : Government Printer, 1989 (p.16), 1990(p.16), 1991(p.17), 1992(p.14)

Table 3 Age-specific Suicide Rate per 100,000 by Years

Age Group	Year							
	1989		1990		1991		1992	
	Population[a]	Rate	Population[a]	Rate	Population[a]	Rate	Population[a]	Rate
60-69	418,200	28.2	429,700	24.9	440,400	27.5	450,000	26.7
70-79	227,900	46.5	238,400	42.9	248,800	42.6	258,800	40.1
80+	75,500	64.9	80,600	69.5	86,800	61.1	93,800	80.1
Total	721,600	37.8	748,700	35.3	776,000	36.1	802,600	37.1

a. Census and Statisticcs Department. (1987). *Hong Kong Population : A 20-year Projection.* Hong, Kong : Government Printer, p.16, Table B.1.

Table 4. Old-old and Young-old Suicide Rate per 100,000 by Years

Age Group	Year					
	1983	1984	1985	1986	1987	1988
Young-old(55-69)	22.3	17.9	26.9	24.1	19.9	21.9
Old-old(70+)	38.1	31.1	47.4	46.8	49.1	40.7

Source : Samaritan Befrienders of Hong Kong. (1991). *30th Anniversary Report.* Hong Kong : Samaritan befrienders of Hong Kong, p.27, Table 2.

Table 5. Old-old and Young-old Suicide Rate per 100,000 by Years

Age Group	Year			
	1989	1990	1991	1992
Young-old (55-69)	28.2	24.9	27.5	26.7
Old-old(70+)	51.1	49.2	47.4	50.5

Table 6. Sex-specific Suicide Rate per 100,000 by Years

Sex	Year							
	1989		1990		1991		1992	
	Population[a]	Rate	Population[a]	Rate	Population[a]	Rate	Population[a]	Rate
Male	329,800	44.6	344,300	42.4	358,800	43,8	373,300	43.3
Female	391,800	32.2	404,400	29,2	417,200	29,5	429,300	31.7

a. Census and Statisticcs Department. (1987). *Hong Kong Population : A 20-year Projection.* Hong Kong : Government Printer, P.16, Table B.1.

painful and/or incurable diseases so that an old person may want to escape into death, For some people, growing older is itself intolerable, with all its associtions of narrowung opportuntites and the diminishing or cessation of some functions (sexual, intellectual, creative…). Grief suicides sanction these blows to one's self-inage.

Secondly, with old age, contact with others becomes progressively rarer, as much because of a growing divergence of intersets as because of the gradual disappearance of contemporaries and the friends of one's youth. Isolation increases, and there are fewer diversions. This alone may induce suicide, or may cause it in a tragically roundabout way : as social links grow weaker or are broken, the ties of marriage may be reinforced to an almost neurotic degree, In old age, the death of a spouse may be the supreme catastrophe, as he or she is irreplaceable.

Finally, material hardship becomes more probable with age. In the absence of effective social assistance or family support, the old person deprived of his own income can be driven to real misery, since he is no longer an exchangeable labor force. In effect, disease and depression in the elderly are universal.

With the increasing trend in elderly suicide in Hong Kong, it indicates obviously that the elderly's formal and informal support network are not functioning adequately. We must begin our serious consideration in preventing this trend to continue. There are at least three types of prevention that should be considered in any discussion of general suicide prevention, The first consists of attempts to ameliorate the societal conditions that lead to suicide, The second is general education directed at increasing elderly's ability to cope with life's stresses, The third type is education directed specifically toward suicide prevention(Stillion, McDowell, and May, 1989, pp.191-200). Clarke and Lester(1989, p.4) proposed that the availability of methods for committing suicide plays a causal role in suicide and that suicide can be prevented by reducing access to these methods.

On the other hand, Maltsberger (1991) suggested that suicide prevention can be done in primary, secondary, and tertiary levels, Primary suicide prevention refers to measures to prevent the development of significant suicide intent. Secondary suicide prevention addresses those measures undertaken to stop the suicidal process once it has begun from moving forward to a lethal culmination, and to reverse it so that the elderly patient will be relieved of the pressure to commit suicide, Tertiary suicide prevention refers to measures to reduce impairment and suicide porbability in the minority of individuals who tend to remain suicidal over many months and years, that is, those who have become chronic suicide cases.

Besides prevention efforts, the government also has a vital role to play in welfare policies formulation concerning the rapidly increasing aging population, We strongly believe that with comprehensive welfare coverage and supports, the hardships encountered by elderly population will be lessened relatively, and the elderly suicide rate will be back to a decreasing trend in future decades, But we should be awared that the impacts of aging trends on urban policies are not clear cut and insufficient information is available to be categorical about them. Some

key policy impacts identified by Organization for Economic Cooperation and Development (1992, pp.50-58) are presented in below for the readers as reference purpose :

1. Increasing number of elderly people—Overall numbers of people over the age of 60 will increase in Hong Kong, with the most rapid increase among very old persons (Kwan, 1992). The impacts of increasing numbers of elderly on policies will include :
   (1) A growth in demand for all kinds of services.
   (2) Political pressure for more publicly provided housing, health, social services and pensions.
   (3) A need for respite care for carers in the community is likely to increase as a result of the expected increase in dementia.
   (4) The need for a systematic assessment of care and service needs before services are given so that they could be allocated more efficiently.
   (5) Greater demand for leisure activities and health prevention from a population which may be fitter and better educated, some of whom will retire early.
2. Increasing number of single person households—More elderly people live alone and numbers are expected to increase (Kwan and Crunk, 1992). The inpacts on policies include :
   (1) The inportance of providing one-way or two-way communications (telephones or alarms) so that elderly people can contact someone in an emergency and/or be monitored (temperature conditions in their homes).
   (2) The need to ensure that elderly people do not become isolated. Living alone does not necessarily mean being 'lonely', but schemes to provide regular contact such as visiting services, meals and day clubs should be available for those who need and want them.
3. Increasing diversity—The elderly population is not a homogeneous group and may become even more diverse (Chan, 1992). The most important impacts of this heterogeneity on policy development are :
   (1) The need for choice by elderly people and different kinds of provision.
   (2) The need to determine costs of alternative options.
4. Inter-generational comprtition—In some cases elderly people will be competing for resources and services with people from different generations (Chan and Yeung, 1991). The impacts of these competing demands on policies include :
   (1) The need to acknowledge competing claims so that they can be discussed in a constructive manner.
   (2) The need to develop and monitor schemes which encourage inter-generational understanding and support.
5. Shortage of carers—As a result of the socio-demographic changes discussed above, thers is likely to be a shortage of cargivers, In most countries families (mainly women) are still the main providers of care. Yet, the decline in number of children, movement of families and the growth in paid employment by women will affect the nature of future care (Kwan, 1991;Ngan and Cheng, 1992).

The likely impacts of the decreasing number of carers on policies include :

(1) The development of housing policies that make it easier for families and older people to move closer to each other.

(2) Increasing demand for accommodation such as granny flats, which enables elderly people to live separately, yet give mutual support.

(3) The development of surrogate family policies, for example, programmes to board out or foster elderly prople on a short or long-term basis.

(4) Requests for compensation by informal carers.

(5) The development of informal care by unrelated persons such as the paid neighbour schemes.

(6) Demands for higher salaries by paid staff such as home helps.

(7) More attention being paid to support measures for both formal and informal carers, not just in monetary terms but also in terms of emotional and social support and respite care schemes.

6. Home and community based care—Regardless of age and health a high value is put on independence. Very clear evidence confirms the desire of most older people to remain in homes of their own. The combination of an aging population and the preferred choice to live independently at home has led to community care policies. This implies that more tailored services, especially more intensive services, will be needed (Chow, 1992;Ngan, 1993). The preferences of elderly people for accessible care that will permit aging in place have the following ramifications on policies :

(1) The need to give top priority to high quality community care options and to develop a variety of services such as home care, home nursing and meal services.

(2) The need to balance risks when elderly people stay in the community and may not be able to take care of themselves but there are also risks in institutional care such as disorientation.

(3) The need for a continuum of services with the emphasis more towards bringing care to people wherever they live, rather than expecting them to move as their needs for assistance change.

(4) The need for measures to set and monitor standards of community care services.

(5) The need to be responsive to the cost-effectiveness of services.

(6) The need for assistance for those who are less able to pay.

(7) The entry to institutional care should be regarded as a 'positive choice' and no one should be required to change their accommodation in order to receive services which could be made available to them in their own homes.

(8) The contribution of institutional care should be valued as much as community care and the two services should be seen as completmenting each other.

7. Housing and living arrangements—The critical role of appropriate housing and living arrangement responding to elderly preferen-

ces (Chan, 1990;Chow and Chi, 1990) puts emphasis on policies that :

(1) Place a particular attention on the conditions of housing of some elderly people in the face of the evidence of poor living conditions.

(2) Give reliable advice and help with repairs to elderly prople who wish to remodel their homes.

(3) Pay attention to the importance of adaptations to buildings.

(4) Stress good design and innovative solutions that can respond to the needs of people of all ages, including younger people with desabilities.

(5) Provide for regulation of new construction or adaptation of both homes and public buildings in order to produce more user-friendly buildings for older prople.

(6) Provide new, specially designed housing and adaptations as well as different kinds of supportive housing.

(7) Enable elderly people and their families to move cloesr if this is what they wish.

8. Transport—Elderly people in inner urban areas without means of transport are likely to be particularly disadvantaged in the future by the continued development of large, out of town shopping facilities and the closure of inner city smaller shops and services (Ming Pao, 1992;Tai Kung Pao, 1993). Transport issues affecting elderly people will have the following impacts on policies :

(1) The need to design pedestrian routes and placement of street furniture and fixtures to enable elderly pedestrians to move easily around cities.

(2) To provide alternative means of public transport to replace private cars.

(3) The need to consider ways in which elderly people can have goods delivered to them.

9. Service provision—The trend to private and non-profit providers should be noted and some of the problems compared with those of the public sector (Tsui, 1990;Wong, 1992). If a political decision is taken to encourage provision from the private and non-profit sectors, then the impacts on policies will include the following :

(1) The need ot take account of elderly people who do not have resources to take part in private programmes (residential care, health insurance, pensions).

(2) The need to clarify the roles of the public, private, non-profit sectors at a national and local level.

(3) The need to create mechanisms to set comparable standards and monitor services in both the public and other sectors.

10. Service delivery—The growing need for increased services and a variety of services for the aging population of cities has been noted. AS a consequence to this growing need, new policy thinking about the kinds of services and the way they are delivered is focuesd on three key concepts ot increase flexibility in new kinds, places and times of services (Yeung, 1992). The impacts on policies affecting service delivery are :

(1) Changes in the organization of services (for example, decentralizing to neighbourhoods).

(2) The need to ensure acceptable stan-

dards when services are dispersed.

(3) The likely need to re-deploy staff with possible problems resulting over demarcation of duties and the need to negotiate with trade unions over changing job descriptions.

(4) The need to accept that flexible services will not adhere to a standard pattern.

11. Finance—The changes affecting financing procedures (Tang, 1991;Leung, Lee, and Ho, 1991;Fung, 1992) will include the following impacts on policies :

(1) The need ot weigh the alternative options of encouraging older people to work for longer periods and contribute to taxes or retire early with a pension.

(2) The need to provide opportunities for the use of equity in personal property to increase the financial resources of elderly persons.

(3) The need to do much more work on costing fo alternative kinds of services.

(4) The need to consider issues of affordability and the extent of subsidy for housing.

(5) Incentives to evoke market responese to service the growing number of elderly people who will move into retirement with higher incomes and savings, occupational pensions and as home owners.

If Hong Kong government intends to promulgate responsive policies for old age, especially in the arena of elderly suicide, it will need to examine its own specific socio-demographic context.

The analysis of relevant data should increase the government's awareness of short and long term implications of aging populations as well as when and what type of interventions are required.

Only with this kinds of unfailing ambitions and committments then the elderly people in Hong Kong will hopefully and possibly avoid the premature exit of their golden years.

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