International Handbooks of Quality-of-Life
Series Editor: Graciela Tonon

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Handbook of Active Ageing and Quality of Life

From Concepts to Applications

Springer

"Active Ageing": Its Relevance from an Historical Perspective

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10.1 Introduction

After several decades of gestation and increasing relevance, Active Ageing received definitive support as a strategy of the international policy on ageing in an official World Health Organisation (WHO) document presented at the World Assembly on Ageing of 2002 in Madrid. Its title was eloquent: "Active Ageing: a Policy Framework" (World Health Organisation 2002). The United Nations health agency thus became the concept's principal guarantor and promoter, as well as its main reference when today seeking its definition ("*the process of optimising opportunities for health, participation, and security in order to enhance quality of life as people age. Active Ageing applies to both individuals and population groups. It allows people to realise their potential for physical, social and mental wellbeing throughout their lives and to participate in society according to their needs, desires and capabilities, while providing them with adequate protection, security and care when they need assistance*").

However, in 2015 the WHO itself has begun to give abundant evidence that its future strategy abandons this concept. It did not mention Active Ageing in its "World Report on Ageing and Health" (World Health Organisation 2015), which bore a status similar to the 2002 document. Nor did it do so in other strategic documents in this area, such as the "Strategy and Action Plan on Ageing and Health 2016-2020", or the scheduled "Decade of Healthy Ageing 2020-2030" (Clare 2019).

Such a radical change in the WHO's dialectic leads to a variety of questions: what has happened? Has the concept already served its purpose? If so, with what results? Is this abandonment exclusive to the WHO or is it common to the other actors who plan for a better old age in the future? (always taking into account that these actors belong predominantly to the part of the world where mortality has already decreased significantly and the aged persons begin to exceed 20% in population pyramids, often higher percent than infant population).

These unknowns have suddenly been added to the ambiguity and polysemy always inherent to the Active Ageing, unknowns that the 2002 document had been able to curtail by turning the concept into an international and interdisciplinary reference. Until then, the progressive, spontaneous spread of its use in planning or research had also increased the need to delimit which of its multiple uses would be adopted in each specific case, and how it would be distinguished within the great family of concepts that always sought to characterise "good" ageing (healthy ageing, participatory ageing, ageing without ceasing labour

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F. Rojo-Pérez, G. Fernández-Mayoralas (eds.), *Handbook of Active Ageing and Quality of Life*, International Handbooks of Quality-of-Life, https://doi.org/10.1007/978-3-030-58031-5_10

activity etc.). In fact, during the first decade of the twenty-first century, when Active Ageing attained the peak of its adherence and popularity, the task of clarification and delimitation of the concept itself became a relevant goal of research.

The study proposed in this chapter is also an attempt at conceptual clarification. Its specificity lies in the fact that the path chosen is not semiological, bibliometric or document tracked (the existing literature is so plentiful today that it proves almost overwhelming). Rather, it is a broad interpretation of the historical development in the construction and use of Active Ageing, embracing too its present and surprising abandonment by the WHO.

We know that Active Ageing has had different impacts and developments as observed in its political/instrumental dimension or its theoretical/conceptual dimension. In the former, it has generated increased practical regulatory activity (entities, financing, legislation, etc.) during the past two decades. However, in "scientific" terms, together with the aforementioned problems of definition and classification (Moody 2005) it has also brought operationalisation and measurement difficulties.

The question arises whether its abandonment by the WHO is a response to the poor results of Active Ageing in one or another dimension (or in both). Or whether, despite its usefulness and effectiveness, there has been a change in the historical or institutional context that has caused it to be left behind. The response obliges clarification of its origins and trajectory in any of its areas of application. What follows is a proposal for a temporal map of the major landmarks that have marked its historical evolution by setting it against the backdrop of the interest in treating population ageing and the way to do so. Our hope is to contribute to greater understanding of Active Ageing as a tool and its present situation following the WHO's shift.

10.2 The Origins

Ever since literature about old age has existed, there have been references, of varying degrees of vagueness, to principles or practices that lead to good ageing. These have been enunciated by thinkers of all times, but especially those who, from the field of medicine, have suggested keys to good health throughout life (food, exercise, medications etc.), and their historical recapitulation is a recurring part of early major treatises of geriatrics (Nascher 1914). However, a significant degree of precision and theorisation on the keys to good ageing was not reached until the psychosocial and geriatric discourses of the 1950s.

These were far of be adopted in public policies as a planning tool. What they proposed, from a highly medical and sectoral perspective, were the first gerontological theories, closely related to daily practice in rest homes. The aim was to find a general guideline for action that promoted "good ageing" for those institutions.

One of the earliest, that of "disengagement" (Cumming and Henry 1961) considered ageing as an irreversible process of function, capacity and social relationship loss. It therefore led to a gerontological practice that promoted social detachment and abandonment of previous activities, in "harmonious" preparation for the inevitable (a theoretical framework, incidentally, that was highly favourable to the institutionalisation of old age). In contrast, the same period saw the proposal of "active ageing" (Havighurst 1954; Maddox 1963), a direct forebear of today's concept. A polar opposite to Cumming and Henri, it understood that maintaining links, activities, even new learning, held the key to a successful old age.

Theories about the nature of ageing and the best way to intervene in it continued to develop and proliferate during the 1970s. These employed very different approaches, but particularly "psycho-social" ones, such as role theories (Rosow 1970), subculture (Rose and Peterson 1965), continuity (Atchley 1971) or age stratification (Riley 1971). However, our focus here is the final structuring of the policies to optimise the ageing process around the concept of Active Ageing.

In reality, the policies about old age in this period were developed with very different bases: since the end of the nineteenth century, medical care for workers and their financial insurance in front to retirement had been the structural topics

with regard to State protection for old age, within the context of incipient social welfare policies. This political orientation responded in large part to a long history of worker and trade-union struggles, but additionally to the usefulness of the pact implicit in liberal parliamentary governments to halt workers' expansion, that was revolutionary initially, and Soviet later. In this way, old age as a State issue had always been linked to overwork, the right to rest and the protection of the worker from illness and poverty once working life had ended. In short, the core of the social policy about ageing was set in the ability or inability to work (Walker 1980, 2016).

Therefore, the first theories of Active Ageing, psychosocial ones, had little impact on the manner of State understanding and treating of old age. Active Ageing was a politically marginal issue during the years in which developmentalism reached its zenith, years of fast economic growth and expansive policies in public spending. Policy on old age continued focusing on and delving into "worker welfare", with different translations according to the most developed major regions where demographic change was already very visible, especially Europe or the US. Further afield, in most of the rest of the world, health remained a subject that was linked to over-mortality in the ages prior to old age, especially children, while the numbers of older persons were still at traditional lows (around 4–5% of the population).

Indeed, after the Second World War, European States had been forced to adopt reconstruction and welfare policies. The onus was on them to present their own political bloc advantageously against their opponent (in this point the two Europes, Eastern and Western, are convergent and competitive). In the US, on the other hand, the War had given way to a period of unprecedented expansion, with very rapid growth of the middle classes and with generations of young people who decades later would have the chance to retire in better conditions than ever before (Marmor 2017); the universal health protection system for American old age, Medicare, was launched during the Johnson administration (1963–1968).

In addition to these two vectors, the theoretical one and that of State policies, the picture would be incomplete without adding demographic evolution itself (MacInnes and Pérez Díaz 2009). Much less circumstantial and dominated by long-range trends, the numbers of older people in the richest countries was progressively increasing. By the end of the 1970s, the proportion of the over-60s, around 5% in all historical human populations, reached 16% in the US and 17% in Europe (while on continents such as Africa, the figure barely exceeds 6% today) (United Nations 2017). This factor was still little in evidence in the political discourse on old age. Despite the increase in life expectancy, the baby boom of the 1950s and 1960s had greatly reduced concern about the population pyramid, which still showed a very broad base, far from what began to occur in the 1970s.

Transfer of the emphasis on protection policies, from worker's health to general health, began to take place after the Second World War, although old age was not yet its central theme. The focus was on general mortality, summarised in the indicator "life expectancy at birth", which in a good part of the world remained at the archaic value of under 40. In developed countries, it was already around 60. Indeed, in the subsequent quarter-century, there was notable progress but health and old age remained separate as two main lines of political concern. Their merger into a single strategic objective only occurred after the economic and political earthquake that hit in the 1970s.

10.3 The Crisis of the 1970s and the Change in the Conditions for Considering Old Age

The 1970s began with a very similar situation, which could be termed post-war or developmentalist. However, profound changes soon took place worldwide that completely subverted the picture we have just drawn.

In 1973, the price of crude oil rose dramatically on international markets, triggering a chain

of effects. By the end of the decade, the economic development model, based on industrial production and employment, and supported by cheap oil, had already begun to decline. The deficit of the leading States soared, without Keynesian policies appearing of any use on this occasion. The second oil crisis, in 1979, led definitively to a rethinking of policies, public spending and the relationship between State and market.

As regards old age, a paradox was produced. For the first time, and only in the most developed countries, an international economic crisis had found older people minimally protected in their income. Never before had an aged generation attained a full, uninterrupted working life, in paid employment and in a principally urban and industrial economy. Combined with the fact that public retirement systems had been deployed intensely after the Second World War, it would be seen that this crisis had very different effects on different ages than before.

Any previous economic crisis had forced workers to prolong their working life indefinitely, even to the point of total exhaustion and death. By contrast, the effect of this crisis was the mass early retirement of workers of mature age. Not only was there huge destruction of employment, but this was concentrated in occupational sectors where increasing proportions of workers had become consolidated and mature, until they had become the majority. In the face of the collapse of a complete production model, closure or reduction in workforce was facilitated by States resorting to the funds accumulated by contributors, allowing and even encouraging the early retirement of a large number of workers (this was justified by the need to pave the way for their substitution by the young, which was mere rhetoric because their entry into the labour market was also significantly blocked in those years). The effects were so great that they significantly brought forward the average retirement age (Guillemard 1993).

The period's economic and productive slump interacted with the demographic point in time: mass generational survival during adulthood, limitation of births by couples who had already completed their family projects in the 1960s and 70s, at unusually early ages, the commercial emergence of "the pill" that provided the youngest with a cheap and effective method to dissociate the forming of a couple from a first child and sizeable relative surpluses of youth labour in a market that had shut its doors (Easterlin 1968; MacInnes and Pérez Díaz 2008).

The baby boom was coming to an end. Fertility rates in the wealthiest countries again began a downward path, which this time led them to minimums they had never experienced before. Although this demographic drift was not a mechanical reflection of the slow progress in improving life expectancy and of the increase of survivors in old age, the rapid decline in the number of births helped to draw public attention to demographic ageing, which was accelerating.

Finally, the demographic weight attained by old age forced the issue of good ageing away from strict care or geriatric practice, or from trade union programmes and social democratic policies on good retirement. Instead, it was placed in a much more general medical and social perspective. In fact, the watchwords began to be "epidemiological transition", rather than the traditional "demographic transition" (Omran 1977). The mere evolution of the population pyramid modified the map of the principal pathologies and causes of death, or of health policies. Care systems created around maternal and child health and the fight against infectious diseases, began to confront the need to adapt to the new majority profile of beneficiaries, who were now much older, and of their principal medical conditions (cardiovascular, degenerative diseases etc.). In this evolution, a milestone was the creation in 1975 of America's National Institute of Aging (NIA), within the general framework of the National Institute of Health.

In summary, the question of how to grow old moved during the 1970s from geriatric practice to a much more general medical-health perspective, one that responded simultaneously to a serious international crisis, to new trends in economic management by States, and to an unprecedented demographic shift.

10.4 The 1980s and New Economic Policy: Old Age as a Problem

The internationally generalised political-economic formula for dealing with the crisis included a profound revision of the role of the State and public spending in their economies. The mandates of Ronald Reagan (1981–1989) and Margaret Thatcher (1979–1990) were emblematic of the new economic policy, but their momentum could also be found in the new recipes of institutions such as the World Bank or the International Monetary Fund (Stiglitz 2002). These were applied inflexibly in the other, less industrialised, part of the world where the crisis was concentrated in an external debt that had become impossible to pay, or in the dismembered Soviet bloc, in a brutal shift towards the free market.

The reduction in public spending was preached in highly different spheres (except in no-go areas, such as defence). This meant that social and old age protection and, in fact, the very change in the age structure were subjected to profound "revision." In this tidal shift, academic research and think tanks played a significant role.

The crisis and subsequent adjustments bolstered one of the most literal meanings of Active Ageing, which referred to the maintenance of labour activity and economic productivity (Foster and Walker 2014). Paradoxically, the crisis led to "employment restructuring" (obligatory in companies, but promoted too by States), whereby a significant proportion of workers in the final stages of their working lives, saw their definitive departure from the labour market abruptly brought forward. The aggregate result was a significant reduction in the average age of effective retirement, which had always been above 65 and which fell to under 60 in many developed countries. In this way, support for adjustments and early retirement co-existed in the 1980s with conflicting support for the prolongation of the years of work activity (Active Ageing in labour terms). Also quickly evident was the lack of preparation with which huge numbers of workers saw their working life terminate without their having planned for the moment or the life strategies they were going to adopt. Therefore, the crisis produced an important precedent of what we now consider Active Ageing; not in the discourse on the prolongation of working life, but in the early preparation for retirement in order to enjoy an equally active and satisfactory life subsequently.

In the 1990's, the average effective retirement age stopped decreasing. However, there was divergence with the US, where it stayed very stable at around 65, while in Europe it reached much lower levels before stabilising. This may explain why in the US during this decade the discourse about good ageing placed less emphasis on work activity and more on health, while in Europe remaining in work was much more the focus.

With regard to pensions, there was a proliferation of "actuarial" studies announcing the unsustainability of public systems. Such studies lacked originality in methodological terms and were supported by population projections by the classic component method, but also by new economic theories such as those of the Chicago School (Friedman 2002).

The best example of this academic-financial synergy was the privatisation of the Chilean pension system in 1981, personally led by Milton Friedman. It was soon imitated by other countries, such as Mexico. The surge reached Europe which, although reluctant to privatise, witnessed an extending of the State's promotion of voluntary, or even obligatory, complements to public pensions through other private savings products. Although take-up was slower, this was made explicit in the EU White Paper on Pensions (European Commission 2012a, b).

The social sciences also saw the deployment of a "sociological/political" discourse that re-examined the State's historical role towards the family with regard to welfare. It was claimed that the traditional protective functions of the family had been "usurped" by the insatiable public services, with negative results, and that such protection would improve if this were returned to the family (Kertzet and Laslett 1995). Although

this discourse was applied to multiple facets of State intervention (some even extended it to children's education), it was especially geared to the old age that needed personal care. These were the years that saw the emergence of language about "formal" and "informal" care (Froland 1980).

In demography, finally, the focus of the discipline began to shift. Since its birth in the late nineteenth century, it had as its central theme "low fertility" and the fear of demographic decline (for ideological reasons and international competition, even in war, because in reality these were years of unprecedented population growth) (Teitelbaum and Winter 1985). After two World Wars and the baby boom that the developed world experienced right at the end of the second, the focus had changed from the low fertility of the wealthy world to the "excessive fertility" of the barely advanced world, especially the Asian continent, a vector for the spread of communism. Only after the baby boom had concluded, the USSR decomposition and the return of a sustained decline in fertility, coinciding with the industrial crisis and new economic policy, was the attention of demographers finally drawn to changes in the age pyramid. The best illustration of this thematic breakdown of the discipline itself was provided by a survey that IUSSP (the world association of demographers) conducted of its members in 2009, canvassing their opinions and attitudes about their field of work, their research topics, their applications, the biggest current problems to be solved or the policies required to confront them. When the analysis of the almost one thousand completed questionnaires was published, the thematic and political predominance of "ageing" was overwhelming (Van Dalen and Henkens 2012).

But the major emergence of the subject of old age during the 1980s, in addition to showing up in the social sciences, economics or demography, was observed especially in the field of health. It was there that a first global review on public strategies on old age appeared, a precedent of what would be articulated around the concept of Active Ageing.

10.5 Adding Life to Years, the Strategic Shift of the WHO

The accumulated changes that led to this first emergence were highly diverse and some of them have already been stated. They included truly disruptive political, ideological and economic factors, beyond the abandonment of Keynesian policies, which were replaced by policies of adjustment, expenditure control or liberalisation of the public sphere. In general terms, advanced societies moved abruptly from a principally industrial economy to one of services, in which the care of people occupied a central place.

However, the demographic and health situation was also regarded as a key focus of the major collective problems in which old age and its growing significance was always indicated as a threat. Terms such as "demographic winter" or even "demographic suicide" were coined, attributing the new population pyramid as leading to an imminent health crisis, the collapse of the public pension systems and the unsustainability of the Welfare State in general.

Perhaps the best example of this change in perspective was to be found in the general strategy of the WHO, this time with regard to mortality. Since the Second World War, life expectancy had been the indicator with the greatest presence, and the one that made the results of development and health policies visible. There could be said to be a real international race, especially between the two major political blocs, to show the greatest progress in years of life. Indeed, such progress occurred in a significant, sustained manner.

However, the new climate that followed the industrial crisis and the change in the political and economic paradigm coincided symptomatically with a radical rethinking of the international health strategy with regard to two crucial issues: the possibility of continuing to improve mortality, and the importance of disability for collective health. This shift was already evident in the Action Plan that arose from the First World Assembly on Ageing in Vienna, organised by the United Nations in 1982 (United Nations

1982), and in the First International Conference on Health Promotion, organised by the WHO in 1986 in Ottawa (https://www.who.int/healthpromotion/conferences/previous/ottawa/en/).

In short, the transition from mortality was regarded as having come to an end. In strict demographic terms, it began to be affirmed that the maximum life expectancy had already been attained by reducing or eliminating premature mortality, especially that of children. It could now not be improved much more in that direction, but it was not even worth making the effort; in line with Ricardo's reasoning about the diminishing yields of cultivated land, when infant mortality is already so low, the costs of any additional improvement grow exponentially and tend to infinity.

The other large age group where mortality remained high, old age, could have been the beneficiary of the efforts to continue increasing life expectancy. However, budgetary stability and the reduction in the public debt demanded by the new economic orthodoxy were accompanied by two presumptive convictions about the inconvenience of making that effort: (1) high mortality in old age was "natural", the limits of life expectancy were predetermined in each species and in the human species they had already been reached (Olshansky et al. 1990), and (2) even if the death affecting the old could be postponed, this artificially-prolonged life would only increase the years lived in poor health; it would be a pyrrhic victory.

In short, the 1980s marked a critical rethinking of growing health spending on old age. Its most radical exponent is Callahan (1987), who stated directly that the concentration on health care and resources in old age was immoral and should be decisively slowed so as not to harm the other ages. Others, who were less radical, proposed the existence of an epidemiological and health transition associated with the new demographic situation, in which the primacy of infectious diseases, acute problems and early mortality had been replaced by degenerative diseases, chronic problems and late mortality (Omran 1983). Those warning of a pandemic of senile disease if the effort to extend the years people lived were maintained received the response that serious morbidity did not extend to all the years of old age but that it was "compressed" in the moments before death (Fries 1980). Others predicted a future "dynamic" balance between health and morbidity, as these advances occur. In any case, the decade signalled the end of self-satisfaction about the progress against mortality. From then on, the aim was to improve the quality of life achieved rather than to keep adding on the years.

Secondly, this change in aspirations obliged health to be conceived in a more complex manner. Disability entered the public agenda as a problem that proved beyond the traditional medical framework. Since people's abilities did not depend exclusively on their physical or mental functionality, being also determined by the environment, resources and their interaction with other people, future ageing strategies could not focus solely on a person's functional state. They had also to embrace the conditions that surrounded them and that helped or hindered them from undertaking activities.

This new conception of health was not individual. But, in addition to being social i.e. collective, it posed a new problem in measuring people's own health. It was no longer possible to resort to medical or clinical data to build a general picture, information was needed on the health of the whole population and not only those who attended the doctor's surgery or were hospitalised. The aim was to establish their relationship with age and whether it had changed. It was necessary to be able to empirically determine the effect of the increase in life expectancy on collective and individual health.

Therefore, States and the scientific community were required to make a significant effort to generate knowledge. This was expressed in three main and complementary directions:

1. A call for proper statistical operations. In fact, the 1980s saw major surveys on health and disability (a notable paradigm shift, as this was no longer a question of medically-diagnosed health, but of subjective responses in which self-perception was crucial). In addition to large national surveys (the first Spanish

one, for example, was conducted in 1986), this effort even shifted to the international statistical agencies, as occurred in the European Union with the creation of SHARE (Survey of Health, Ageing and Retirement in Europe, see http://www.share-project.org). It should be added that the new sources increasingly sought knowledge that was longitudinal, of the life cycle, rather than transversal and exclusively devoted to a "snapshot" about each age. Contributing to this were statistical advances such as panel and biographical surveys, together with methodological ones, such as "event history analysis" (Courgeau and Lelievre 1989).

2. A notable effort was also made to conceptualise and classify the various health problems and abilities affected, which gave rise to the International Classification of Functioning, Disability and Health, the ICF (WHO 2001). Just as a century earlier through the international classification of causes of death, a fundamental tool for achieving comparability and unity of criteria in the political and scientific effort being made was thus achieved,
3. Building on the progressive achievements in the first two points, the aim was to create indicators that measured which part of the life expectancy achieved was translated into years of good health or, conversely, into years affected by disability and morbidity. This would provide an international comparative picture, one that would also be seen over time [these were years of abundant technical and methodological proposals for measuring "life expectancy in health" (Robine et al. 1991), which culminated in the 1990s with major reports like the "Global Burden of Disease" (Murray and Lopez 1996)].

Parallel to the effort to improve the knowledge of old age and the process by which people grow older, the other visible result of strategic change was a progressive attention to the individual's own role in their way of ageing and optimising the way to do so. Epidemiological and health research revealed the growing importance of "lifestyles" or of a healthy environment to reach old age in optimal conditions, without the need for medical or pharmacological treatments. Consequently, the various facets with which the general objective of "good ageing" was pursued were translated into equally diverse labels, which were often too vague and undefined (successful, healthy, active ageing). It was not until 2002 that the concept of Active Ageing received decisive support.

10.6 Finally, the Summit of 2002

The process by which health became the focal point of old age policies culminated in the Second World Assembly on Ageing, which was organised by the United Nations and held in Madrid in 2002. This combined the political interest and two decades of conceptual, scientific and strategic change with regard to old age (Sidorenko and Walker 2004). The Assembly also took place in a far less restrictive economic context than that of Vienna in the early 1980s. The ambition contained in the objectives had only grown, but it also served to disprove that the transition from mortality had been concluded. On the contrary, precisely since the 1980s, in the countries advanced in this transition the possibility of death had only receded in the advanced ages, exactly the opposite of what was predicted. This unexpected good news had, however, its troubling side because it raised renewed challenges in all the areas where the alarm bells had been ringing two decades earlier (Pérez Díaz and Abellán García 2016; Bárrios 2015).

Thus, international consensus was sought to structure the measures to meet the challenge of ageing and the result was the approval of the Madrid International Plan of Action on Ageing (United Nations 2002). It happened that this document faithfully adopted the definition of Active Ageing that the WHO had just proposed the same year in its document Active Ageing: A policy framework (available at https://www.who.int/ageing/publications/active_ageing/en/).

From then on, the primacy of active ageing became overwhelming. It was adopted by national, regional and international policies, in

their respective agendas, in funding lines, in strategic and research plans, until it became part of the official language. That orthodoxy may be seen from the fact that the EU declared 2012 as European Year of Active Ageing and Intergenerational Solidarity.

It seemed that the multitude of proposals for conceptualising good ageing (healthy, successful, good life, productive, optimal etc.) had been left behind and a unitary vision and a common definition finally achieved. But the difficulties did not disappear. It became urgent, as had happened two decades earlier with regard to disability, to discover the data and methods to quantify Active Ageing and determine its evolution over time and the degree of success of the measures undertaken to achieve it. Otherwise, the unification represented by the new WHO paradigm was in danger of only being a rhetorical proposal without any real usefulness.

In fact, the United Nations Economic Commission for Europe created the Active Ageing Index, which is multidimensional and bares great conceptual ambition. It brought together 22 different indicators grouped into four major domains: work, social participation, independent living and the capacity for Active Ageing. The first three measured the individual's degree of achievement, while the latter sought to measure their readiness to achieve them (Zaidi et al. 2017; Rodriguez-Rodriguez et al. 2017; Lamura and Principi 2019).

However, compared to the situation in the 1980s, the attention now devoted to old age had become much more diverse and holistic. Active Ageing was actually an "umbrella" slogan with which WHO wished to guide States towards comprehensive and very broad policies on old age, including health, but also economic security and participation in society, which embraces political and citizen participation. All this significantly hindered quantification, despite the fact that the initial studies on the index were presented in 2012, coinciding with the European Year on Active Ageing and Solidarity between Generations. The subsequent sustained statistical effort was enshrined in the Second International Seminar on the Active Ageing Index UNECE 2018 (the studies presented may be viewed in full at https://www.unece.org/index.php?id=49105) and the European Centre for Social Welfare Policy and Research was especially prominent (https://www.who.int/ageing/events/world-report-2015-launch/en/) in it. However, so far there has been little international implementation of the index, despite the satisfaction its authors showed in presenting it.

10.7 Abandonment in 2015

The second decade of this century began with Active Ageing apparently consolidated as a global objective and political concept, a theoretical paradigm around which action and research were structured.

However, to the surprise of all the scientific community dedicated to clarifying, conceptualising, measuring and discovering the most effective keys to promoting Active Ageing, or for all the types of bodies determined to use it as a reference for their own activities, the newest official WHO documents suddenly began to drop the term (Fernández-Ballesteros 2017). Once again, they replaced it with some of its other variants and, particularly, with "healthy ageing." This was already manifest in the World Report on Ageing and Health 2015 (https://www.who.int/ageing/events/world-report-2015-launch/en/), but above all in the Global Strategy and Action Plan on Ageing and Health 2016-2020, approved at its 69th World Assembly in 2015 (https://www.who.int/ageing/global-strategy/en/).

Unexpectedly, the international organisation that since 2002 had become the main driving force behind the concept, and an obligatory reference when providing it with a definition accepted by all, had stopped using it. The change must have occurred sometime in 2014, when the studies were commissioned to organise the following year's Assembly where the new action plan was to be approved. However, the reasons have never been made explicit. Active Ageing has disappeared from the most important documents that the WHO drafts today, but at no time has the organisation issued an official statement or a

document that we can use to find an explanation for the term being dropped.

With the perspective provided by the cumulative silence that has appeared since then, it is worth considering the possible reasons that, either separately or in combination, could explain this odd turn of events:

- The apparent international unity hid important differences. Europe had adopted and promoted the approach approved in 2002 (visible in the inclusion of Active Ageing as the objective of its research framework programmes, and in particular in the creation of the FUTURAGE and similar networks) (Rodríguez Rodríguez et al. 2012). However, in the US, where the medical and hospital industry carries significant weight and a lesser connection to State policies, there is still a preference for the terms "healthy ageing" and "successful ageing", which display a greater tradition and special emphasis on individual achievements. In American gerontology, there is a long tradition of publishing and revised re-editing of large reference "Handbooks", which are true encyclopaedias on the state of the field, such as Springer's The Encyclopedia of Aging: 2-Volume Set: (Noelker et al. 2006), The Encyclopedia of Aging (Maddox 2013), or the monumental Handbook of Aging and Social Sciences (eighth edition) of Academic Press (Ferraro and George 2015). After a review of the main ones, we have verified that the degree of implementation of Active Ageing in these manuals is practically nil. Even the Futurage researchers, the promoters of the Active Ageing Index and those who were convinced of their good analytical results, systematically avoid addressing its limited international implementation (Zaidi and Howse 2017).
- After the apparent consensus after 2002, the truth is that operational problems persisted. Polysemy continued to hinder unambiguous definition and the breadth of the concept hindered its measurement. Holistic and transversal ambition, which had removed it from the strict medical and health field, did not produce the same positive results as in the precedent of the International Classification of Functioning, Disability and Health, the ICF-2001 (WHO 2001). It is therefore unsurprising that there was no consolidation of the way to measure the weight of the different risks that affect Active Ageing (e.g. non-participation), as opposed to the success achieved by measures of the risk of disease or disability (Pérez Salanova 2016).
- The economic crisis that began in 2008 significantly hindered the viability of action plans on Active Ageing in Europe too. Unemployment and the consequent shrinkage in contributions again made public finances a priority compared to the mere change in the population pyramid and the needs it raised. The issue of pensions again gained in uncertainty in the face of the approved purposes of greater economic protection. This was visible even in the European Year for Active Ageing, 2012, in keeping with the European Commission publishing a White Paper on Adequate, Safe and Sustainable Pensions (European Commission 2012a, b), which followed on from the Ageing Report 2009 in recommending increasing the retirement age, limiting access to early retirement, and linking what would be received to what had been contributed. This consolidated a perverse use of the "active" concept as a literal synonym for the postponement in the age at which the active working life ends. This was the case in the Spanish reform of 2013, approved under the following label: "Royal Decree-Law 5/2013, of March 15, on measures to encourage the continuity of the working life of older workers **and promote Active Ageing**" (Jefatura del Estado 2013) (highlighted by the author). The contrast with the concept defined and promoted by the WHO was very visible.
- Without the WHO being able to anticipate it in 2002, much of the research work on old age has been diverted to new technology companies that will save in health spending in the future thanks to information and communication technologies (ICT). This

unforeseen reorientation is enshrined in the statement of priority research topics to be funded by the EU in Horizon 2020, where ageing only appears unless in relation to the development of these ICTs (https://ec.europa.eu/programmes/horizon2020/en/news/horizon-2020-work-programme-2018-2020).

- The WHO is in reality reinforcing its strategy embodied in the ICF-1991 by now placing the emphasis on health and healthy ageing, defined as that in which functional capacities are maintained (Rodríguez Mañas 2016). The current replacement of Active Ageing with "healthy" occurs with a much broader conception of health than was covered in the 1980s. Internal dynamics have certainly influenced the WHO itself; the sectors that are less satisfied by the great breadth and vagueness inherent in the concept of "active" in reference to ageing have never gone away. These sectors are more likely to circumscribe the general strategy of good ageing in its facet of health. It is even possible that behind the big issues, strategies, international agreements and action plans, the action and ideas of individuals within the WHO itself carry significant weight in the most recent change. We may, for example, speculate on how this coincides with the retirement of Alexandre Kalache, the Director of the WHO's "Ageing and Life Cycle" programme until 2008. He was one of the most involved and influential supporters of Active Ageing as a lynchpin of strategies and the promoter of the work document Active Ageing: a Political Framework, which was presented at the Second World Assembly on Ageing in Madrid in 2002. The founder in 2012 of the International Longevity Centre Brazil (ILC-BR) and Co-Chair of the Global Alliance of ILCs and prominent promoter of the WHO Friendly Cities project in 2007, even in 2015 he stood out for initiatives like the inclusion of a fourth pillar of Active Ageing -lifelong learning-, adding to the three proposed in the 2002 document (health, participation and safety) (ILC-BR 2015; Bárrios 2015).

10.8 Discussion and Conclusions

Whatever the reasons why the WHO has suddenly stopped using Active Ageing as the axis for its action plans with regard to old age, we need to take stock of the results obtained after over a decade of its promotion, an indispensable element for judging why the term has been dropped. Even if this leads us into an area that might be open to subjectivity, the authors of this chapter believe that the expectations generated have not been properly satisfied.

From the conceptual and scientific viewpoint, unification and clarification remain a challenge. On the one hand, the notable institutional and financial support for research has been made from a political and dirigiste conception of the topics to be funded. The result has been that for years practically the only way of receiving financial support for research into old age has been to propose studies that included the Active Ageing label. Paradoxically, the result has been to increase heterogeneity and noise, and hinder conceptual and methodological unification.

Another trend observed whose results were surely not expected is the intensification of holism in official discourses. Until the 1980s, old age and health were separate as public policy objectives, but since then they have tended to become a single issue that encompasses increasingly more dimensions (health, well-being, participation, quality of life etc.). The problem is that the change from "old age" to "ageing" becomes a black hole that drags everything in. Ageing is a process that embraces practically all life and all its spheres, so that since 2002, by subsuming issues as different as pensions, work, disability, political participation or social and family relations, the conceptual framework of Active Ageing has ended up including the full life cycle. However stimulating it may be, this globalising effort makes it very difficult to implement the strategies and actions to be taken.

On the other hand, and with regard to the recent changes observed in old age, which include a marked improvement in its life expectancy both in terms of years and living conditions,

these can hardly be attributed to policies associated with Active Ageing. More than the recent recommendations on individual behaviour or public strategies, and with the same logic of the life cycle that sustains the perspective of Active Ageing, it should be acknowledged that improvements were gestated many decades earlier, in the earlier stages of life, including childhood, of the successive generations to have now entered old age. Long before, that is, the strategy of Active Ageing was formalised.

In the light of the above, Active Ageing has probably been ambiguous in sustaining a strategy on old age, understood as a part or type of the population, while appealing to the dynamic concept of ageing as a universal life process. On many occasions, what in theory were proposed as new ways of ageing, directed by public policies, were really only new ways of treating those who are now aged.

But this criticism can be made even more insidious and general. In this chapter, we have attempted to clarify the present state of Active Ageing as a concept with differing degrees of implementation and possible uses, drawing a broad historical picture of its evolution. Observing its origins in the specialised practices of the healthcare facilities for the older persons, and its conversion into a tool of international strategies since the 1980s, it might be asked whether its underlying engine has not always been to reduce public spending. Throughout this process, and despite the official rhetoric of national and international bodies, it is possible that Active Ageing has always served to shift a growing burden imposed by the weight of good ageing onto individuals themselves, onto their families and social environments, and onto the market. If this general criticism were substantiated, then the labels and theories employed to denominate this strategy would have been merely instrumental for the institutional, political and scientific actors involved; each would have done so for their own reasons (the need to finance their work in the case of researchers, the need for administrations to give themselves an innovative sheen etc.).

Among all the uncertainties that the WHO has generated in recent years when reverting to the term "healthy ageing" instead of Active Ageing, the most obvious is whether this change will become generalised and signal the end of the concept. In any case, if the change of label entails the abandonment of the aspirations of the 2002 action plan, based on the trilogy of health-participation-financial security, to reduce everything again to the first, it seems clear that we are talking about a backward step. Beyond the concepts on which the strategies regarding old age and health are based, the challenges to which the initiative on Active Ageing attempted to respond remain very much with us. It would have helped for the WHO to explain to some degree its terminological and conceptual change, because it is also possible that, far from a retreat towards a more health-based conception of strategies to promote good ageing, the explanation lay in the broadening of the concept of "health" to extend it to the other two areas, participation and security. Even former proponents of Active Ageing as a strategic lynchpin are currently reclaiming other terms (healthy, successful etc.) without experiencing any difficulty in continuing to support the same strategic proposals. Fernández-Ballesteros et al. (2019) provide a manifest example of this attitude.

In any case, the need for a global, coordinated response to the revolutionary change in dynamics and demographic structures has not gone away. Rather, it will become increasingly urgent. The baby-boom generations will soon be reaching the age of 65 but there also will be a rapid expansion of life beyond 100 years, a radical modification of traditional human population survival. We are at the threshold of super-longevity, and this must begin to be raised seriously as a challenge (Araújo et al. 2016) beyond the simple increase of old age in age ranges as a whole.

Acknowledgments This study was funded by: i) SURVIVAL-APC project (MICINyU, Retos Investigación 2018; ref. RTI2018-097812-B-100; 2019-2021); ii) ENVACES project (MINECO/FEDER/UE; ref. CSO2015-64115-R; 2016-2019); iii) ENCAGE-CM Program (Comunidad de Madrid/Fondo Social Europeo; ref. S2015/HUM-3367; 2016-2019).

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