##### 加下划线的词是相关资料之间的衔接句，拓展的内容根据时间考虑是否讲。这里的句子仅供参考，可以根据自己讲的思路进行替换或者改变。

##### 说完了台湾，我们来看一下别的国家在对待慢性疾病的态度和方针是什么样的。

##### 以美国为例，整个国家的慢性疾病预防和治疗主要是通过疾病预防控制中心的国家慢性病预防和健康促进中心来进行的。

Chronic conditions represent the single largest threat to health in America. According to the CDC's latest statistics, roughly half of all adults suffer from at least one chronic disease, with a quarter of all adults suffering from two or more. In 2014, seven chronic conditions were responsible for nearly 65 percent of all deaths.

**慢性病是对美国健康的最大威胁。 根据CDC的最新统计，大约一半的成年人至少患有一种慢性病，而四分之一的成年人患有两种或两种以上疾病。 2014年，七种慢性疾病占所有死亡人数的近65％。**

##### 来源：<https://www.cdc.gov/chronicdisease/center/nccdphp/how.htm>

CDC’s National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) supports a variety of activities that improve the nation’s health by preventing chronic diseases and their risk factors. Specifically, NCCDPHP:

Finds out how chronic diseases affect populations in the United States.

Studies interventions to find out what works best to prevent and control chronic diseases.

Funds and guides states, territories, cities, and tribes to use interventions that work.

Shares information to help all Americans understand the risk factors for chronic diseases and how to reduce them.

疾病预防控制中心的国家慢性病预防和健康促进中心（NCCDPHP）支持通过预防慢性病及其危险因素来改善国家健康的各种活动。 具体来说，NCCDPHP：

了解慢性疾病如何影响美国人口。

研究干预措施，找出最能预防和控制慢性病的方法。

资助和指导州，领地，城市和部落使用有效的干预措施。

分享信息，以帮助所有美国人了解慢性病的危险因素以及如何减少这些疾病。

##### Examples of Community-Clinical Links

* Increasing the use of effective community-delivered interventions—such as chronic disease self-management programs, the National Diabetes Prevention Program, and smoking cessation services—through clinician referrals and health insurance coverage.
* Linking public health services, such as tobacco quitlines, to health care systems.
* Using health care workers like pharmacists, patient navigators, and community health workers to help people manage their own health.
* Educating people to become more involved in their own health care.

社区临床联系的例子

通过临床医生的转诊和健康保险覆盖，越来越多地使用由社区提供的有效干预措施，例如慢性疾病自我管理计划，国家糖尿病预防计划和戒烟服务。

将公共卫生服务（例如烟草戒烟热线）与卫生保健系统联系起来。

利用药剂师，患者导航员和社区卫生工作者等卫生保健工作者来帮助人们管理自己的健康。

教育人们更多地参与他们自己的卫生保健。

**同时一些组织也在提倡和实施自己的一些计划。**

来源：<https://www.apha.org/topics-and-issues/chronic-disease>

Over the last year, APHA has been working with the American Planning Association to support and implement the Plan4Health project (funded through PICH). APHA Affiliates are collaborating with APA Chapters to address physical activity and nutritious eating at the local level – the nontraditional, cross-sector partnership is helping to embed the culture of health in planning. Read the letter APHA joined in support of PICH.

We also support the Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians Act, which would help to improve coordination of care for Medicare’s Therapeutic Shoe Program for patients with diabetes. Read APHA's letter of support.

The Prevention and Public Health Fund supports federal programs that are essential for diabetes prevention, including the National Diabetes Prevention Program, Diabetes Self-Management Education, State and Local Public Health Actions Program. Read this Senate DC letter with details on these programs.

在过去的一年中，APHA一直与美国规划协会合作，以支持和实施Plan4Health项目（由PICH资助）。 APHA会员正在与APA分会合作，以解决地方一级的体力活动和营养饮食–非传统的跨行业合作伙伴关系正在将健康文化纳入计划中。 阅读APHA加入以支持PICH的信件。

我们还支持《帮助确保生命和肢体拯救足病医生法案》，该法案将有助于改善Medicare针对糖尿病患者的治疗鞋计划的护理协调。 阅读APHA的支持信。

预防和公共卫生基金支持对糖尿病预防至关重要的联邦计划，包括国家糖尿病预防计划，糖尿病自我管理教育，州和地方公共卫生行动计划。 阅读有关这些程序的详细信息的参议院DC信函。

来源：

<https://www.apha.org/topics-and-issues/environmental-health/healthy-community-design>

What is healthy community design?

The built environment is the human-made features of our communities — sidewalks, public transportation, housing and more. The way we design and build our communities affects our physical and mental health. When communities have plenty of walkable sidewalks and bike-friendly routes for kids to take to school, students are more active. When people can walk where they need to go, car traffic decreases, and that can improve air quality and respiratory health. When children live in homes that do not contain lead or asthma triggers, they are better able to grow and develop.

We believe everyone deserves healthy communities. Those are communities where everyone has a safe and healthy home, everyone has access to safe and healthy food and decision-makers consider health and equity when making transportation and land-use decision.

什么是健康的社区设计？

建筑环境是我们社区的人为特征-人行道，公共交通，住房等。 我们设计和建立社区的方式会影响我们的身心健康。 当社区中有许多可步行的人行道和供孩子上学的自行车道时，学生会更加活跃。 当人们可以走到需要去的地方时，汽车交通会减少，这可以改善空气质量和呼吸健康。 当孩子住在没有铅或哮喘触发因素的房屋中时，他们的成长和发育能力就更好。

我们相信每个人都应该拥有健康的社区。 在这些社区中，每个人都有一个安全健康的家园，每个人都可以获得安全健康的食物，决策者在做出运输和土地使用决策时考虑健康和公平。

**紧接着我们来关注英国，英国的医疗服务主要由国家卫生局（NHS）组织和提供的。**

In 2014 the total UK population was 64.4 million inhabitants, with 11.3 million (17.5%) aged 65 andover, and 3 million (4.7%) aged 85 years and older(comparative EU-27 population rates: 18.5% (65yrs+) and 5.1% (80yrs+). An estimated 15 million (about 23%) of people in England were reported to have at least one chronic or long term condition (LTC).

In England, the number of people with one chronic is projected to be relatively stable over the next

ten years. However, those with multiple chronic health conditions are set to rise to 2.9 million in 2018 from 1.9 million in 2008. The Scottish Health Survey shows that 46% of those aged 16 and

over have at least one chronic health condition, and that prevalence increases with age, from 25% of adults aged 16-24 to 77% of those aged 75 and over. However, there are more people in Scotland with multimorbidity who are under 65 years of age than people who are over 65 years of age.

Individual UK countries govern their health care in their own unique ways and data are collected in their individual country specific ways. UK wide data regarding specific conditions are thus not collected in one single place.

**英国的慢性疾病率也不容乐观，有1500万人，占总人口的23%至少有一种慢性疾病。**

2014年，英国总人口为6440万居民，其中65岁及以上的人口为1,130万（17.5％），年龄在85岁及以上的人口为300万（4.7％）（欧盟27国人口比例为：18.5％（65岁以上）和5.1％ （80岁以上）：据报道，英格兰有1500万人（约23％）患有至少一种慢性或长期病（LTC）。

在英格兰，患有慢性病的人数预计在下一个时期会相对稳定

十年。然而，患有多种慢性疾病的人将从2008年的190万增加到2018年的290万。苏格兰健康调查显示，在16岁和16岁的老年人中，有46％的人至少有一种慢性健康状况，而且患病率随着年龄的增长而增加，从16-24岁的成年人中的25％上升到75岁以上的成年人中的77％。但是，在苏格兰，患有多种疾病的65岁以下的人比65岁以上的人更多。

英国各个国家/地区以自己独特的方式管理其医疗保健，并以各自国家/地区特定的方式收集数据。因此，有关英国在特定条件下的数据不会在一个地方收集。

**在过去的20年中，NHS开展了一系列措施来应对慢性疾病。**

来源：<https://www.ncbi.nlm.nih.gov/books/NBK458740/>

Health care in England1 is primarily organized and delivered through the National Health Service (NHS), which was founded in 1948 (Boyle, 2011). Services provided through the NHS are funded through general taxation (2012: 82.5% in the United Kingdom), complemented by OOP payments (12.6%) and VHI (1.8%) (WHO, 2014). In 2012, national health expenditure in the United Kingdom as a whole was 9.4% of GDP. The NHS covers all residents, and health services are free at the point of use (with some exceptions such as prescription drugs and dental care for certain groups of the population) (Boyle, 2011).

英格兰的医疗服务主要由国家卫生局（NHS）组织和提供，该机构成立于1948年（Boyle，2011）。通过NHS提供的服务由一般税收筹集资金（2012年：英国的82.5％），另加OOP付款（12.6％）和VHI（1.8％）（WHO，2014年）。 2012年，整个英国的国家卫生支出占GDP的9.4％。 NHS覆盖了所有居民，并且在使用时免费提供医疗服务（某些人群的处方药和牙科保健除外）（Boyle，2011年）。

Health care reforms over the past 20 years have focused on the creation of a market within the NHS, starting with the introduction of an ‘internal’ market in 1991, which separated the purchasing function from the provision of care. The reform introduced, among other things, GP fundholding, enabling GP practices to purchase elective care on behalf of their patients (Mays, Mulligan & Goodwin, 2000). GP fundholding was abolished under the 1999 Health Act, although the principle of a purchaser–provider split was maintained by introducing into the English NHS primary care trusts (PCTs), which assumed payer responsibilities. This was accompanied by substantial investments under the 2000 NHS Plan, along with the introduction of national standards and targets and the strengthening of inspection and regulation, and which was to be supported by newly created national bodies such as the aforementioned National Institute for Health and Clinical Excellence (National Institute for Health and Care Excellence (NICE) from 2012) and the Commission for Health Improvement (Care Quality Commission (CQC) from 2009) (Department of Health, 2000).

Further reforms saw the introduction of patient choice of hospital, provider incentives through payment reform and the admission of private providers into the NHS (Department of Health, 2002; Stevens, 2004). These provisions were strengthened by the 2004 NHS Improvement Plan, which introduced GP-practice based commissioning (Department of Health, 2004a). The 2004 plan also explicitly placed the care for those with chronic conditions at the centre of (successive) government reform, by committing to invest in services closer to home provided by specialist nurses and GPs with special expertise and requiring all PCTs to implement case management by 2008. The 2009 Health Act introduced the NHS Constitution, which set out rights and responsibilities for NHS patients and providers (for example, access, privacy, dignity, choice). It also introduced provisions to enable the piloting of direct payments for health care, within a broader personal health budget pilot scheme for those with long-term needs including the chronically ill.

The aforementioned 2012 Health and Social Care Act constitutes the latest set of reforms, which introduced considerable changes to the NHS while expanding further on existing features, such as the further integration between health and social care services and extending patient choice. It abolished PCTs and transferred responsibility of most health care purchasing to clinical commissioning groups while public health responsibility was transferred to local authorities, supported by PHE. Other changes included the strengthening of patient and public involvement through the creation of Healthwatch England at the national level (set up as a statutory committee of the CQC) alongside local Healthwatch organizations, which are funded by and accountable to the public through local authorities (Healthwatch, 2014). Newly established health and well-being boards bring together local authorities, clinical commissioning groups, local Healthwatch, public health, social care and children’s services leaders to assess the health and care services needs of the local population to ensure collaboration of services and seamless care for the community (Department of Health, 2012b).

在过去的20年中，医疗保健改革的重点是在NHS内部创建市场，首先是从1991年引入“内部”市场开始，该市场将购买功能与提供医疗服务分开了。这项改革除其他外，引入了全科医生的资金持有，使全科医生能够为患者购买选择性护理（Mays，Mulligan＆Goodwin，2000）。尽管通过将承担付款人责任的英格兰初级保健信托（PCT）引入英国NHS来维持购买者与提供者分开的原则，但根据1999年的《卫生法》废除了全科医生的资金持有。这是根据2000 NHS计划进行的大量投资，同时还引入了国家标准和目标，以及加强了检查和法规，并由新成立的国家机构（例如上述国家卫生与临床研究所）提供支持。卓越奖（2012年获得美国国家卫生保健卓越研究所（NICE））和健康改进委员会（2009年获得保健质量委员会（CQC））（卫生署，2000年）。

进一步的改革包括引入患者选择医院，通过支付改革提供医疗服务的激励措施以及允许私人医疗服务提供者进入NHS（卫生部，2002； Stevens，2004）。 2004年NHS改进计划加强了这些规定，该计划引入了基于GP惯例的调试（卫生部，2004a）。 2004年的计划还明确承诺将对慢性病患者的护理放在（成功的）政府改革的中心，承诺投资于由具有专业知识的专科护士和全科医生提供的离家较近的服务，并要求所有PCT机构通过以下方式实施案件管理： 2008年。2009年的《健康法》引入了NHS宪法，其中规定了NHS患者和提供者的权利和责任（例如访问，隐私，尊严，选择）。它还引入了一些条款，以使能够在更广泛的个人健康预算试点计划中试行直接支付卫生保健的费用，以应对那些有长期需求（包括慢性病）的人。

前面提到的2012年《健康与社会护理法》构成了最新的一整套改革，给NHS带来了重大变化，同时进一步扩展了现有功能，例如健康与社会护理服务之间的进一步整合以及患者选择范围的扩大。它取消了PCT，并将大多数医疗保健采购的责任转移到临床委托小组，而公共卫生责任在PHE的支持下转移到了地方当局。其他变化包括通过与地方健康观察组织一起在国家一级创建英格兰健康观察（由CQC成立的法定委员会）来加强患者和公众的参与，这些活动由地方当局资助并向公众负责（健康观察，2014）。新成立的卫生与福利委员会将地方当局，临床委托小组，地方卫生观察，公共卫生，社会护理和儿童服务领导者召集在一起，以评估当地居民的健康和护理服务需求，以确保为以下人群提供服务和无缝护理社区（卫生部，2012b）。

**针对于老年人，英国拥有其特有的PPOP计划。**

The Department of Health’s Social Care, Local Government and Care Partnerships Directorate led the ‘Partnerships for Older People Projects’ (POPP) from 2005 to 2010 as a means to encourage provision of person‐centred and integrated services for older people, to encourage investment in care approaches that promote health, well‐being and independence and to prevent or delay the need for higher intensity or institutional care (Department of Health, 2006b). POPP comprised 29 local authority-run pilot sites throughout England, with the first round of 19 sites starting in May 2006. POPP were intended to test ways of shifting resources and culture away from the focus on intensive and institutionalized care towards preventative and locally focused care approaches, integrating the health and social care sectors (Windle et al., 2009).

Projects varied in their use of elements of self-management support, delivery system design and clinical information systems.

Self-management support included the involvement of older people in the development, running and evaluation of each of the projects and so better meet the needs of the target populations. Some project strategies involved peer support, including the promotion of the Expert Patients Programme but also broader health and well-being advice from other older people. Others used staff and volunteers acting as ‘navigators’ to help older people through the health, social care and other statutory agency network, as well as monitoring current services (Department of Health, 2006b).

Delivery system design involved the development of community-based multi-agency teams, including rapid response services to reduce use of emergency services. One site (Leeds) developed a psychiatry liaison service, which consisted of a multidisciplinary team of psychiatrists, psychiatric nurses, an occupational therapist and health support workers, with administrative support. Multiple projects made use of designated roles, such as community matrons and case workers.

Clinical information systems involved the introduction of integrated IT systems between primary and secondary care, and in some cases between primary and social or community care. Some other projects made use of telehealth technology and case finding software.

POPP was supported by a major grant by the Department of Health of a total of £60 million over the period 2006–2008. This was specifically targeted at local authority-led partnerships to develop pilot projects for older people. Participation was further incentivized by means of becoming a designated POPP pilot site and the opportunity to enter into partnerships with local independent sector organizations. Following completion of the pilot period, 85% of POPP projects secured funding to continue in some form, in many cases funded through the local PCT (Windle et al., 2009).

Altogether, 522 organizations were involved with projects across the POPP programme, including NHS organizations, such as PCTs, hospitals and ambulance trusts as well as organizations outside the NHS such as the fire service, police and housing associations; national and local voluntary organizations; and private sector organizations. The programme covered around 264 000 older people over the three years, with particularly heavy use in the third year. A number of projects within POPP were sustained beyond completion of the pilot phase.

卫生部的社会护理，地方政府和护理合作伙伴关系局从2005年到2010年领导了“老年人合作项目”（POPP），以此鼓励为老年人提供以人为本和综合的服务，鼓励对老年人的投资。促进健康，福祉和独立性的护理方法，以防止或延迟对更高强度的护理或机构护理的需求（卫生部，2006b）。 POPP包括英格兰各地29个地方政府管理的试点，第一轮19个试点于2006年5月开始。POPP旨在测试将资源和文化从重症监护和制度化护理重点转向预防性和本地化护理的方式方法，整合卫生和社会护理部门（Windle等，2009）。

项目在使用自我管理支持，交付系统设计和临床信息系统的元素方面各不相同。

自我管理支持包括老年人参与每个项目的开发，运行和评估，从而更好地满足目标人群的需求。一些项目策略涉及同伴的支持，包括推广专家患者计划，还包括其他老年人的更广泛的健康和福祉建议。其他人则利用员工和志愿者作为“领航员”，通过健康，社会护理和其他法定机构网络来帮助老年人，并监督当前的服务（卫生部，2006b）。

交付系统设计涉及开发基于社区的多机构团队，包括快速响应服务以减少对紧急服务的使用。一个地点（利兹）开发了一个精神病学联络服务，该服务由多学科的精神病医生，精神病护士，职业治疗师和卫生支持人员组成，并提供行政支持。多个项目使用了指定角色，例如社区护士长和案例工作者。

临床信息系统涉及在初级保健和二级保健之间以及在某些情况下在初级保健和社会或社区保健之间引入集成的IT系统。其他一些项目则使用了远程医疗技术和病例查找软件。

在2006-2008年期间，POPP得到了卫生部的一笔总额为6000万英镑的重大资助。这专门针对地方当局领导的伙伴关系，以开发针对老年人的试点项目。通过成为指定的POPP试点地点以及与当地独立部门组织建立合作伙伴关系的机会，进一步激励了人们的参与。在试点期结束后，有85％的POPP项目获得了某种形式的继续资助，在许多情况下是通过当地PCT资助的（Windle等，2009）。

共有522个组织参与了整个POPP计划的项目，包括NHS组织（例如PCT，医院和救护车信托基金）以及NHS之外的组织（例如消防，警察和房屋协会）；国家和地方志愿组织；和私营部门组织。该计划在三年中覆盖了约264 000名老年人，第三年使用量特别大。在试点阶段结束之后，POPP内的许多项目得以维持。