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EDITORIAL

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Currently, throughout Europe, as well as in all countries of the world where the process of demographic aging is most evident, there are several concerns about what is conventionally called "sustainability of the system", a concept that encompasses health and social security.

We will not divagate on the stigmatizing potential of many of the unsustainability theses, but, in fact, their central idea is that the elderly are their fundamental reason.

From this logic, in fact, those responsible for the supposed unsustainability will be all the people who, regardless of their ages, meet a certain set of characteristics, among which we highlight the combination of multimorbidity and dependence. It is a fact that this conjugation occurs with greater prevalence in elderly people, especially in those who are very elderly. However, since it is not an inevitability, it also occurs in other ages, in some cases, even at very early ages.

In this context, it is our duty to develop the necessary strategies to reduce the prevalence of this binomial. It does not eliminate the need to think about new models that give financial sustainability to the social security system.

Regarding the strategies, understanding that one of them will go through what the WHO called as "active and healthy aging", there are many questions left to be answered.

Some of these questions have to do with the political decision. Although it is often heard that the political decision does not have to be based on scientific evidence, we have s-me difficulty understanding that it can be ignored. Thus, we ask ourselves: are the organizational structures of political decision-making in health prepared to make decisions supported by scientific evidence immune to the oscillation of short political cycles? Do the decisions provide for independent and robust monitoring mechanisms that grant continuous improvement to the strategies and, at the same time, increase the scientific evidence? In other words, is there permanent "strategic intelligence" in political decision-making structures?

These questions are also a challenge to the research sector. We understand that, in Portugal, the research funding has privileged the so-called "fundamental" and technological areas. This, when applied to the binomial under analysis (i.e., multimorbidity-dependence) makes it clear that a cell biology study on aging is more easily funded than a study on a model of active and healthy aging promoting care; or the development of a robot to support the dependent elderly, than the necessary technologies and enhancers of the aforementioned care model. This means that, as a rule, these studies are developed in teams with little disciplinary diversity.

Thus, we understand that, in addition to the need to review and balance priorities, we also need to increase inter and trans disciplinary studies and, at the same time, to do so in context, thus giving scientific robustness to the interventions and increasing the evidence. Developing them in context, it is essential to understand that the research teams that have been excluded up to now will have to be integrated. In other words, if the goal is to develop models and/or products that will ultimately be used by patients and health professionals, it will be crucial for them both to participate as research co-producers. One of the many consequences of this participation is the acceleration of the process of transfer of knowledge and technology.

We also need to do this in respect for a politically defined health technology development strategy; however, it must be open, promoting the involvement not only of academia, but also of the business sector. Thus, we will increase the research and innovation potential, but also the potential for the development of marketable products.

Finally, we need to pay more attention to the group of people who, being more and more numerous, live more and more years with more dependence – the elderly. Giving them more attention is not a figure of rhetoric or imbued with good intentions. It has essentially to do with the main problem that affects them, that is, the multimorbidity-dependence binomial. The first factor of this binomial (i.e., multimorbidity) will result, among others, in a life course with certain health behaviors. On the other hand, the multimorbidity situation, in order to be properly managed, will require lifestyle changes, which require high levels of literacy. The second factor of the binomial (i.e., dependency) and which often results from the former one, weakens the person in all dimensions of their life. This conjugation creates the ideal conditions to enter into a spiral of successive aggravation of one and other factor, culminating in the institutionalization.

In many cases, it is possible to reverse this process by rehabilitating and re-adapting, in other cases it is possible to mitigate the decline of losses, and in all it is possible to provide more well-being and quality of life. In order do this, we need to define the care path for the dependent person and create the conditions so that most of this path is done in a context, with logic of integration and continuity of care.

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