

# RIASE

REVISTA IBERO-AMERICANA DE SAÚDE E ENVELHECIMENTO  
REVISTA IBERO-AMERICANA DE SALUD Y ENVEJECIMIENTO

## EDITORIAL

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### *Aging and health systems*

Recognizing the scale of the phenomenon of aging and its repercussions on different levels of social and political life, we assumed it as the main focus of RIASE in our first Editorial. At the time we mentioned some of the various challenges that this phenomenon puts us and we stated the following: "... the conjugation of health and aging confronts us with the need for a paradigmatic shift of great dimension and enormous impact. The current health systems were designed and developed according to the paradigm of the acute disease. However demographic changes led to epidemiological changes that we need to consider when we equate health systems". We now return to the topic to add more detail to the "paradigmatic change" we mentioned then.

In a brief way, we can say that the aging of the population can be understood as the result of the decrease in the birth rate combined with the increase in average life expectancy. However, for a deeper understanding of this phenomenon we must add other no less important variables that have a synergistic effect on it. Thus, we should look carefully at the migratory phenomena that affects some countries: when there's a strong emigration tendency, it contributes to aging aggravation; when the effect of immigration is stronger that tendency is obliterated; there is also the internal migration processes of the countries themselves, accompanied by the desertification of rural areas and the gentrification of large urban centers; and the sociological changes in family structure, particularly those that aggravate the trends of family isolation, contributing to the increase of families constituted by two elderly people or even elders with no family.

Although epidemiological changes may, in a way, be regarded as the simple consequence of longer life expectancy, they should also deserve a closer look. In fact, the main epidemiological change is characterized by a decrease in the prevalence of infectious disease and an increase in chronic-degenerative diseases. In the case of Portugal, one of the European countries where the aging phenomenon is more pronounced, we found that: for each 10 deaths, only 1 may be attributed to infectious disease (respiratory infection), while the other 9 are due to chronic-degenerative diseases. If we analyze the evolution of the statistics between 2005 and 2015 we find that the only infectious disease in the ranking went from 3<sup>rd</sup> to 4<sup>th</sup> place<sup>(1)</sup>.

If we now focus on the risk factors most associated with this new epidemiological picture we find that they are essentially behavioral and associated with lifestyle (e.g., diet, alcohol and tobacco consumption, physical activity).

In light of the above, we can say that we have an increasingly aging population, that is chronically ill (multimorbidities), affected by diseases strongly associated to lifestyle. We realize the true dimension of the challenge if we consider that, in some countries, the percentage of older people<sup>(a)</sup> is already above 20% of the total population, in a trend that, according to statistics, will be growing, at least, until 2050, particularly among the very old (85+).

Are the health systems prepared and can they answer to a change of this nature?

We would take a chance in saying that health systems are changing their answer reactively rather than proactively, and have, consequently, less capacity of anticipation due to insufficient planning.

In short manner, as befits an editorial, we would say that health systems should, among other things, focus on the prevalence of chronic diseases and multimorbidity as a public health issue, as well as on the re-engineering of the system according to this new epidemiological reality.

Concerning the first priority (i.e., the prevalence of chronic diseases and comorbidity) we highlight the immense challenge that arises from the fact that we are facing a reality which is defined as chronic in nature and which risk factors are essentially behavioral and associated with lifestyle. This reality becomes even more complex if we think that the majority of the elderly do not have one but several chronic diseases (multimorbidity), and we can say that each different conjugation of chronic diseases is, in itself, a distinct nosological entity.

We are thus faced with situations that evolve in a chronic way, over, at least, 20 years<sup>(b)</sup>, thus calling for a considerable investment in risk factors at a communitary level, but also a huge investment in the capacity for self-management of the individual health-disease processes through increased health literacy. This one effort is particularly difficult because we know that the greatest deficits in literacy (general and health) occur exactly in older population.

On the other hand, this effort is assumed as decisive because, according to several studies, although there is no association between aging and health spending, there is however a clear relationship between aging with disease and health spending<sup>(2)</sup>. Therefore, any investment made in the preservation of health or in the control of chronic diseases contributes to the sustainability of public health systems.

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(a) In the European Union, people over 65 years.

(b) The average life expectancy at 65 is, in Portugal, of 19.3 years.

The second priority (i.e., reengineering the system in the light of this new epidemiological reality) is complementary to the first, but it has some elements that seem crucial to us and deserve to be highlighted. Thus, redesigning a health system, designed for a prevalence of chronic diseases and where the majority of the beneficiaries are elder, requires the adoption of compatible models. Among the main features of this “new” system we would emphasize as a central pillar the need to bet on the continuity of care through the definition of people-centered care pathways. This statement, so simple and so glossed, collides with the vertical organization of health systems and requires the mobilization of new actors for the care process. A care system built around care pathways will ensure that each person finds at every moment the needed answer. It will require the potential for caring of all the actors (including the potential for self-care) to be taken into account and for them to be integrated into the process of care. It will therefore require new roles for all involved entities. The people in need of care must become citizens co-responsible for their care process, instead of consuming-beneficiaries; health professionals need to evolve to a level of proactivity where they include and mobilize the multiple actors in the process (e.g., the patient, the care-taking family members, the insertion community, and the local authorities); the other social actors (e.g., social and solidarity sector, local authorities) need to view health care as a priority; and political agents need to consider health in all policies<sup>(3)</sup>.

In this context, health services need to (re)think their organizational models so they can meet these challenges. Thus, multidisciplinary teamwork will be a compulsory basic requirement, the nosological diagnosis will only be part of a necessarily multidimensional diagnosis, the communicational competence will be increasingly crucial and new technologies will be an essential tool to facilitate and embody this new reality by allowing the health services to no longer being limited to their physical spaces.

Across the two stated priorities lingers the need for us to assume the evaluation of outcomes in health. For that and as a way of ensuring, on the one hand, that we are responding to people's expectations and, on the other, to the needs of system sustainability, we need to adopt the evaluation of the functionality as recommended by WHO<sup>(4)</sup>.

The challenges, only briefly stated, are huge. They require therefore that each one of us, as a citizen, assumes them so that, in this way, we can continue to contribute to the development and well-being of people.

## REFERENCES

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