系所組別： 公共衛生研究所甲乙組在一般、在職生

考試科目： 公共衛生學

※ 考生請注意：本試題 □可 □不可 使用計算機

1. 臺灣早在 1993 年就開始步入「高齡化社會」，「老人問題」的探討或政策的擬議因此成為熱門的議題。吊詭的是，延長壽命原來是公共衛生進步的重要指標，如今老年人口的增加卻被視為一個社會必須面對的問題。論者認為，這個吊詭現象反映當前老年政策的缺失，其中老年歧視及性別盲點是兩個重大缺失。請（1）詳細敘述這兩大缺失的內容；（2）臺灣正推動的長期照顧政策如何反映這樣的缺失 。（25%）

2. 近日臺灣社會因 H1N1 新型流感疫苗政策的推行及民眾注射疫苗相關不良反應的媒體報導，而議論紛紛。而衛生署推動的 H1N1 新流感疫苗注射則出現緩打潮甚或拒打潮。作為一位公衛人或將要成為公衛人，你如何分析這個現象、你認為這個緩打潮反映公共衛生體系什麼問題？（20%）

3. 接續上題，下面是在沸沸揚揚、有關疫苗的論爭的諸多文章之一，你同意本文的觀點嗎？請詳細分析（1）你同意或不同意的理由；（2）臺灣公衛界就疫苗政策，應該如何因應？（25%）

中國時報 2010.01.05 **(時論廣場 A15)**

社論－理盲當道 防疫治絲益棼

本報訊

Ｈ１Ｎ１新流感疫苗緩打潮已經持續近月，外界對疫苗的安全性，質疑不斷。疑似施打疫苗後有不良反應的通報案例，衝高到近五百例；國內甚至出現第一例因疫苗死亡的救濟案例，由政府給予五萬元賠償。種種發展，都對新流感疫苗接種政策造成打擊；儘管政府醫政單位說破了嘴，強調疫苗的安全性及施打之必要，仍無法挽回疫苗「人氣」，逼的疫苗生產業者也在媒體大打廣告，洋洋灑灑的澄清、說明加宣導。

民眾對新流感疫苗接種的態度，由一開始的怕打不到，到如今畏如蛇蠍，何以致之？

去年五月間，墨西哥出現新流感第一波病例。因為它已五十年未出現過，對絕大多數人等於是一種新病毒，也就是人類的體內完全沒有抗體；加上至今已經造成美國境內一萬多人死亡，其它歐美國家也有不少死亡案例，新流感對人類健康的威脅，確實不能小覷。

去年夏天開始，各國政府為了防疫，展開一連串全球搶藥、搶疫苗行動。台灣曾經因為市場小，一度在供應名單上排不上隊，造成全國緊張；當時社會的整體焦慮，大家應該記憶猶新。只是，民眾對疫苗的關心，漸漸變了調，質疑疫苗安全性的聲浪愈來愈高，搶打疫苗變成緩打。衛生署從擔心疫苗不夠，到現在是煩惱緩打潮影響防疫，讓已經明顯下降的新流感病例及流行趨勢又有機會再起。

(背面仍有題目,請繼續作答)

※ 考生請注意：本試題 □可 ☑不可 使用計算機

新流感疫苗安不安全，是可以用專業及科學數據理性討論的問題。可是，在目前的社會氣氛下，「理性缺貨」、「專業瘖啞」。曾有線營名嘴主持人在電話 call-in 中，質問疾管局長，「敢不敢拍胸脯保證，打了疫苗後，不會有一個人死亡」。這個問題，既不科學且無知。

自從有疫苗發明以來，就沒有一個科學家可以「保證打了後沒有人死亡」。疫苗是由病毒或生物體製成，打進人體後，一定會產生化學的、生物的反應，如果碰上敏感體質，就會有副作用；而副作用的嚴重與否，也要看先天體質與事後的醫療措施而定。要疾管局長百分百保證疫苗「安全」，就算上帝來當局長也做不到。

對名嘴這種質問，衛生署長楊志良公開怒斥：「全世界有哪一個國家，會有非專業人士在媒體上對疫苗說三道四？」他的憤怒，再度反映了社會「理盲」的一面。

從公共衛生與流行病學觀點而言，打疫苗已經被證實是最有效的防疫方式。如果有人因為新流感疫苗是由國光生技公司生產，對國產疫苗不放心，質疑與討論的方式應該是要求國光生技和疾管局完整公開疫苗生產方式，包括原料、製程、品管與動物實驗結果。雖然這些問題也不是一般人可以輕易了解，但政府公布後，自然有體制外專業人士看得懂，他們可以替人民檢驗政府的說法與資料是否正確，進而替社會大眾的健康安全把關。

可是，在新流感疫苗爭議中，我們看不到這種理性的討論。特定陣營對新流感疫苗的質疑已經到了無限上綱的地步。注射疫苗是面對疾病威脅時，保護人命的方法，一旦被操作到不問是非的地步，究竟對誰有利？

疫苗有副作用是民眾的恐懼之源；衛生署與其讓各種專家、院士上媒體宣導，不如明白的告訴大眾，打了新流感疫苗，可能會出現什麼副作用、最嚴重會有什麼後果、以目前的醫療水準，又能治療到什麼程度。一旦沒救，政府有什麼補救措施。這些問題關係每一個國民的健康與權益，可惜衛生署錯失先機，如今事後說明也只能事倍功半。

從八八風災、美牛風波到新流感疫苗，這些問題都可以透過科學數據與論理來解決爭議，我們的社會最後卻出現事實「兩極化」的怪異結局。執政黨的政策說服能力不足、在野黨的反對邏輯扭曲，激化並提供了反智與反科學氣氛成長的空間，這是比疫苗緩打潮更令人痛心的局面。

4. 請閱讀完次頁附件文章後，回答下列問題。

1-1. 請問本文作者以哪兩個例子來說明"all tip and no iceberg"？ (10%)

1-2. 請問本文作者指出哪些是影響慢性病與肥胖的 below-surface 因素？ (10%)

1-3. 請用本文"more than the tip of the iceberg"的觀點解讀台灣 2002 到 2008 年燒炭自殺死亡率顯著上升的現象。(10%)

※ 考生請注意：本試題 □可 □不可 使用計算機

More than the tip of the iceberg: health policies and research that go below the surface

Fran Elaine Baum

Two years ago, a former Australian prime minister said of a politician from the opposite side of politics "he's all tip and no iceberg". Unfortunately, much the same can be said of national and international health policy. This is despite compelling arguments and evidence presented by the Commission on the Social Determinants of Health (CSDH)[1] in favour of looking below the surface for solutions to improve health. Typically, responses to diseases and health problems are knee jerk and concerned with ameliorating immediate and visible causes. This is well illustrated by health sector budgets, which are generally vastly in favour of hospitals and treatment services to the detriment of disease prevention and health promotion.

The "all tip and no iceberg" approach is illustrated by two examples. The first is that of suicide. Most responses to high comparative rates of suicide treat depression as a strong risk factor. It is rare for responses to be based on the question why some societies or communities have higher rates than others. When Canadian researchers Chandler and Lalonde[2] asked such a question in relation to the different rates of suicide among indigenous peoples, they found the notion of cultural continuity more useful than individual pathologies. They found that communities that had self-government with women well represented, recognised land claims, controlled their services, had good family and children services and used their traditional languages had significantly lower rates of suicide. In a similar vein, a consideration of harm from firearm injuries could lead to a focus on education about gun management, while a comparative view of injuries and deaths from firearms between different countries would suggest that the policies and social mores concerning firearms were far more vital in determining death and injury rates.

One of the main messages from the CSDH is a call for governments and international agencies to avoid tip of the iceberg solutions. The final report[1] calls for improving the conditions of everyday life and for a fairer distribution of power, money and resources globally as a prerequisite for achieving health equity in a generation. Assuming that governments work from a value base that privileges equity as a social outcome and have a commitment to promote equity, what will it take for responses to health equity to tackle the more hidden and powerful determinants of health? Three factors appear crucial.

First, governments and international agencies need to avoid privileging behavioural responses to health issues. Much contemporary public health dialogue focuses on the chronic disease and unhealthy weight epidemic. There have been dire warnings about the dangers of ignoring these trends within countries and internationally.[3 4] Commentators have analysed the below-surface dimensions of this iceberg and pointed to changes in urban planning, the availability of high fat and sugar, cheap foods and the increased possibilities of sedentary lifestyles at home and work.[5] Yet, even when governments and other agencies recognise the complexity of the forces driving the chronic disease and unhealthy weight, invariably the responses concern the tip of the iceberg and lead to the development of programmes to provide people with advice about their lifestyle and measures to help people already afflicted with chronic disease and unhealthy weight. The *Closing the Gap in a Generation* report suggested that a far more systematic response is needed that starts with changing our conditions of everyday life in all sectors by placing a health impact lens over transport, planning, education and employment.

The second factor is that the pursuit of health and well-being needs to be broadly accepted as a central goal of society that all sectors are accountable for. Currently, most governments privilege economic growth as a societal goal.[6] Often, this means that the health and well-being of citizens takes second place to the needs of profit and the economy. Progress to health equity will need a change in these priorities. This change will only happen as a result of citizen campaigns demanding a rebalancing of goals. The likelihood of this happening seemed like cloud cuckoo land a year ago. The global financial crisis has made it seem plausible and attainable in the wake of questioning about the nature of profit and who gains and loses when profit is king.

The final factor to enable governmental and international agencies to go below the surface is the development of a research base that asks social rather than individual questions. Most epidemiological and community health research focuses on the characteristics of individuals rather than those of societies. Although there are exceptions,[7] most research starts by asking questions such as "why does this group of individuals smoke" rather than by asking "why do these societies have higher smoking rates than others"? Research incentives favour the tip of the iceberg questions because the designs are easier and less controversial.[8] Questions that delve below the surface are less straightforward and messier. Yet they promise to yield insights that will be far more helpful in the goal of closing the health equity gap in a generation.

A test for policy and research in public health should be the extent to which they are truly going below the surface and dealing with the underlying determinants that are likely to lead to lasting change. Or will they continue to be "all tip and no iceberg"?

Southgate Institute of Health, Society and Equity, Flinders University, Adelaide, Australia

Correspondence to: Professor Fran Baum, GPO Box 2100, Adelaide 5001, Australia; fran.baum@flinders.edu.au

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