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REVISTA IBERO-AMERICANA DE SAÚDE E ENVELHECIMENTO
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EDITORIAL

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Population aging is one of the central phenomena of developed societies. If this aging is one of the achievements of socio-economic development, advances in public health and health care, it poses a threat to the health and social services of these societies.

The probability of the occurrence of comorbidity and multimorbidity associated with advancing age is a source of concern for current states, where increased spending on health care and social security are constantly being considered.

Pressure on the health system resulting from the continuous increase in life expectancy has been the focus of constant attention, and strategies to alleviate this pressure have essentially been aimed at promoting active and healthy aging (AHA), following the guidelines of the WHO.

When the concept began to be publicised in societies such as Portugal, the association with the term 'active' prevailed and for some time it was considered that the activity alone – "the moving" – was a way to actively age. And this first message about activity was so important that never as much as today have elderly people and adults and young people in villages, towns and cities, been seen exercising and walking or doing another type of physical activity daily. This phenomenon may mean that the message of the importance of activity being practised daily penetrated the social imagination. It should be noted that for this image, the municipalities contributed a lot by building their own areas/spaces for walking/activity and by offering active seniors programmes. If in strict terms of activity many of the objectives were achieved, this alone is insufficient for characterising AHA. Active aging involves other dimensions that are much more complex and to these there has clearly been no response, neither central nor regional nor local.

In Portugal, despite several attempts, a real AHA programme was never implemented, leaving the elderly and the country faced with the consequences of this situation on a daily basis. It is considered that this lack of answers will have led the Portuguese State, through a group of experts, to outline the National Strategy for Active and Healthy Aging 2017-2025 (ENEAS – Dispatch No. 12427/2016). The document sets out the guiding principles, objectives and strategic axes of the AHA and sets out the guidelines on the **health** dimension (promoting healthy lifestyles, health monitoring and management of comorbidity processes), guidelines for the **participation** dimension (lifelong education and training and creation of environments that foster integration and participation), guidelines for the **safety** dimension (creation of physical environments that guarantee safety and identification, signalling and support in situations of vulnerability). For each set of actions of the different guidelines, there are defined measures, actions and responsible entities (most of them at a central level such as ministries, general directorates,

public institutes, social solidarity services, security forces, national associations of municipalities and parishes and at a regional level, the Regional Health Administrations. At a local level, there are no entities responsible for the implementation of the National Strategy for AHA.

Finally, it establishes the guidelines for measuring, monitoring and researching the implementation, monitoring and evaluation of the current national strategy (ensured by the National Interministerial Commission for Active and Healthy Aging in partnership with research institutions).

It is understood that the measures and actions will be centrally advocated and triggered locally and regionally. Given this scenario, it is questioned whether this strategy will respond effectively to the needs of the populations in terms of AHA. Likewise, questions are raised about partners who will implement this strategy at a local level. Will it be the health units (USF, UCSP or UCC), local authorities, the social sector, civil society, or a set of key players that involves the various entities?

These issues need to be answered because the AHA's assessment points out, as has already been pointed out, an intervention at the safety, participation and health level that is complex and requires resources (human, material and financial resources) for its operation.

Analysing the specific indicators of each of the dimensions, we would say that at a **safety** level, the AHA involves/requires activities such as accident prevention; prevention of falls; prevention of violence, abuse and ill-treatment; prevention of social discrimination; prevention of abandonment; promotion of family involvement; promotion of involvement in social networks; and stimulation of self-care and autonomy.

The activities on **participation** and **citizenship** include the promotion of the rights and duties of the elderly (e.g., the right to their individuality, respect for and consideration of their wishes), the life purpose of the elderly, stimulation of programs and forms of social participation, for participation in volunteering activities, for participation in intra- and intergenerational programs (I/elderly person and others) for the stimulation of balanced social relations (with family and social development and recognition); for programs to prevent/combat social isolation and loneliness; for issues of gender, equality and freedom and for programmes to fight against ageism and for social recognition of the elderly.

Interventions in the **health** dimension of the elderly involve the promotion of health literacy; of regular physical activity; of intellectual/cognitive stimulation activities; the promotion of self-esteem and self-realisation, the stimulation of self-expression; of the prevention of/fight against depression; stimulation of the affective life; of stress management in daily life; of the prevention of diseases (screenings, vaccines, appointments etc) and of healthy lifestyles (fruit, vegetables, fibre and fish; salt consumption, sugar consumption, alcohol consumption or other harmful substances; tobacco consumption).

In the face of such targeted and complex interventions, it is necessary to have multiprofessional teams in the field who operate the different responses required by the AHA. Without this clearly established and defined multiprofessional component and without the clear involvement of the State (along with the social sector and civil society), the National Strategy for Active Aging and the AHA of the Portuguese elderly are clearly compromised.

As in many other eras and contexts of health, changes in the daily work of health professionals and indicators established/contracted with health units and the social sector are necessary. Short-term investment is imperative for long-term success. Whether it is viewed as a right or as a duty of the elderly, the AHA necessarily requires articulated responses, which are fundamental to the achievement of all its dimensions and indicators, which promote healthy daily practices and enable Portuguese elderly people to live longer, healthier lives, with quality of life and well-being, similar to that of more developed countries.

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