Oñati Socio-Legal Series (ISSN: 2079-5971)
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Challenges of health and ageing in Portugal's population: Promote dignity and non-discrimination

OÑATI SOCIO-LEGAL SERIES FORTHCOMING
DOI LINK: HTTPS://DOI.ORG/10.35295/OSLS.IISL.2338
RECEIVED 18 APRIL 2025, ACCEPTED 2 JUNE 2025, FIRST-ONLINE PUBLISHED 17 JUNE 2025

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Abstract

The article discusses the challenges that arise from the population's increasing longevity and the need to address complex physical and mental health issues to ensure high-quality health services for older people. It emphasises the importance of reflecting on and addressing these challenges to ensure there are more means and policies in the future, particularly in Portugal. Based on a qualitative methodology, the analysis draws on international legal instruments, public health policy frameworks, and scientific literature concerning ageing, health systems, and the legal implications of age-based discrimination. The WHO's Decade of Healthy Ageing 2020–2030 plan highlights the need for changes to promote healthy ageing. To meet the needs of older people, integrated care, long-term care, and primary healthcare services centred on the elderly are necessary. In Portugal, geriatric medicine is still not an officially recognized specialty or subspecialty. Additionally, awareness-raising campaigns on ageism and the prevention of age discrimination are crucial. Discrimination can have a detrimental effect on the provision of healthcare and the health of older people. While establishing or re-establishing formal equality for older people is important, it is not sufficient to guarantee their dignity. It is crucial to ensure the dignity and non-discrimination of older people through positive measures.

Key words

Health; ageing; equality; ageism; positive discrimination

I would like to express my deepest gratitude to the anonymous reviewers for their insightful and constructive comments, and to Leire Kortabarria for her meticulous and professional editorial assistance. This article is part of the Health4All research project, developed at the Instituto Jurídico Portucalense in collaboration with the Faculty of Medicine of the University of Porto and the International Chair of Bioethics.
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Resumen

El artículo analiza los retos que plantea la creciente longevidad de la población y la necesidad de abordar problemas de salud física y mental complejos para garantizar servicios sanitarios de alta calidad a las personas mayores. Destaca la importancia de reflexionar y abordar estos retos para garantizar una mayor dotación de recursos y políticas en el futuro, especialmente en Portugal. El análisis se basa en una metodología cualitativa y en instrumentos jurídicos internacionales, marcos de políticas de salud pública y bibliografía científica relativa al envejecimiento, los sistemas de salud y las implicaciones jurídicas de la discriminación por motivos de edad. El plan de la OMS para la Década del Envejecimiento Saludable 2020-2030 destaca la necesidad de introducir cambios para promover un envejecimiento saludable. Para satisfacer las necesidades de las personas mayores, es necesario contar con una atención integrada, cuidados de larga duración y servicios de atención primaria centrados en este colectivo. En Portugal, la medicina geriátrica todavía no es una especialidad o subespecialidad reconocida oficialmente. Además, son cruciales las campañas de sensibilización sobre el edadismo y la prevención de la discriminación por motivos de edad. La discriminación puede afectar negativamente a la asistencia sanitaria y a la salud de las personas mayores. Aunque es importante establecer o restablecer la igualdad formal para las personas mayores, no basta para garantizar su dignidad. Por tanto, es crucial garantizar la dignidad y la no discriminación de las personas mayores mediante medidas positivas.

Palabras clave

Salud; envejecimiento; igualdad; edadismo; discriminación positiva

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1. Introduction

The health challenges we face are complex and multifaceted. The COVID-19 pandemic, which exposed significant systemic weaknesses and exacerbated the vulnerability of older people, adds another dimension to these challenges.

Focusing on the health of older people is a crucial strategy for promoting a wide range of social and political objectives. It ensures that Portugal is a country for all, and that age is not a factor in harmful discrimination, exclusion, neglect, and abuse.

Given the scale of figures, the ageing population's impact on health means that existing legal standards must be adapted or new ones created to ensure adequate protection for the elderly. The Portuguese Constitution recognises health as a fundamental right (Article 64 CRP), and any limitations or adjustments to this right must respect the requirements of Article 18 of the Constitution, which imposes conditions of necessity, appropriateness, and proportionality on any restriction of fundamental rights. This framework is especially relevant in the context of ageing, where protective measures must avoid unjustified paternalism.

In addition, the principle of material equality (Article 13 of the CRP) necessitates the implementation of targeted measures to address systemic disparities. This can justify the adoption of positive discrimination, affirmative action, or special rights. Positive discrimination involves giving preferential treatment to address factual inequality, while affirmative action involves broader programmes to promote inclusion. Special rights are based on legally protecting vulnerability. However, these measures must be legally justified and comply with the principle of proportionality.

According to the latest world statistics, the number of people aged 60 and over is expected to double by 2050 and triple by the end of the century. By 2050, the number is projected to rise to 2.1 billion, and by 2100, to 3.1 billion. In 2021, this group accounted for 13% of the world's population, with 1 billion people. The same source predicts that the number of people aged 80 and over will triple, reaching 426 million in 2050, compared to 146 million in 2021 (United Nations 2022).

According to global predictions, the number of people aged 65 or over in Portugal is expected to increase from 2.2 million to 3 million between 2018 and 2080. This will result in a decline in the working-age population. By 2080, there will be 300 older adults for every 100 young people. The sub-groups of 75+ and 85+ will experience a more significant increase than the 65+ group, leading to an ageing population. Additionally, by 2060, people aged 85 or over could represent between 12.7% and 15.8% of the population (Portugal INE 2020).

These demographic projections make it clear that population ageing raises social, economic and legal concerns. This article examines how Portuguese health law and policy address the specific needs and vulnerabilities of older people, particularly in light of constitutional principles such as the right to health and material equality.

The analysis begins with an exploration of the link between ageing and discrimination, followed by an evaluation of national and international legal frameworks relating to ageing and health. It then considers future challenges and outlines possible ways to

strengthen the legal response. Finally, the article reflects on the adequacy of current standards and the need for a coherent, rights-based approach to ageing.

2. Ageing

There is no agreed age at which a person is considered elderly. This boundary is linked to socio-cultural trends and regional aspects. The United Nations uses the age of 60, while the World Health Organisation (WHO) sets the age at 65. The benchmark is between 60 and 65, but an upward trend is due to increased life expectancy. In Portugal, life expectancy ranges from 78 to 83 years (Portugal Pordata 2024).

For instance, Portuguese legislation defined elderly individuals as those aged 60 or over in 1991 (Article 6, paragraph a) of Decree-Law 391/91, 10 October). However, in 2016, the age was raised to 65 or over (Article 3, no. 2, paragraph b) of Decree-Law 58/2016, 29 August). Currently, an older adult is someone who is retired. Article 1 of Ordinance no. 307/2021 of 17 December 2021 states that the average age for accessing the old-age pension in 2023 is 66 years and four months.

Portuguese civil law defines 'old age' as 'velhice' (an expression used in articles 63, no. 3 and 4, and 64, no. 2, subparagraph b) of the Constitution of the Portuguese Republic). Moreover, it has several age brackets, including 60, 65, 70, and 80. According to Article 1720, no. 1, paragraph b) of the Civil Code, a marriage celebrated by a person reached 60 is subject to the separation of property. Additionally, Article 1979, no. 3 of the Civil Code prohibits a person over 60 from adopting a child unless the adopted child is the child of the adopter's spouse (Article 1979, no. 5 of the Civil Code) or if the adopted child is the child of the adopter's partner (Article 7 of Law no. 7/2001, 11 May). According to Article 6, paragraph a) of Decree-Law no. 391/91, of 10 October, which concerns the foster care system for the elderly and disabled adults, an elderly person is defined as someone 60 or older. The article stipulates that the older adult must be at least 60 years old as a prerequisite for foster care (Fidalgo 2020).

Article 1934, paragraph 1, subparagraph g) of the Civil Code allows individuals over 65 to renounce guardianship of children. Article 26, paragraph 4, subparagraph c), of law no. 6/2006, of 27 February, on the new urban lease regime, prohibits the termination of a lease contract solely based on the tenant being over 65. Article 2085, no. 1, paragraph a) of the Civil Code permits the family member responsible for administering the estate to relinquish this role at any time if they are over 70. Additionally, Article 114, no. 1 of the Civil Code states that in the event of presumed death, a declaration of presumed death may be requested five years from the last news of the absent person, provided that the latter has reached the age of 80 in the meantime.

Any attempt to automatically place older people in a category reserved for older people will unnecessarily restrict their rights. Moreover, creating a separate category for older people would reinforce age discrimination and also have a stigmatising effect (Fidalgo 2020). While it is true that there are circumstances arising from ageing that need to be taken into account by the law, the emphasis is not on the fact that a person has reached a certain age but rather on the need for protection arising from their specific condition (Vítor 2008).

The ageing of the population raises questions about the humanisation of ageing and the notion of vulnerability, understood not merely as a physical decline but as a multidimensional condition encompassing frailty, dependence, and social exposure. The concept of vulnerability has gained prominence in discussions on ageing, healthcare, and social policy, particularly when articulated with the notion of frailty. Although often used interchangeably, these terms refer to distinct but overlapping dimensions of human experience. As framed by Barranco (2014), vulnerability is not simply a condition of weakness but a fundamental aspect of the human condition that underpins the recognition of rights and the need for protective mechanisms. From this perspective, vulnerability is relational and structural, shaped by social, political, and institutional contexts. In the context of ageing, vulnerability frequently relates to health decline and reduced autonomy, but it also carries subjective meaning. Sarvimäki and Stenbock-Hult (2016), for instance, argue that vulnerability among older adults is not merely a sign of deficiency; rather, it may coexist with resilience and autonomy, reflecting a complex interplay between dependence and agency.

Frailty, on the other hand, is a clinical and functional concept that denotes increased susceptibility to adverse outcomes such as falls, hospitalization, and mortality. According to De Lepeleire *et al.* (2009), frailty is characterized by diminished physiological reserves and reduced resistance to stressors, and its identification is crucial in primary care settings. However, frailty extends beyond physical health. Markle-Reid and Browne (2003), in their review of frailty conceptualizations, emphasize its multidimensional character, which includes biological, psychological, and social components. They argue that frailty is shaped not only by health status but also by social determinants such as poverty and access to care, thus aligning it more closely with the broader notion of vulnerability.

When considered together, vulnerability and frailty offer a more nuanced understanding of older adults′ risks and challenges. Frailty may be viewed as a clinical manifestation of vulnerability, especially when physical decline intersects with social marginalization. Conversely, the broader concept of vulnerability provides a humanistic and ethical framework through which frailty can be interpreted - not merely as a deficit, but as a condition that calls for supportive and empowering responses. Integrating both concepts allows for a more comprehensive approach to care, grounded in respect for older individuals′ rights, dignity, and lived experiences.

With regards to equality and non-discrimination, these are dynamic principles that demand not only neutrality but also proactive measures to achieve fairness. As Rui Medeiros argues (2005, 115–127), proclaiming equality in rights and duties is, however, insufficient when not all citizens possess the same means and conditions to exercise those rights or to bear those duties. In this particular context, Canotilho (2003, 382-384) advances the argument that the constitutional clause of equality, as enshrined in Article 13 of the Portuguese Constitution, should not be interpreted as a static command of legislative neutrality. Instead, it functions as a dynamic normative vector, capable of evolving in tandem with the historical transformations of social conflict and the changing contours of distributive justice. Fredman (2011, 15-18) has developed a multidimensional normative model that reconceptualises the principle of equality, thereby transcending the traditional binary of formal and substantive approaches. She

hypothesises that the convergence of identity categories, encompassing gender, ethnicity, class and disability, functions as an amplifier of exclusion, engendering cumulative and systemically entrenched disadvantages that frequently evade conventional anti-discrimination frameworks. The Portuguese Constitutional Court (Judgments 186/90 and 39/2006) has recognised that eliminating structural barriers may necessitate differential treatment. Concurrently, seminal cases such as *D.H. and Others v Czech Republic* (ECHR, 2007) and *Bilka-Kaufhaus* (CJEU, 170/84) elucidate the phenomena of direct and indirect discrimination, respectively. Direct discrimination is characterised by explicit differential treatment based on protected grounds. In contrast, indirect discrimination occurs through neutral rules that disproportionately affect certain groups. Positive discrimination measures, upheld in *Grutter v Bollinger* (USSC, 2003) and affirmative-action policies, such as Portugal's gender-parity law, reflect the obligation to translate substantive equality into practice. As Dworkin (1996, 1-2). contends, authentic egalitarianism necessitates "equal concern and respect," thereby substantiating the legitimacy of bespoke interventions to ensure substantive inclusion.

2.1. Ageing - a factor of discrimination

The increase in the number of older people was initially perceived negatively, with age being a factor of social discrimination. This is known as ageism (Marques 2011). The concepts created around the cost of ageing continue to give rise to negative representations of ageing and older people, fostering prejudice, promoting the phenomenon of ageism (age discrimination) and encouraging isolation, thereby exposing older people to social exclusion (Rebelo and Penalva 2004, Jacob 2013).

Many studies have comprehensively analysed the impact of structural and individual ageism on older people in many areas of health.

Ageism was first defined by psychiatrist and gerontologist Robert Butler (1969) as the systematic stereotyping of and discrimination against people because of their age, on a par with racism and sexism. Older people are called as senile, rigid in their thinking and manners, old-fashioned in their morals and skills... Ageism allows the younger generation to see older people as "different" so that they stop identifying with their elders.

Ageism can manifest itself in two main ways: implicitly, through unconscious thoughts, feelings and behaviours, or explicitly, through conscious actions or verbal expressions (Iversen *et al.* 2009).

Furthermore, ageism is not limited to being directed at others; it can also be directed at oneself (Ayalon and Tesch-Römer 2017). Exposure to ageism over time can lead to the adoption of stereotypical attitudes, as described by Levy (2009) in stereotype embodiment theory. Many older adults tend to internalise the negative stereotypes of ageism that continue to be perpetuated in today's society and tend to limit themselves to age-related stereotypes, becoming weak, unhealthy and even less able to accept new learning opportunities (Streb *et al.* 2008).

A distinction can be made between 'individual ageism', which includes culturally rooted negative age-related stereotypes and negative self-perceptions of ageing that affect the health of older people, and 'structural ageism', which refers to explicit or implicit

policies, practices or procedures of social institutions that discriminate against older people (Butler 1989, 2005).

Ageism seriously impacts all aspects of health, defined by WHO as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[1] Its impact on health is as damaging as, if not worse than, racism - a form of prejudice and discrimination whose effects on health have been widely studied (Chang *et al*. 2020).

A WHO-commissioned global review of the effects of ageism on health, which included 422 studies from 45 countries, found that in 405 studies (96%), ageism was associated with the worst outcomes in all areas of health (Chang *et al*. 2020).

According to the WHO (2021), negative attitudes towards ageing and older people have a significant impact on their physical and mental health. The report by the Royal Society for Public Health (RSPH 2018) and Calouste Gulbenkian Foundation, entitled "That Age Old Question - How attitudes to ageing affect our health and wellbeing", goes in the same direction. Older people who feel they are a burden perceive themselves as having less value, putting them at risk of depression and social isolation. The ageing process is associated with a progressive decline in the efficiency of the metabolic process, which increases the likelihood, for these people, of feeling even more frail.

WHO (2021) warns of the link between discrimination against older people and the consequences for their health. Older people who have a negative view of their ageing do not recover well from disabilities and live on average 7.5 years less than older people who have a favourable view of ageing (Levy *et al.* 2002, Centre for Ageing Better 2021). Discriminatory practices related to ageism are mainly related to the labour market and health policies.

Ageing is a typical dynamic process, not a disease. Although there is a decline in functional capacity, which tends to confine older people to limited family or neighbourhood interaction and situations of loneliness in their own homes or institutions, this should not justify the exclusion of older people from social life. In this sense, WHO affirms that the longer older people remain healthy, non-disabled, and productive, the better their quality of life is, the more significant their contribution to society is, and probably the lower the expenditure on health and social services. The definition adopted by WHO in 1948 states that "health is a state of complete physical, mental and social well-being and not merely the absence of disease".[2] The WHO defines health as complete well-being, not merely the absence of disease. This is especially relevant to older adults, whose health is about more than the absence of disease. Empowerment enables individuals to make decisions about their own health, fostering self-determination, self-esteem and self-confidence (Glicksman 2018). Autonomy is the right of older persons to make informed life decisions, respecting their agency even with limitations (Beauchamp and Childress 2013). Participation is the active involvement of older adults in personal and community health, reducing social isolation and promoting inclusion (Baeriswyl and Oris 2023). Resilience, the capacity to adapt, supports well-being, fostered by social support and cognitive stimulation (Resnick *et al.* 2018).

[1] See: "What is the WHO definition of health? (https://www.who.int/about/frequently-asked-questions)
[2] Quoted in the preamble.

Together, these concepts enrich the WHO's definition, integrating social, psychological, and legal dimensions, and promoting dignity and full rights later in life.

According to Buss (2000), although health and quality of life are used synonymously, they are concepts with their specificities and a relationship between them. It is also necessary to distinguish 'health-related quality of life' from 'health status', although the two are often used synonymously in the literature (Guyatt *et al.* 1993). Quality of life is a fundamental aspect of health, not vice versa (Renwick and Brown 1996). Furthermore, autonomy and independence are associated with perceptions of health (Santos *et al.* 2008).

A good example is the WHO's *Principles of Ageing, Active Ageing, a Policy Framework*, published in 2002. This document defines ageing as a process by which health, participation, and security opportunities can be optimised to ensure the quality of life as people age. These factors have led to a shift in public policy towards older people. These policies have moved away from a supportive and residual perspective towards a genuine inclusion policy and consideration for older people.

However, age discrimination is an obstacle to developing suitable policies on ageing and health because it affects how problems are analysed. We must continue to work to change society's negative stereotypes and promote a change of mentality among our citizens.

2.2. Ageing and health policy in Portugal

2.2.1. National legal and policy framework

The Portuguese Constitution recognises health as a fundamental right (Article 64), and any limitation or adaptation of this right must comply with the requirements of Article 18, which imposes conditions of necessity, appropriateness, and proportionality on any restriction of fundamental rights.

The Basic Health Law was replaced by the new Law of Health Bases (Law n.º 95/2019 of 04 September 2019). This law advocates a vision of co-responsibility for health in all its dimensions. The right to health protection is a shared responsibility of the individual, society and the State. It includes lifelong access to health promotion, prevention, treatment, rehabilitation, continuing and palliative care. While the principles of material equality and non-discrimination are long-standing and foundational in Portuguese law (Article 13 CRP), the demographic ageing of the population has led to a renewed emphasis on ensuring their concrete application in protecting the rights of older persons - particularly in terms of access to health, well-being, and autonomy, thereby promoting their ability to exercise choice and control over their lives.

The Directorate-General for Health (DGS) approved the National Programme for the Health of Older People in Portugal in 2004.

Other significant public health actions followed, including:

- - the National Strategy for Healthy and Active Ageing (2017),
- - the proposal for a National Health Plan for People with Dementia (2018),

- and the National Palliative Care Programme (2004), approved in line with WHO and EU guidelines, recognising that palliative care requires a specific organisation and approach, provided by technical teams prepared for this purpose. This programme addressed a critical structural gap in Portuguese healthcare systems at the time.

It is worth highlighting the importance of the National Health Plan 2004–2010 – the current plan covers 2021–2030 – and the National Programme for the Health of Older People 2004–2010, as they were the first two official documents addressing elderly health policy in Portugal. The latter recognised the need to increase the number of years of independent living and improve professional-elderly relationships. Its three pillars were: promoting active ageing across life; adapting healthcare to older persons' needs; and developing intersectoral environments for autonomy and independence.

Other major programmes include:

- The National Network of Integrated and Continuous Care (Decree-Law No. 101/2006),
- The Dental Health Project for the Elderly (2008),
- The National Accident Prevention Programme (2010),
- The National Programme for the Promotion of Healthy Eating (2012),
- The National Programme for Health Education, Literacy and Self-Care (Decree No. 3618-A/2016),
- The National Programme for the Promotion of Physical Activity (2016),
- The Health Literacy Action Plan 2019-2021.

Law 25/2012, of 16 July, on Advance Directives enables granting a mandate in case of incapacity, including provisions for the healthcare proxy and the Living Wills Registry ("Testamento Vital").

The Solidarity Supplement for the Elderly (Decree-Law No. 232/2005) and a complementary healthcare system (Decree-Law No. 252/2007) were created to reduce inequality and improve quality of life.

It is also relevant to include Law No. 46/2006, of 28 August, which prohibits discrimination based on disability or aggravated health risk. In this particular legislative text, the legislator defines 'people with an aggravated health risk' in addition to direct, indirect and positive discrimination concepts. Accordingly, as delineated in Article 3(c) of the aforementioned Law, the definition of 'aggravated health risk' is as follows: this term refers to a state of being in which an individual is afflicted with a pathology that results in a chronic, progressive, and potentially disabling organic or functional impairment. This, in turn, adversely affects the individual's quality of life across the physical, mental, emotional, social, and economic domains. In extreme cases, the condition may lead to premature invalidity or substantially reduced life expectancy.

However, in various studies on the relationship between access to healthcare and old age in Portugal, the most prominent factor identified was socioeconomic deprivation (Ribeiro *et al.* 2017), with older people in more disadvantaged socioeconomic situations experiencing a lower quality of life (Henriques *et al.* 2020). In addition, municipalities with a higher proportion of elderly citizens also have a lower proportion of doctors per

1,000 inhabitants. These municipalities are concentrated in rural inland areas, which have historically been poorly served by healthcare facilities, particularly primary care units (OECD 2019).

2.2.2. European and International Instruments

From a more global perspective about the fundamental rights of older citizens, in 1948, the United Nations adopted the Universal Declaration of Human Rights, which recognises the dignity and worth of every human being, regardless of age (Article 25). However, in order to strengthen action in favour of older people, given the expected increase in the number of older people in the world, those who wish to correct or improve legal and social rules must go back to the origins of the debate, i.e. to 1982, when the United Nations General Assembly organised the first World Assembly on Ageing, in Vienna, this led to the International Plan of Action on Ageing, divided into sixty-two fundamental points, one of which was health.

In 2000, the Charter of Fundamental Rights of the European Union, including social rights, was adopted in Nice. The Treaty of Lisbon gave the Charter the same legal value as the Treaties and formally guaranteed the autonomy of social policy (Articles 3(3) and 6(1) of the Treaty on European Union). From then on, social rights became fundamental rights and enjoyed the same legal protection as fundamental rights.

The Charter of Fundamental Rights of the European Union contains a provision relating to older people, stating that the European Union recognises and respects the right of the elderly to lead a life of dignity and independence and to participate in social and cultural life (Article 25 of the Charter). This is the only provision that explicitly refers to older people, but it encapsulates the current, modern approach to ageing: active ageing. We are moving from a simple, platonic protection of the elderly to a genuine right to old age. This provision must be read in conjunction with the European Social Charter, which contains a provision for older people (Quadros 2018, 209). This standard recognises the right of older people to remain active members of society for as long as possible. It aligns with the concept of active ageing, which is still relevant today. It also recognises the right of older people to make free choices about their lifestyle and to maintain their independence as long as possible (Article 23 of the Social Charter).

At the European level, the European Court of Human Rights plays a central role in promoting equality and addressing discrimination. The European Court of Human Rights applies the European Convention on Human Rights (ECHR). Article 14 prohibits discrimination concerning rights in the Convention, while Protocol No. 12 introduces a general ban on discrimination. The Court recognises several forms of discrimination, including direct (*Aziz v Cyprus*, 2004) and indirect (*D.H. and Others v the Czech Republic* 2007, *Sampanis and Others v Greece* 2008, *Horváth and Kiss v Hungary* 2013).

In September 2022, the European Commission presented a European strategy for care with the following main objectives :

- To guarantee high-quality, affordable care services accessible to all. A large number of people aged 65 and over - almost half - need long-term care, but it remains unaffordable, unavailable or inaccessible. What is more, waiting lists are long and procedures cumbersome;

- to improve the situation of people needing care and those who provide it, whether professionally or informally.

The Commission also offers technical support to Member States through a new flagship project, "Towards person-centred integrated care," and financial support through the future Horizon Europe partnership on health and care system transformation. Given that most care providers are of the average level of qualification, she suggests that all types of care providers should be able to participate in high-quality education and training and career development programmes to ensure the quality of care provided.

Implementing these reforms is essential to promote justice and dignity in ageing policy across the EU.

3. Legal and policy framework for the rights of older people

3.1. Future challenges and strategic directions

We must not forget that it is not enough to express intentions in legislation. The ageing population's right to equality and health must be clearly and effectively guaranteed. People's views of ageing and age-related stereotypes impact various individual health outcomes. For example, age discrimination can be a form of social exclusion and can affect an individual's mental health and life expectancy. One study found that people with more positive perceptions of ageing lived on average, 7.5 years longer than those with less favourable perceptions of ageing (Levy *et al.* 2002).

Kingston, Herrera and Jagger (2018) studied the future health needs of older people in England. They found that over the next 20 years, the population of England over the age of 65 will not only see an increase in the number of independent individuals (4.2 years for men; 0.9 years for women), but also an increase in those requiring complex care. The study also predicts a rise in the number of people aged 85 and above who will have higher levels of dependency, dementia, and co-morbidities.

This highlights the urgent need for health and social care to adapt to this growing population. Memory loss is commonly associated with ageing and attributed to a biological process. However, research suggests that negative stereotypes and discrimination against older individuals can negatively impact memory performance (Levy 1996).

Several other studies, such as those by Levy *et al.* (2000, 2016, 2018, 2020) and by Kang and Kim (2022), show that people's perceived negative judgements about their age can exacerbate stress, while the feeling of being younger, of having a "younger subjective age", can help to buffer the decline in functional health, offsetting and counterbalancing the detrimental effects of stress on functional health (Wettstein *et al.* 2021). Other studies suggest that negative attitudes toward ageing can interfere with a patient's recovery (Levy *et al.* 2006, 2012).

The accumulation of experiences or perceptions of ageism (age discrimination) is also associated with an increase in depressive symptoms, as well as stress, as previously reported, and anxiety, as shown in a study by Lyons *et al.* (2018). Zhang *et al.* (2019) reached the same conclusion. They suggest that negative age-related stereotypes are associated with higher levels of depression, loneliness and undervaluation of the 'self'.

Psychological and emotional factors, alongside biological processes, greatly affect the health of older people. A study of 5,000 older individuals revealed that a positive perception of age lowers the risk of developing dementia, even for those genetically predisposed to it (Levy *et al*. 2018).

A study in *The Lancet Public Health* (GBD 2022) predicts that the number of people worldwide with dementia will triple to 153 million by 2050 due to an ageing population and demographic growth. Portugal is projected to have 351,504 people with dementia in 2050, nearly double the number in 2019 (200,994).

Despite a decrease in dementia cases, Europe is expected to see the number of people with dementia double by 2050, according to a report by Alzheimer Europe (2019). The WHO (2017) endorsed the Global Action Plan on Dementia (2017-2025), emphasising the urgent need for governments to address dementia care globally. The Portuguese Order of Psychologists (OPP 2019) highlights the insufficient response to dementia in Portugal and advocates for recognising it as a public health issue. This would improve the quality of life for individuals and their families by providing access to quality social and health services. The OPP recommends early diagnosis, personalised healthcare throughout the dementia process, a range of interventions including pharmacological, psychological, and neuropsychological rehabilitation, palliative care and other forms of support such as home assistance, transportation, and structured day activities.

Combating ageism among medical staff, as well as comprehensive gerontological training aimed at breaking down stereotypes and helping health professionals to fulfil their role as moral defenders against discrimination against older patients, should also be a priority. The level of ageism practised by health and social care workers towards patients appears to be high, although it is still uncertain (São José and Amado 2017, Wilson *et al.* 2017). According to research published in 2020 (Chang *et al*. 2020), in 85% of the 149 cases studied, age was a factor in determining who received certain medical treatments and who did not.

Several studies also show that mental health professionals are not sufficiently trained to work with older patients, that they do not have the necessary skills to diagnose older patients with mental disorders, that they have negative attitudes towards this population, and that they are less willing to work with them (Bodner *et al.* 2018).

Suppose healthcare professionals are not necessarily aware of the specific health problems of older people and consciously or unconsciously discriminate against them. In that case, care must be taken to ensure that artificial intelligence (AI) technologies do not reproduce implicit and explicit social biases. Especially when you consider that AI is the future and the WHO (2022) states that AI technologies for health can strengthen health and social care for older people by helping identify risks and empowering them to manage their own needs, individually or in collaboration with their healthcare providers. For AI technologies to play a beneficial role, ageism must be identified and eliminated from their design, development, use and evaluation.

Inadequate healthcare for older people is also a form of violence against them, whether it is institutional violence, violence resulting from discrimination, or violence of a structural, social or systemic nature (Glasgow and Fanslow 2007). The OECD (2021) reports need more planned or implemented responses to meet older people's current

and future healthcare needs in the European Union. The increase in life expectancy has not been matched by an increase in healthy life expectancy at 65. The report explicitly mentions Portugal, where the number of older people receiving continuous care, including home care, was below the OECD average in 2019. The text emphasises the importance of investing in long-term care networks and qualified professionals and promoting healthcare for the elderly. On the other hand, in Portugal, geriatric medicine has not yet been recognised as a speciality or subspeciality, although it has been recognised as a medical competence (Reiter *et al.* 2014). Furthermore, no specialised services are dedicated to geriatric rehabilitation (Grund *et al.* 2020). Despite its recognised importance, geriatric medicine is still an area of study that is not systematically integrated into the curricula of all medical students, i.e. no medical internship programme incorporates geriatrics as a compulsory area. Given the circumstances in Portugal, the elderly population is the group most vulnerable and sacrificed by the system. As of late 2023, Portugal had only 101 geriatricians officially recognized as specialists in elderly care, according to the Portuguese Medical Association.

Violence against older persons is a complex and multifaceted issue with serious implications for health and human rights. It encompasses not only physical harm, but also psychological abuse, neglect, and systemic or institutional practices that undermine dignity and autonomy. In the family context, such violence may arise from caregiver fatigue or economic dependence; in institutions, it often reflects poor staffing, inadequate training, or discriminatory attitudes within care systems. In Portugal, for example, a study by Gil *et al*. (2014) found that 12.3% of individuals over the age of 60 had experienced violence in the past year - yet under-reporting remains a significant barrier to prevention.

Healthcare professionals play a crucial role in detecting and addressing elder abuse. However, several studies highlight a widespread lack of training. Medical students often fail to recognise elder abuse until there is significant evidence, suggesting a lack of training in this area (Fisher *et al.* 2016). Many health professionals feel that they have received inadequate training in elder abuse and feel that further training is needed (Wagenaar *et al.* 2010). A significant number of professionals, particularly those under 30, have not received specific training on elder abuse (Vognar and Gibbs 2014). Although some studies (Eraslan *et al.* 2018, Corbi *et al.* 2019) show improvements in training and awareness, much remains to be done. Elder abuse, which is a violation of human rights, is a widespread public health problem that is expected to increase in the future (Berman and Lachs 2011, Caines and Ward 2017, Yon *et al.* 2019). Ensuring robust training, implementing accessible complaint mechanisms, and promoting cross-sectoral collaboration are essential to transform protection from a legal ideal into a practical and ethical imperative. Whether perpetrated by society, family, or professionals, violence against older adults must be systematically addressed to safeguard the well-being and dignity of ageing populations.

3.2. Discussion

Support and social solidarity for the elderly and the need for human rights education are essential to combat the violation of a primary and fundamental right: the right to

equality. Hence, we can all play a role in reversing the various forms of discrimination against older people.

Older people belong to a vulnerable group whose vulnerability is accentuated. For the purposes of drafting and applying laws, they are included in the category of vulnerable persons, i.e., those who, by force of circumstance, are already in a situation of inequality and must be the subject of "positive discrimination" to safeguard their dignity (Barboza 2008).

As a fair criterion of equality, the right to difference seeks to recognise the existence of multiple positive discriminations between subjects. Overcoming inequalities requires measures that guarantee equal rights and dignity between different people. Applying the right to be different as a right to equality does not mean granting privileges. Prejudice and discrimination, far from upholding the right to a dignified existence, reduce the quality and conditions of life.

The Constitution of the Portuguese Republic has established the principle of equality as a fundamental legal principle. Article 13 states that all citizens have the same social dignity and are equal before the law and that no one may be privileged, favoured, disadvantaged, deprived of a right or exempted from a duty based on descent, sex, race, language, territory of origin, religion, political or ideological conviction, education, economic situation, social condition, or sexual orientation. This list is indicative and not exhaustive, and other potentially discriminatory factors may be considered, such as health, age or vulnerability.

The principle of equality in applying the law gives rise to a right to non-discrimination.

Canotilho and Vital Moreira (2007) consider that equality consists of a specific and autonomous subjective right of a defensive, positive and corrective nature, which imposes measures to correct de facto inequalities. This principle is not taken up by the Constitution purely formally, as a legal equality prohibiting discrimination. A global reading of the Constitution allows us to understand the principle of equality as a principle that imposes tasks on the State, such as the promotion of concrete equality between all Portuguese (article 9, paragraph d) of the CRP) and the construction of equality between men and women (article 9, paragraph h) of the CRP), implying that to achieve this it is necessary not only to overcome obstacles but also to adopt measures of positive discrimination, which in our case are aimed at reducing inequalities in the health of older people. It is precisely because these measures aim to address and reduce existing inequalities that they are referred to as "positive." In contrast to neutral or passive approaches that merely prohibit discrimination, positive measures involve proactive steps taken by the State to create conditions that enable disadvantaged groups – in this case, older persons – to achieve real and effective equality. These measures acknowledge that formal equality, defined as the treatment of all individuals equally, is frequently inadequate when historical, social, or economic impediments endure. Consequently, the promotion of access to healthcare and well-being for older adults is a positive measure that seeks to level the playing field, ensuring that individuals facing systemic disadvantages can enjoy the same opportunities and rights as others. This active commitment to overcoming structural inequalities defines such discrimination´s "positive" nature.

The right to care is increasingly recognised as a fundamental human right, especially in the context of ageing, dependency, and the global demographic shifts reshaping societies. Care should not be understood merely as a private, familial, or medical obligation, but as a collective social and ethical duty, rooted in human dignity, equality, and inclusion. This perspective challenges long-standing assumptions that equate care with charity or passive protection, advocating for a rights-based approach that affirms the value and autonomy of those who require support.

The special issue of the *Oñati Socio-Legal Series* (Neto *et al.* 2022), titled *Vulnerabilidad y cuidado: Una aproximación desde los derechos humanos*, provides an important contribution to this emerging framework. It brings together interdisciplinary perspectives that explore the legal, social, and institutional dimensions of care, including analyses specific to the Portuguese context. These contributions underscore the need to reframe care not as a residual function of the welfare state, but as a central component of democratic citizenship and intergenerational justice.

Understanding care in these terms demands a paradigm shift: from paternalistic models of protection to frameworks that prioritize active empowerment; from fragmented and conditional service provision to coordinated, accessible, and person-centred support systems. Such a shift also entails recognising informal and unpaid care work - often performed by women - as a critical part of the social infrastructure, deserving public recognition and support.

Embedding this rights-based vision of care into public policy is essential for safeguarding the rights of older persons and strengthening the foundations of solidarity within the welfare state. It calls for integrated legal and institutional mechanisms that ensure continuity of care, accountability, and participation and respond to the diverse and evolving needs of ageing populations. Only through this comprehensive and inclusive approach can societies ensure that care is not a privilege, but a guaranteed right for all.

The Portuguese Constitution also stipulates that the State must protect the most vulnerable, especially the elderly (Article 72) and the sick (Articles 63 and 64). Article 18 of the Portuguese Constitution, while not exclusively pertinent to older persons, is pivotal in preserving their fundamental rights. The fundamental rights enshrined in the document encompass dignity, autonomy, and social protection, ensuring their direct enforceability against both public and private entities. Furthermore, ensuring that any limitations imposed on these rights are strictly necessary, lawful, and proportionate is imperative. This is to avoid unjustified restrictions, particularly within institutional care or medical decision-making contexts. The principle of proportionality balances the protection of fundamental rights with the need to avoid unjustified, condescending paternalism (Mac Crorie 2020) towards older people, ensuring that any state intervention is necessary, appropriate and as least restrictive as possible (Miranda 2015). In conjunction with Article 72, which explicitly protects the rights of the elderly, Article 18 reinforces the constitutional guarantee of complete and adequate protection of older persons' fundamental rights.

The jurisprudence of the Portuguese Constitutional Court interprets the principle of equality, a parameter for assessing the constitutionality of rules, not in a positive sense, in the sense of promoting social equality, but only in a negative sense, prohibiting

arbitrariness, and acting in a double sense, either by legitimising differences when they are not based on objective and reasonable grounds, or by preventing disparities when they are not based on objective and reasonable grounds. One of many examples is the Constitutional Court's judgment n.º 232/2003 which defines this dimension of the principle of equality as the legislator must treat what is essentially the same in the same way and treat what is essentially different in a different way (as enshrined in Article 13(1) of the Portuguese Constitution). This prevents arbitrariness and acts as a negative control principle over legislative options.

Different treatment of situations based on the same factual circumstances or equal treatment of situations based on different factual circumstances violates the principle of equality if no logical reason can be found for the legal differentiation or for equal legal treatment, which follows from the nature of things or which is otherwise comprehensible in concrete terms, i.e. if the provision must be qualified as arbitrary. However, the fact that the legislator is subject to the principle of equality does not limit the freedom of the interpreter, and it is up to the legislator to identify or qualify the factual situations that will serve as reference points for the equal or unequal treatment of certain situations. There is a violation of the principle of equality as a prohibition of arbitrariness if no material support can be found to justify the legislative measure. As the Constitutional Court stated in judgment no. 353/2012, legal equality is always proportional, so inequality that can be explained by comparing different situations is also not immune from a proportionality judgment. The degree of inequality must be proportional and not excessive.

The European Court of Human Rights, when faced with the question of equality, has held, in the light of Article 14 of the European Convention on Human Rights (Council of Europe), that there is discrimination only where there is a difference in treatment between persons who are in comparable situations (*Hämäläinen v Finland*, § 108, Application n.º 37359/09, of 16 July 2014) or where States do not apply different treatment to persons whose situations are appreciably different (*Thlimmenos v Greece*, § 44, Application n.º 34369/97, dated 6 April 2000). It is important to remember that Article 14 prohibits discrimination only in the enjoyment of the rights and freedoms outlined in the Convention and is not a standalone provision. In addition, Protocol No. 12 to the Convention introduces Article 1, which provides an autonomous and broader prohibition of discrimination, extending beyond the scope of the Convention rights. This article demands that no one is discriminated against on grounds such as race, sex, religion, political opinion, national or social origin, or any other status, in public or private life. It is a more comprehensive and far-reaching norm that protects against discrimination, even beyond the scope of human rights recognised by the Convention.

In this respect, the Court recalls that Article 14 does not prohibit a Member State from treating groups differently in order to correct "factual inequalities" between them; indeed, in certain circumstances, the absence of differential treatment to correct an inequality may in itself constitute a violation of the provision in question (Pelloux 1968 or *Muñoz Diaz v Spain*, § 48, Application n.º 49151/07, dated 08 March 2010). In addition, the Court has accepted that a policy with a disproportionately adverse effect on a group of persons may be regarded as discriminatory, even if it is not explicitly targeted at that group. In addition, the Court has accepted that a policy that has disproportionately

prejudicial effects on a group of persons may be considered discriminatory, even if they are not explicitly aimed at that group and if there is no discriminatory intention, provided that the policy lacks "objective and reasonable" justification (*Baio v Denmark*, § 91, Application n.º 38590/10, 24 May 2016, among others). In other words, indirect discrimination, like direct discrimination, violates the principle of equality.

Legal equality, as liberal or formal legal equality, is insufficient to protect the health of older people. Precisely because it is linked to an abstract idea of equality and a universal notion of the subject of the law, it does not encompass the quite natural difference between subjects and groups of subjects, and it even exacerbates this difference. This is why it is essential to implement positive discrimination measures in health policy, granting certain specific rights or advantages to the elderly, who are more vulnerable and deprived of sufficient medical care or care adapted to their condition.

Positive discrimination is an instrument to (re)establish effective equality (Campos and Martinez de Campos 2020). Furthermore, European human rights law still fails to recognise 'age' as a distinct and unique discriminatory factor, even in cases such as Carvalho's, where ageism — the systematic stereotyping and discrimination against older people — is clearly and unequivocally described (Mantovani *et al.* 2018).

The particular duties to protect vulnerable persons are closely linked to positive discrimination. The State must intervene to protect those who find themselves in situations of power asymmetry, whether concerning public bodies, private bodies or other individuals and to protect those who no longer have the means to exercise their fundamental rights freely and autonomously, as in the case of some elderly persons who, due to specific vulnerabilities, face barriers to full participation. However, it is crucial to avoid generalizations based solely on age. Not all older individuals experience such limitations; interventions should, therefore, be tailored to individual circumstances to prevent age-based stereotyping and unjustified paternalism. The latter, due to biological and psychological actors, but also because of entrenched ageism, may face health problems that increase their dependence on the care of third parties, such as the State, public and private institutions, family and society in general.

Several studies show that a better perception of ageing can significantly reduce ageist behaviours (Cherry *et al.* 2019, Donizzetti 2019, Cooney *et al.* 2021), as in Portugal (Fernandes *et al.* 2022). According to Kim *et al.* (2019, 105), it is essential to develop anti-ageing policies and "increasing positive self-perceptions of ageing (...) could be the key to a better quality of life for older adults".

Analysing the specific problems of vulnerable groups requires a specific application of the principle of equality (Neto 2022).

Preventing violence against older adults in Portugal requires a multifaceted approach, with coordinated strategies across public health, legal, and social sectors. The Smart Against Ageism (2024) project has proposed a practical recommendation for addressing ageism in healthcare settings. These are summarised in the following table:

TABLE 1

Education and training - Healthcare providers and professionals could undergo training to recognise and combat ageist biases. This includes understanding the diversity of health needs among older people.
Patient advocacy - Older patients and their families can become advocates for their healthcare. This involves understanding their rights, asking questions, and seeking second opinions.
Research and data collection - Gathering data on ageism in healthcare can help identify trends and areas that require intervention. Research can also highlight the economic and health impacts of ageism.
Public awareness - Raising awareness about ageism and its consequences is essential. Campaigns and educational initiatives can help combat stereotypes and biases by giving recommendations for policymakers.
Policy changes - Advocacy groups, policymakers, equality and diversity officers can work to change discriminatory policies and regulations that perpetuate ageism in healthcare.

Table 1. Recommendations from the Smart Against Ageism (2024) Project.

These measures are essential for building a care model that is both ethically grounded and effective in addressing the real needs of Portugal's ageing population.

The sustainability of the National Health Service (SNS) and the defence of equity make it imperative to adopt a new strategic vision. In the specific case of geriatric medicine, health literacy and the use of technology should be considered central pillars of this strategy. The potential of smart homes, for example, must be harnessed to support the well-being and autonomy of older people - even though this area is barely addressed in the proposed National Strategy for Active and Healthy Ageing 2017-2025 (Estratégia nacional 2017-2025).

Public policies must also prioritise awareness-raising campaigns and integrate the recognition of informal carers' roles, as defined in the *Estatuto do Cuidador Informal* (Law No. 100/2019 of 6 September), which acknowledges and regulates informal caregivers' rights and support measures.

Smart Homes represent tremendous potential in well-being, the promotion of independent living, and disease prevention and monitoring. By using different types of sensors (Franco *et al.* 2014), they allow both a quick assessment of vital signs (such as temperature, blood pressure, heart rate, cholesterol and glucose levels, etc.) and a faster response in the event of a medical emergency (Sundmaeker *et al.* 2010).

It is essential to create geriatric units in hospitals and multidisciplinary ageing teams composed of doctors, psychologists, social workers and other professionals. The inclusion of specific geriatric training in medical education is also essential to ensure a clinical and social response that meets the needs of this population.

3.3. Structuring a health response to ageing challenges

Societies must adapt to a demographic profile different from the twentieth century, with multiple needs, where the vulnerability associated with ageing is manifested in

particular regarding health. Moreover, creating systems capable of defending and protecting the oldest and most vulnerable populations is essential.

There is still a long way to go. Recently, Portugal's health regulator identified waiting times as the main problem in the Continuing and Integrated Care network, which has 15,800 beds at the end of 2022. On 31 December 2022, 1,562 users were waiting for a vacant place in these services, 252 more than a year earlier.

The health needs of older people tend to increase with age due to their frailty, a fact noted by several authors (Santos-Eggimann *et al.* 2009, Collard *et al.* 2012, São Romão Preto *et al.* 2018). This means an increase in the workload of health services, which are already unable to cope with the many demands placed on them for a variety of reasons: lack of specialised staff (Meira *et al.* 2023, 49), lack of public health policies aimed at the elderly, economic shortcomings of the Portuguese National Health Service; a degree of ageism that persists both at the state level and among health professionals, which hinders the development of health policies adapted to the elderly, etc. Ageism is harmful to the health of older people because it can lead to a deterioration in their quality of life. Ageism is terrible for everyone, young and old. A tenacious fight must be waged against this problem, this violation of human rights, to prevent discrimination from hindering these people's access to health, dignity, and well-being. This fight could begin with the implementation of positive discrimination for older people.

Healthcare often involves ethical issues that challenge professional careers, informal carers, and society in general (Arena Ventura *et al.* 2023). In the case of older people, the ethical challenges are of a particular nature that we need to recognise and seek to address. Since the turn of the century, reflections on the ethical challenges of caring for the elderly have begun to appear, such as P. Muller's 2004 article *Ethical Issues in Geriatrics: A Guide for Clinicians*. Many other texts deserve special mention, such as the 2014 opinion of the National Ethics Council for the Life Sciences in Portugal on the vulnerability of the elderly (Portugal CNECV), especially those living in institutions, or the Council of Europe's guide on the decision-making process for medical treatment, published in the same year (Barreto 2022). However, ethics is needed more than just medical decision-making (Ikeda and Teixeira 2023).

Ethics in the health of older people is a rule that must be applied everywhere: in the national health service, in health policy, in the training of doctors, nurses and other health professionals, and in society as a whole.

In summary, the following policies are proposed, always from a humanist and ethical perspective:

1. It is recommended that geriatrics courses be incorporated into the curricula of medical schools.
2. The establishment of a residency programme in geriatrics is recommended.
3. The implementation of multidisciplinary geriatric units is recommended.
4. The development of smart homes can potentially enhance the quality of life for the elderly population.

When organising these units, it is recommended that countries with advanced systems be considered. The challenges faced by more experienced systems can inform a tailored model for Portugal.

The prevailing perception of working with the elderly as unattractive necessitates urgent awareness and attitude changes among healthcare professionals. Enhancing It is the visibility and desirability of Geriatric Medicine and cultivating an appreciation and respect for geriatric care is imperative.

4. Conclusion

Like many ageing societies, Portugal must restructure its healthcare system to meet the increasing demands of an older population. Ageism, both implicit and structural, remains a significant barrier to adequate and equitable care. This paper has shown how demographic trends necessitate a comprehensive rethinking of the legal, institutional, and professional frameworks for healthcare delivery.

Guaranteeing equal access to quality care for older adults demands not only legislative safeguards, but also the implementation of proactive, supportive public policies. These include the formal recognition of geriatric medicine, integrating age-related education in medical training, and creating multidisciplinary units dedicated to ageing-related conditions. Social responses must also acknowledge the reality of dependence, frailty and informal caregiving, promoting dignity and autonomy in line with human rights standards.

The recognition of vulnerability and the fight against ageism should guide future strategies. Positive discrimination, far from creating privilege, is necessary to restore fairness and guarantee the effective exercise of fundamental rights. Only through a shared societal effort – involving professionals, families, institutions, and the State – can we ensure that ageing does not become synonymous with an exclusion but with recognition, inclusion, and protection.

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