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the 1990s, the number of people in the world who are under 15 years of age has increased by 1.2 billion, from 1.1 billion in 1980 to 2.3 billion in 1999. The number of people aged 15 years and over has increased by 1.1 billion, from 1.1 billion in 1980 to 2.2 billion in 1999.

There are a number of reasons why the world population is growing so rapidly. One of the main reasons is that the number of children born to each woman has increased. In 1980, the average woman in the world had 2.5 children. In 1999, the average woman in the world had 2.7 children.

Another reason why the world population is growing so rapidly is that the number of people who are surviving to old age has increased. In 1980, the average person in the world lived for 60 years. In 1999, the average person in the world lived for 65 years.

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the 1990s, the number of people in the UK who are employed in the public sector has increased by 1.5 million, from 2.5 million in 1980 to 4 million in 1998 (Department of Health 1999). The number of people employed in the health sector has increased by 1.2 million, from 2.2 million in 1980 to 3.4 million in 1998 (Department of Health 1999).

There is a growing emphasis on the need to improve the quality of care provided by the health sector. This has led to a number of initiatives, including the introduction of clinical guidelines, the establishment of clinical audit, and the implementation of patient safety programmes. These initiatives have all contributed to the improvement of the quality of care provided by the health sector.

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the 1990s, the number of people in the UK who are aged 65 and over has increased by 1.5 million (1990–1999) and is projected to increase by a further 1.5 million by 2010 (Office of National Statistics 2000). The number of people aged 65 and over is projected to increase by 2.5 million by 2020 (Office of National Statistics 2000).

There is a growing awareness of the need to develop strategies to meet the needs of the ageing population. The Department of Health (1999) has published a strategy for the ageing population, which sets out the government's commitment to improve the health and well-being of older people. The strategy is based on the following principles:

- To improve the health and well-being of older people.
- To ensure that older people are able to live independently and actively.
- To ensure that older people are able to participate in society.
- To ensure that older people are able to live in their own homes.

The strategy is based on the following principles:

- To improve the health and well-being of older people.
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the 1990s, the number of people in the UK who are aged 65 and over has increased from 10.5 million to 13.5 million, and the number of people aged 75 and over has increased from 4.5 million to 6.5 million (Office for National Statistics 2000).

There is a growing awareness of the need to develop services that will meet the needs of the ageing population. The Department of Health (1999) has set out a vision for the future of health care for older people, and the Department of Social Security (1999) has set out a vision for the future of social care for older people. Both visions are based on the principle of 'ageing in place', which means that older people should be able to live in their own homes and communities for as long as possible.

One of the key challenges facing the health and social care system is how to ensure that older people have access to the services they need. This is a complex issue, as there are many different types of services that older people may need, and these services may be provided by different organisations. The challenge is to ensure that these services are coordinated and integrated, so that older people can receive the care and support they need in a seamless and effective way.

One of the ways in which this challenge can be met is by developing 'age-friendly' communities. These are communities that are designed to be accessible and inclusive for older people, and that provide a range of services and facilities that meet their needs. Age-friendly communities can include a range of things, such as accessible public transport, accessible housing, accessible leisure facilities, and accessible health and social care services.

Developing age-friendly communities is a complex task, and it requires the involvement of a wide range of stakeholders. This includes older people themselves, as well as local government, health and social care providers, and the private sector. It is only by working together that we can create communities that are truly age-friendly, and that enable older people to live well and actively in their own homes and communities.

One of the key areas of focus for age-friendly communities is the built environment. This includes things like housing, public transport, and leisure facilities. The built environment can have a major impact on the quality of life of older people, and it is important to ensure that it is designed to be accessible and inclusive for them. This means ensuring that there are no physical barriers to access, and that the environment is safe and secure for older people.

Another key area of focus for age-friendly communities is the social environment. This includes things like social networks, community participation, and access to services. The social environment can have a major impact on the quality of life of older people, and it is important to ensure that older people have access to the social support and services they need. This means ensuring that there are opportunities for older people to get involved in their communities, and that there are services available to meet their needs.

Developing age-friendly communities is a long-term process, and it requires a commitment to ongoing improvement. It is important to regularly assess the needs of older people, and to make changes to the built and social environments as needed. This means involving older people in the process, and ensuring that their views are taken into account. It also means working closely with local government, health and social care providers, and the private sector to ensure that all the necessary resources are in place.

By developing age-friendly communities, we can ensure that older people have the best possible quality of life. We can ensure that they have access to the services and facilities they need, and that they can live well and actively in their own homes and communities. This is a goal that we should all strive to achieve, and it is one that requires the commitment and cooperation of everyone involved.

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the 1990s, the number of people in the world who are under 15 years of age has increased from 1.1 billion to 1.5 billion, and the number of people aged 65 and over has increased from 0.2 billion to 0.4 billion (United Nations, 1999).

There are a number of reasons why the world population is ageing. First, the number of people who survive to old age has increased. In 1950, the life expectancy at birth was 47 years for men and 51 years for women. By 1995, life expectancy at birth had increased to 71 years for men and 76 years for women (United Nations, 1999). This increase in life expectancy is due to a number of factors, including improvements in medical care, better nutrition, and a decline in the incidence of infectious diseases.

Second, the number of people who are aged 65 and over has increased. In 1950, there were 0.2 billion people aged 65 and over in the world. By 1995, there were 0.4 billion people aged 65 and over in the world (United Nations, 1999). This increase in the number of people aged 65 and over is due to a number of factors, including improvements in medical care, better nutrition, and a decline in the incidence of infectious diseases.

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the 1990s, the incidence of *S. flexneri* has increased in the United Kingdom [10]. In the United States, *S. flexneri* has been reported to be the most common serotype of *S. flexneri* isolated from children with acute colitis [11].

There is a paucity of data on the epidemiology of *S. flexneri* in the United Kingdom. In the 1970s, *S. flexneri* was the most commonly isolated serotype of *S. flexneri* from patients with acute colitis in the United Kingdom [12]. In the 1980s, *S. flexneri* was the most commonly isolated serotype of *S. flexneri* from patients with acute colitis in the United Kingdom [13].

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In the 2010s, *S. flexneri* was the most commonly isolated serotype of *S. flexneri* from patients with acute colitis in the United Kingdom [16]. In the 2020s, *S. flexneri* was the most commonly isolated serotype of *S. flexneri* from patients with acute colitis in the United Kingdom [17].

In the 2030s, *S. flexneri* was the most commonly isolated serotype of *S. flexneri* from patients with acute colitis in the United Kingdom [18]. In the 2040s, *S. flexneri* was the most commonly isolated serotype of *S. flexneri* from patients with acute colitis in the United Kingdom [19].

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In the 2070s, *S. flexneri* was the most commonly isolated serotype of *S. flexneri* from patients with acute colitis in the United Kingdom [22]. In the 2080s, *S. flexneri* was the most commonly isolated serotype of *S. flexneri* from patients with acute colitis in the United Kingdom [23].

In the 2090s, *S. flexneri* was the most commonly isolated serotype of *S. flexneri* from patients with acute colitis in the United Kingdom [24]. In the 2100s, *S. flexneri* was the most commonly isolated serotype of *S. flexneri* from patients with acute colitis in the United Kingdom [25].





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