Chapter

Perspective Chapter: Age Is Not Just a Number – Understanding Ageism and Its Health Implications for Older Adults

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Abstract

Demographic changes present both benefits, such as the increased longevity of older individuals, and potential concerns, including ageist expressions. Ageism is a complex phenomenon, deeply rooted in modern societies, encompassing stereotypes, prejudice, and discrimination that affect billions of older adults globally. The stereotypes surrounding older people combine both positive and negative traits, with negative aspects such as illness and dependence being socially emphasised. Emotional responses of pity and sympathy, linked to paternalistic or benevolent forms of prejudice, are commonly associated with these stereotypes. Ageism can manifest at micro, meso, and macro levels, and it can be directed towards other individuals or oneself. Stereotype Embodiment Theory offers insight into how age-based stereotypes influence self-perceptions of ageing and subsequently impact health and well-being. When stereotypes become self-relevant, they can act as either facilitators or barriers to the health outcomes of older persons. Internalised age stereotypes can result in self-fulfilling prophecies through three primary pathways: psychological, behavioural, and physiological. The detrimental effects of ageism on the health conditions of older adults compromise their active ageing, have been observed globally and have increased over time. Efforts to combat ageism must consider various factors across different levels and domains, requiring a coordinated international strategy for success. Three effective strategies include the development of policies and laws, educational and intergenerational contact interventions. Changing stereotypes is essential; it is crucial to rethink practices and institutional norms or policies that place older persons in positions of inequity or jeopardy while also promoting contact and solidarity between generations.

Keywords: ageism, health outcomes, older people, age-based categorisation, stereotypes, discrimination, self-perceptions of ageing, education, intergenerational contact, active ageing

1. Introduction

> *It's the old 'does she take sugar in her tea?' syndrome… I found the same, I was in a wheelchair because I had an operation on my foot, and I suddenly became a body, not a person. And I think that happens. … If I'm on the phone and I give my date of birth, it's immediately this slow, do you understand what I'm saying? I said, well, I understand you before you knew how old I was, so why should not I understand you now?*

Population ageing has become a central topic of concern in the last few decades. In 2020, for the first time, the number of people aged 60 years and over exceeded the number of children under 5 years old [1]. Undoubtedly, the demographic changes resulting from advances in technoscience constitute a challenge around the world. While these changes bring significant benefits associated with the increased longevity of older people, they also introduce potential concerns due to the rise of comorbidities, social isolation and dependence on long-term care affecting the ageing population. This results in decreasing opportunities for individuals to live longer with good health and dignity. These global challenges add pressure on the capacity of healthcare services, economic stability, and social protection systems for older people and all age groups. Worldwide, the emergence of intergenerational division and negative attitudes towards older people is growing. The COVID-19 pandemic is a good example to show how older people can be treated, especially in times of scarce resources [2].

In the context of an increasingly ageing population and higher risks of vulnerability, promoting active ageing is part of an international strategy aimed at optimising opportunities for health, lifelong learning, participation and security to enhance quality of life [3]. The initial quotation of this chapter was taken from an interview conducted with a 69-year-old English woman as part of a European study dedicated to professional competencies in health and social care of older adults [4]. During the interview, she discussed her overall experience as a user of health services in her town. In this quote, she specified her view on the nature of the attitudes and behaviours of some professionals when interacting with older people during the delivery of care.

As the quote suggests, one of the first aspects we recognise in other people is age [5]. Chronological age constitutes one of the three basic dimensions of 'automatic' social categorisation, along with gender, race, and ethnicity, which people use to navigate their daily lives and in social interactions [6, 7]. In other words, the way we see others, but also ourselves, as young or old, male, female or other, is an essential clue to understanding and interpreting how, and to whom, certain traits, characteristics or behaviours will be associated.

Studies in the field of social psychology allow us to comprehend how these age-related representations are attached to social norms and expectations, as well as stereotypes that vary among different age groups (for example, see [8, 9]). When age-based categorisation results in to situations of disadvantage, injustice, or inequality, one should acknowledge the underlying forms of prejudice and discrimination that sustain ageism in different contexts of social life.

This chapter provides a literature review focused on ageism and its impact on the health of older persons. It aims to clarify the construct of ageism, highlighting its complexity, and presents research that illustrates how ageist processes affect the health outcomes of older adults. The first section examines the conceptual framework of ageism, focusing on its primary dimensions. Theoretical models will be discussed

to further explore the consequences of paternalistic and benevolent forms of ageism, as well as the impact of negative self-perceptions related to ageing. Different levels of ageism will be analysed, with examples of discrimination against older people presented within these contexts. The second section will delve into research that investigates the effects of age discrimination on the health outcomes of older persons. The final section will concentrate on projects and initiatives aimed at reducing ageist bias in the lives of older people and in broader society.

The research questions guiding this literature review are: (1) How does ageism impact the lives of older persons? (2) What health outcomes are affected by ageist bias in older adults? and (3) What interventions have been most successful in combating ageist bias in older persons and society?

1.1 Methodological considerations

In alignment with the established research questions, this review aims to deliver a comprehensive overview of ageism and its impact on the health of older persons. It encompasses a broad examination of relevant information and research studies that contribute to understanding its key dimensions and underlying processes. Additionally, the review examines secondary studies to summarise and evaluate the impact of ageism on the health outcomes of older persons.

The literature search was conducted in the Web of Science Core Collection, Scopus, PubMed, and PsycInfo for peer-reviewed articles; Google Scholar was used to search for grey literature, such as reports and policy documents. The search strategy combined key terms related to 'ageism', 'age stereotypes', and 'perceptions of ageing' with terms related to 'older persons' or 'older adults', 'systematic review', 'meta-analyses', and health. These terms were combined in various ways using Boolean operators. The selection of research studies was based on the screening of title/abstract, as well as authorship, primarily for the conceptual framework. A snowball approach was also adopted to identify relevant material cited by key articles identified in the previous round of search. The software Mendeley was used for reference management.

2. Ageism and its core dimensions

Ageism is a multifactorial phenomenon and it is deeply rooted in modern societies. Six in ten people around the world, aged 16–64, agree that 'people don't respect old people as much as they should', and the level of agreement increases with age [10]. Ageism, or age discrimination, was first described in 1969 by the American psychologist Robert Butler as unjustified prejudice or bias of one age group towards other age groups [11]. Butler coined the term following a protest by a community against the construction of a residential building for older people in their neighbourhood. Age discrimination was one of the most relevant factors explaining the residents' discontentment with the building construction in their surroundings. According to the author, prejudice against the old reflects how young and middle-aged people feel uneasy about growing old, disease, disability, and fear of becoming powerless, useless, and ultimately, dying. And culture reinforces such feelings of vulnerability, incapacity, and worthlessness [11, 12].

Individuals from any age group can be victims of ageism; however, much of the research conducted has been focused on age-based bias directed towards and

experienced by older people [13]. Ageism against older adults affects billions of people, with at least one in two people holding ageist attitudes directed at this social group [14, 15].

In terms of definition, literature seems consensual about the central dimensions of ageism: stereotypes (what we think about older people, often supported by institutional practices and policies), prejudice (how we feel about older people, late adulthood, or even ageing), and discrimination (how we behave towards older people) [12, 16, 17]. As shown in **Figure 1**, these interact and influence each other; however, the relationship between thoughts, feelings, and actions is not automatic.

The simple activation of stereotypes does not suffice to determine the expression of negative feelings or discriminatory behaviours towards older people. Ageism can operate both in implicit (unconscious) and explicit (conscious) ways.

2.1 Age-based categorisation and stereotypes

As mentioned before, ageism is related to a process of social categorisation, which is based on discrete age categories that ascribe both descriptive and prescriptive attributes to people of different age groups [9]. For example, when we think about someone in adolescence, young adulthood, or old age, we tend to associate certain traits or expected behaviours resulting from a combination of maturation, biological, and social processes that are divided by age and age-based stereotypes [9]. Life cycle is marked by a series of normative events whose main organising variable is age (e.g., formal education, coming of age, retirement age, etc.). In this sense, age categories project relevant, socially constructed, and rooted symbolic meanings that help to organise social life. Formal age-related roles are also associated with several fluid informal social roles and expectations (what is socially expected or *approved* to each stage of the life cycle) [7].

Categorising others into age groups is more cognitively efficient than evaluating each person individually. However, this process creates space for overgeneralisation and simplification of information about personal attributes, and the risk of cognitive bias and error increases. Hence, perceptions based on age stereotypes are more likely to happen, and people of the target group become more vulnerable to experiences of prejudice and discrimination [13].

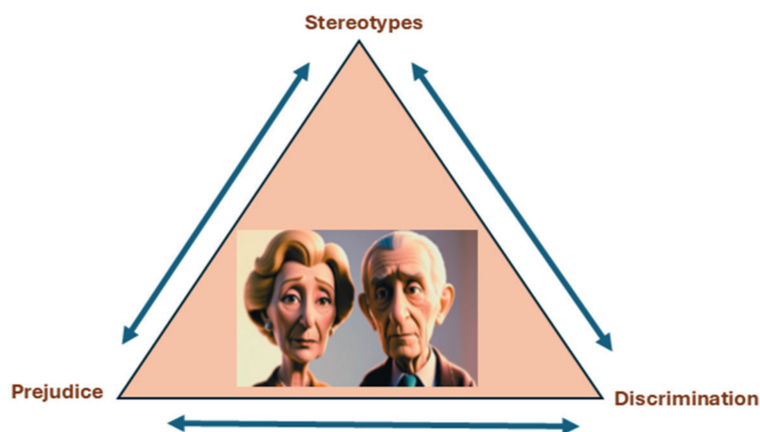

Figure 1.
Key dimensions of ageism.

Through the process of stereotyping, the heterogeneity and diversity that mark late adulthood, more than any other phase of the life cycle [18], are reduced, and the similarities between older people and their life trajectories are exaggerated [19]. Gerontologists have highlighted the distinction between 'young-old' (55–75 years), middle old (75–85), and 'old-old' people (85+ years) to evidence the large variability of ageing processes; the first group represents a competent majority, potentially active and productive, but often marginalised by society, and the third group is more associated with the idea of fragility, illness, and dependence on care [20]. The middle-aged group represents a 'grey zone' between the two prototypical poles of the old age spectrum [21].

The distinction between old age groups is also related to the division between third age and fourth age, which are defined in terms of people's functionality and not so much on their chronological age; the former is associated with autonomy and activity, and the latter with dependence and illness [22]. Still, even if it is true that health problems become more prevalent in older old ages, it is fundamental to acknowledge how the enormous diversity of lifestyles can predict a diversity of ageing patterns.

Research shows that stereotypes related to old age and ageing combine both positive and negative attributes [8, 16, 23]. The most common negative stereotypes relate to physical and cognitive decline, illness and incompetence, frailty, loneliness and dependence, while the most positive highlight wisdom, generosity, friendship, morality and reliability [8, 23–25]. This combination reflects the mixed nature of the stereotypical representations and beliefs that are often associated with older people.

The Stereotype Content Model (SCM) [8, 26] provides a framework for interpreting evaluations of different social groups based on two dimensions, warmth and competence, resulting in four clusters of groups (high/high; high/low; low/low; low/high). In this context, across multiple studies and populations, older adults have been persistently stereotyped as low in competence but high in warmth or affection [8, 26, 27], corresponding to the classical stereotypical image of 'doddering but dear' [28]. In one of these studies, older people's representation was clustered together with that of people with disabilities, suggesting that these combined stereotype content dimensions often result in evaluatively inconsistent stereotypes [8].

The mixed nature of stereotypes associated with older people is pervasive over time, space and cultures and resistant to change. Research conducted in Western and Eastern countries, associated with more individualistic or collectivist cultures, respectively, consistently shows that ageism is pan-cultural, and older people are seen as significantly warmer and less competent when compared with younger groups [26, 27, 29]. Findings of a cross-cultural meta-analysis comprising 23 countries indicate an association between population ageing rates and negative attitudes towards older people (e.g., East Asia), which may indicate the rise of burden perceptions from younger generations [27].

2.2 Links between age-based stereotypes and prejudice

One of the assumptions of the SCM model is that the perceived social status of groups is linked with the type of stereotypes and prejudice they are likely to face, with high-status groups being seen as competent (e.g., rich people) while low-status groups being perceived as incompetent (e.g., beggars or poor people) [8, 26]. In the case of older people, they are generally assigned to a low-status social position, associated with a mixed evaluation that is positive (high on warmth) but also negative (low in competence), as mentioned before [8, 25].

Each combination of stereotypes results in different emotional reactions: envy, pity, admiration, and contempt; regarding low-status groups like older people, the stereotype content elicits emotional reactions of pity and sympathy, as shown in **Figure 2** (for a deeper revision on the other types of prejudice see [5, 8, 26]). This emotional pattern gives rise to expressions of paternalistic or benevolent forms of prejudice, such as over-help and protection, which may lead to the isolation, lack of control, or lack of autonomy of older people [13]. Using patronising and infantilising language in the healthcare context or promoting exclusion from activities that are considered beyond the competences of older people are other examples of benevolent prejudice [4].

Evidence has shown that older women are viewed more benevolently than older men, as the latter are generally attributed with more competence than the former. This aligns with gender stereotypes, which perceive men as having higher status and greater competence than women [8]. The intersection of age and gender prejudices has been coined as 'gendered ageism' and permits framing the differences in ageism faced by women when compared to men [30].

Emotional reactions like pity and sympathy can give a false impression that age prejudice is insignificant; however, these are fully consistent with benevolent forms of prejudice. This is what makes it particularly insidious due to its subtlety, potentially reinforcing the belief that ageism is not a problem for older people. Nevertheless, those who face such types of prejudice can be easily disrespected, diminished, or excluded in contexts where their competences are undervalued.

Ageism is more likely to be manifested indirectly, as a lack of respect, rather than directly, which has been described as 'benign indifference' [7]. Findings from the European Social Survey (ESS, Round 4), conducted in 28 countries in the European region, are particularly illustrative about this phenomenon; overall, respondents considered that someone showed a lack of respect more often than they treated them badly because of their age [29]. One may presume that the higher prevalence of

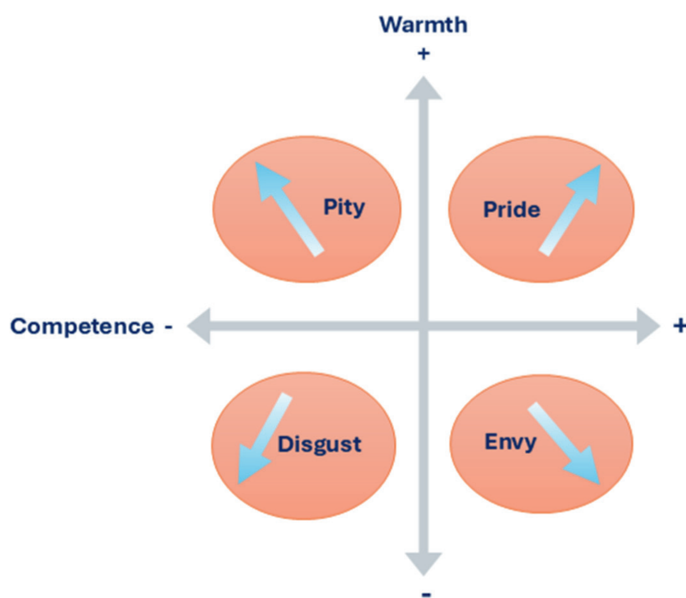

Figure 2.
Stereotypes, subtypes, and related forms of prejudice.

age-based prejudice, such as lack of respect and being ignored or patronised, when compared to more explicit and hostile forms, such as being insulted or abused, is mostly due to its implicit nature.

Implicit forms of ageism may not be intentional, depending on the level of awareness that each person has about their own ageist attitudes. People may associate their reactions with other factors, such as personal attributes of the older person or even contextual clues or practices. The normalisation of ageist prejudice and discrimination in different contexts of everyday life, such as institutions, contributes to reinforcing negative attitudes towards ageing and older people. This situation can limit opportunities for promoting active ageing in late adulthood. Such ageist beliefs have become embedded in the subconscious framework of societies [17] and may represent one of the few remaining socially tolerated forms of prejudice in contemporaneity.

2.3 Multilevel facets of ageism

Ageism can operate both in implicit (unconscious) or explicit (conscious) ways and be expressed at different levels, which are intertwined and mutually reinforcing. It can manifest at micro-level (individual), meso-level (interpersonal/intergroup) and macro-level (institutional and cultural) [17, 31]. Also, it can be directed towards other individuals (other-directed ageism—when we think 'older people are less competent') or directed towards oneself (self-directed ageism—when we think 'I feel bad about my ageing').

The internalisation of age stereotypes significantly contributes to individual and interpersonal ageist processes, such as patronising, disrespecting, or marginalising older people. At the institutional level, the expression of ageist attitudes is manifested through unfair treatment resulting from policies, laws, institutional practices, rules, or social norms that limit opportunities and systematically hinder individuals based on age criteria [14, 27]. These sources of ageism must be framed at a structural level, where the implicit or explicit policies, practices, or procedures of societal institutions promote bias against older people [26].

Interpersonal forms of ageism may overlap with institutional-level manifestations (e.g., employment practices and management decisions restricting promotion of older workers or lack of training opportunities; decisions to exclude older people from clinical treatments made by healthcare professionals based on age criteria, following policies or protocols of institutions). Recent events lived during the pandemic crisis are a clear example of this overlap between interpersonal and institutional ageism. Moreover, the effects of intersectionality between age (ageism) and gender (sexism) are also evident across various institutions, where inequalities have been documented regarding older women's access to preventive care and treatment when compared to older men (e.g., more medical examinations, more follow-up) [17, 32].

People often overlook institutional ageism due to long-standing rules, norms, and practices of these institutions, which become ritualised and are perceived as normal [14]. Although unintentional, these still legitimise the exclusion of older people in specific situations, reinforcing social asymmetries rooted in age and age-based assumptions.

Children at young ages already show negative ideas about old age, and young people internalise mostly negative social representations about older people, which impacts their self-perceptions as they age [9, 29]. This is to say, young people and older adults themselves can hold negative attitudes towards ageing and other older adults. Unlike gender or race, age groups vary across the lifespan, which means that

all people are susceptible to experiences of ageism with time. Hence, at some point, negative attitudes towards age eventually become self-relevant [16, 33]. This can weaken well-being, reflecting on the self-image, self-esteem, confidence, and skills of ageing and aged people [34]. Self-directed ageism may constrain the types of activities that older people are keen to engage in, such as learning new skills or hobbies.

Long-term effects of self-perceptions of ageing have been documented in some studies conducted in the U.S. [35], as well as in Europe [36], with similar findings. These studies show that holding more positive self-perceptions of ageing and age beliefs is related to better functional health over time and longer life expectancy compared to holding more negative self-perceptions and views of ageing [33].

Stereotype Embodiment Theory (SET) helps to explain how stereotypes and beliefs about old age influence self-perceptions of ageing and how these can impact health and well-being outcomes [33]. Within this framework, three predictors of ageism are defined: detrimental treatment of older people (age discrimination), negative age stereotypes, and negative beliefs of older people about their own ageing (self-perceptions of ageing) [37, 38]. According to SET, embodiment happens when stereotypes are assimilated from culture and social contexts, leading to self-definitions that subsequently influence functioning and health. This is a top-down process (from macro level to individuals), which occurs over time [33], meaning that age stereotypes have a developmental dimension.

Internalisation of age beliefs from culture starts at a young age, and these beliefs are reinforced throughout the lifespan [39]. However, individuals are less likely to defend against it before stereotypes are directed at themselves. Thus, their susceptibility is increased. In the long term, however, age stereotypes may negatively affect them. When individuals recognise they have reached old age, the relevance of age stereotypes increases, as it brings identification with other older people [33]. This recognition of the onset of old age is a subjective process, although marked by several social cues (e.g., infantilising speech, over-help, being denied employment) that remind the person they are old.

Yet, there is substantial variation in the balance of positive and negative stereotypes held by older individuals. One possible explanation relates to the extent to which an individual is immersed in the mainstream 'culture of ageing' of their country or region during their lifespan [21, 33]. Moreover, evidence also indicates that the way older people are viewed is domain-specific, depending on the contexts or life situations to which stereotypes are applied (e.g., health or family relations) [21]. Therefore, the balance between positive and negative stereotypes held by older people can also be diverse.

3. Consequences of age discrimination on health outcomes of older people

Internalised age stereotypes through stereotype self-embodiment form the basis for self-directed ageism. Once stereotypes become self-relevant, they can work as facilitators for or barriers against older people's health outcomes, depending on whether stereotypes are positive or negative. Evidence suggests that negative age beliefs provide worse strategies for coping with exposure to ageism present in society [33, 39].

Internalised age stereotypes become self-fulfilling through three main pathways: psychological, behavioural, and physiological [33]. In the first one, expectations related to ageing become self-fulfilling prophecies through unconscious automatic

processes when the content of the activated stereotypes aligns with the outcome domain. Experimental studies have shown that age stereotypes can be activated and influence functioning in the predicted direction on an unconscious level, known as the 'stereotype-matching effect' (e.g., in cognitive and physical performance) [40].

The behavioural pathway is associated with lifestyle and behavioural choices that people make over time; if someone has the belief that health problems are inevitable in old age, the probability of engaging or maintaining healthy behaviours is lower (e.g., practicing physical activity) [41]. Overall, older individuals with more positive self-perceptions of ageing seem to be more likely to engage in healthy practices [42].

The physiological pathway involves the autonomic nervous system that responds to environmental stress [33]. Research with older persons exposed subliminally to negative stereotypes before facing mathematical and verbal challenges showed heightened physiological responses to stress [43]. Participants included in the condition 'negative stereotypes' exhibited a heightened cardiovascular response to stress, as indicated by increased systolic and diastolic blood pressure and heart rate, compared to those in the positive condition. These findings also suggest that negative ageing stereotypes may contribute to adverse health outcomes in older persons without their awareness [43].

Extensive research conducted around the world, supported by five meta-analyses, consistently indicates that the SET model predictors of ageism show a negative impact on the health outcomes of older people [37, 38], even years later (e.g., Ref. [44]). A systematic review examined the longitudinal consequences of self-perceptions of ageing, a measure of internalised stereotypes of ageing, in participants 50+ years [45]. Primary outcomes were physiological (longevity and better health, health behaviours, and diseases) and psychological (depression, cognitive function, and other psychological outcomes). Results show that more positive self-perceptions of ageing were consistently associated with healthier longitudinal outcomes, including better self-rated health and less obesity, greater longevity, better performance of the activities of daily living, less depression, and better cognitive functioning (including reductions in cognitive decline and incidence of dementia). These findings support the detrimental consequences of ageing stereotypes over time and are fully aligned with the SET assumptions [45].

Along with individual-level sources of ageism, the consequences of macro-level expressions of ageism on the health of older people, across geography, health outcomes and time, have also been examined in another systematic review [37]. In this study, besides policies, practices, or procedures of societal institutions, structural ageism also included the age-based actions of individuals who are part of these institutions, such as the healthcare professionals of hospitals.

From the point of view of health categories under analysis, this review included seven individual health domains: reduced longevity, poor quality of life, poor social relationships, risky health behaviours, mental illness, cognitive impairment (as assessed by cognition over time), and physical illness. Besides, four structural health domains related to social institutions or organisations were integrated: denied access to healthcare and treatments, exclusion from clinical trials, devalued lives, and lack of work opportunities (**Table 1**) [37].

Overall, in 95.5% of the 422 studies and 74.0% of the associations analysed, ageism predicted significantly worse health outcomes, which supports its strong and consistent association with adverse health outcomes of older people. Ageism was significantly related to worse health in all 11 health domains under analysis (the proportion of significant ageism-health associations ranged from 94.4% to 63.0%).

Level of analysis	Health Domains (number of studies[1])
Structural	Denied access to healthcare (141)
	Exclusion from clinical trials (49)
	Devalued lives of older persons (3)
	Lack of work opportunities (60)
Individual	Reduced longevity (10)
	Poor quality of life (29)
	Poor social relationships (13)
	Risky health behaviours (27)
	Mental illness (42)
	Cognitive impairment (4)
	Physical illness (50)

[1]*According to the authors, some studies included different outcome; the total number of studies exceeded the number of articles included.*

Table 1.
Individual and structural sources of ageism identified in the studies.

At the structural level, all four health domains showed evidence of ageism; denied access to health services and treatments based on age (84.6% of the studies and 63.0% of the associations); older persons' exclusion from clinical trials (100% of the studies and 94.4% of the associations), even in clinical conditions more prevalent in later life (e.g., Parkinson disease); in the devalued lives of older persons (100.0% of the studies and 80% of the associations); and in the lack of work opportunities, ageism predicted worse health, such as increased depressive symptoms (91.2% of the 34 associations) [37].

Authors also found a significant association between ageism and all seven health domains under the individual level. Risky health behaviour was related to outcomes such as unhealthy diet, medication noncompliance, excessive drinking, and smoking (100% of studies and 79.4% of the associations); in the mental illness domain (outside of work environments), 95.5% of the studies and 93.2% of the associations found evidence of ageism influencing psychiatric conditions. In the physical-illness domain, ageism significantly predicted physical illness, assessed by functional impairment, chronic conditions, acute-medical-event incidence, and hospitalisations (96.2% of the studies and 80.9% of the associations) [37].

Ageism was observed in all 45 countries represented in the sample and all six continents where studies were conducted. The prevalence of significant associations was higher in less-developed than more-developed countries; however, the former may experience higher prevalence due to their limited resources for providing healthcare to older people. This result is also supported by other systematic reviews focusing on determinants of ageism against older people [31]. Moreover, research conducted in Australia and Asia showed more significant findings than in other continents, although only one study was conducted in Africa.

Ageist effects were observed in every year under study, and the proportions of significant associations between ageism and adverse health in all 422 studies increased over time: 51.3% from 1970 to 1989, 69.6% from 1990 to 2009, and 85.3% from 2010 to 2017. The proportion of significant findings for structural ageism also increased

over time: 51.3% from 1970 to 1989, 66.8% from 1990 to 2009, and 86.6% from 2010 to 2017 [37].

Older persons with lower levels of education were more likely to experience the harmful health effects of ageism. This finding is supported by literature related to health inequities, which indicates that members of disadvantaged social groups are more likely to become targets of discrimination [46]. However, a systematic review focusing on determinants of ageism against older people showed inconclusive results about the effects of years of education (24 papers) [31].

A trend of increasing ageism over time, related to healthcare professionals, was also found. This association may be due to the growing demands and time pressures of the daily tasks of healthcare staff. However, the reach of ageism seems to have clinical implications; ageism influenced a wide range of health outcomes of older patients; moreover, vignette studies from eight countries showed that medical students and practitioners often made clinical decisions that restricted patients' access to care based on age criteria rather than patients' health needs (e.g., [47–49]) [37]. This is a concerning result, since risk assessment and access to medical care should not rely solely on age [50].

Finally, this systematic review also reveals that while significant ageism-health associations have become more prevalent over time, the number of studies focusing on structural-level ageism has declined since 2010 [37]. This recent decrease in research interest limits the recognition of society's central role in promoting and reinforcing discrimination towards older people.

4. A call for action to combat ageism

Ageism is a critical social determinant of health that has been largely overlooked [14, 37] and needs to be actively and urgently addressed. Like all forms of discrimination, ageism generates divisions and hierarchies in society, leading to numerous harms and injustices, such as health inequities and poorer health outcomes [14, 17]. Recent global challenges like the COVID-19 pandemic shed light on the vulnerability of older people and exposed ageism in different settings worldwide (e.g., discrimination in access to healthcare, inadequate protection of older people in care homes) [14].

Evidence from ESS (Round 4) shows another example aligned with widespread ageist attitudes; around Europe, people aged 70 and more are perceived as a burden on healthcare services [29], however, this representation needs to be considered the other way around. Ageism places a heavy economic burden on individuals and society, including in healthcare costs, due to its damaging impact on health conditions [15, 17, 38]. Overall, $63 billion, or one in every seven dollars, spent on healthcare for the eight most expensive conditions during 1 year in the United States, was due to ageism [38]. Thus, reducing ageism could not only improve the health of older persons, but it could also be cost-effective.

Global efforts must be concerted, strategic and sustained to effectively combat ageism. One of the four action areas of the United Nations (UN) Decade of Healthy Ageing (2021–2030) [1] is combating ageism, aligned with the UN Agenda 2030 on Sustainable Development [51] and the Sustainable Development Goals. It is the second action plan of the WHO *Global strategy on ageing and health* (2016–2030) [52].

The evidence examined in the WHO report indicates that three strategies are effective to combat ageism: policy and law, education, and intergenerational contact interventions. Policy and law can address age-based discrimination and inequality

and protect human rights. Educational interventions across all levels of education can contribute to changing misconceptions, providing accurate information, and challenging stereotypes. Intergenerational contact interventions are particularly effective in reducing ageism against older persons and may also help combat ageism against younger people.

PEACE (Positive Education about Ageing and Contact Experiences) is an integrative theoretical model proposed for reducing ageism towards older adults and promoting intergenerational peace [53]. Its key dimensions are (1) education about ageing and older adulthood at all education levels, including positive role models of older adults; and (2) positive contact experiences with older adults that are individualised, cooperative, and that promote mutually valuable intergenerational contact. These two key elements have the potential to be interconnected and work together to reduce negative stereotypes, ageing anxiety, prejudice, and discrimination associated with older persons and ageing [53].

The positive impact of educational and intergenerational contact strategies for reducing ageism identified in the WHO report and the PEACE model has already gathered a growing body of literature. A systematic review and meta-analysis evaluated experimental and quasi-experimental studies on ageism to examine the relative effects of different interventions: education, intergenerational contact, and a combination of both to reduce ageism among youths and adults [54]. The analysis focused on several outcome measures, including attitudes towards ageing, knowledge about ageing, comfort with older adults, anxiety regarding one's own ageing, and working with older adults.

The overall results indicate that those interventions significantly lowered self-reported levels of ageism among participants versus control groups, and the size of these proportional reductions was broadly consistent across the intervention types. This result suggests that education, intergenerational contact, and combined programmes support broadly generalisable benefits. Moreover, in the meta-analysis, interventions combining education and intergenerational contact were associated with larger effects on attitudes, suggesting that this type of intervention can be more effective for combating negative attitudes towards ageing. This study also reveals that research examining the effect of ageism interventions among older persons is still lacking, which is critical given the robust evidence identifying a high prevalence of internalised ageism in this population and its damaging effects [54].

More recent and interesting examples of strategies to combat ageism can be found in education aimed at preparing future professionals to work with the ageing population. This is of paramount importance given the trend of increasing ageism over time among healthcare professionals.

For instance, educational interventions with undergraduate students to promote a more positive understanding of ageing [55, 56] and intergenerational contact programmes exposing undergraduate students to older adults in retirement villages [57], first-year medical students connecting with older persons through phone and video calls [58], and fourth-year medical students conducting life-story interviews with older patients for reducing age bias and promoting empathy [59]. Overall, these interventions provide encouraging results, indicating a reduction in ageist attitudes and an increased positive perception of students regarding older adults [60]. Positive quality of contact between younger and older people has already been identified as a protective determinant of ageism in a systematic review [31].

The WHO *Global Report on Ageism* [17] provides three recommendations for concrete actions that all stakeholders can take to combat ageism. First, investing in effective

strategies to prevent and respond to ageism. Second, funding and expanding research to better understand ageism and how to address it, although evidence has grown considerably in the last decade. Still, it would be important to reach a broader and deeper understanding of which age stereotypes cause more impact and to identify the domains in which individuals and groups are most vulnerable to them. Further research on the intersectionality of ageism and other 'isms', such as sexism and racism, will also have important implications for addressing and acting against ageism and other forms of stereotypes, prejudice and discrimination [17]. Thus, intervening to reduce ageism and its harmful impact implies gathering more knowledge and insights on the factors contributing to or determining its genesis and persistence in our societies [31].

The WHO report also recommends initiating a movement to change the narrative surrounding age and ageing. This involves deconstructing the harmful narrative of loss, decline, and disengagement and replacing it with a narrative that highlights opportunities and challenges [21, 61]. This approach aims to explore the potential that old age offers while also recognising the increasing diversity within the ageing population. Aligned with the fundamental pillars of active ageing, a new narrative on ageing is essential to highlight the choices and opportunities available to individuals while also acknowledging the challenges that come with growing older [61]. This includes changing negative messages in public debates and media about older people and promoting workplace-based health and wellness programmes for middle-aged and older persons. These programmes can serve as an excellent context for sharing relevant information on healthy lifestyles and successful ageing.

5. Conclusions

The potential for longer life spans is a significant achievement of civilisation, presenting great opportunities for overall human development. However, living longer does not always guarantee an active ageing experience and quality of life in the later years. To address the first research question guiding this literature review, findings demonstrate that ageism is a complex phenomenon, deeply rooted in modern societies. It encompasses stereotypes, prejudice, and discrimination, affecting billions of older adults worldwide. Ageism can manifest at micro, meso, and macro levels, and the resulting stereotypes integrate both positive and negative traits; however, negative traits, such as illness and dependence, are socially emphasised. Emotional responses like pity and sympathy, associated with benevolent forms of prejudice, are frequently linked to these stereotypes.

Following the second research question, findings demonstrate that ageism negatively impacts the health outcomes of older persons and is associated with individual and structural sources of discrimination and prejudice. The former, mostly related to negative self-perceptions of ageing, can impact health outcomes such as physical and mental illness, adoption of risky health behaviours, and poor social relationships. On the structural level, negative health outcomes of older people are related to factors such as denied access to healthcare and exclusion from clinical trials. However, global health strategies have not yet considered ageism as a modifiable risk factor [54]. Nonetheless, this situation is changing, and positive steps have been taken as the WHO has identified reducing ageism as a key target for improving healthy and active ageing [14].

To address the last research question guiding this review, findings show that combating ageism effectively requires both individual and social change, along with

sustained and coordinated action from various sectors and stakeholders. In line with WHO recommendations, key actions to address ageist phenomena should cover three main areas: policy, research, and practice.

Both younger and older individuals frequently hold age-based stereotypes without recognising their problematic nature. The first step should be to raise awareness about age stereotypes and their dangerous effects, and to uncover the widely shared myths that reinforce the notion that old age is a burden for society and give little recognition to the past or current contributions of older people.

Campaigns to combat ageism will necessarily need to consider factors spanning different levels and domains and act as a globally concerted strategy to be successful. Distinguishing between individual and societal ageism is crucial, as interventions will vary depending on whether they target internal age stereotypes or policies and institutional manifestations of ageism.

Changing stereotypes is essential; rethinking practices and institutional norms or policies that place older people in positions of inequity or jeopardy. It is important to promote contact and solidarity between generations while combating discourses that reinforce intergenerational conflicts, such as the notion of 'grey plague'. At the same time, national and international policies should foster and emphasise the involvement of people of all generations in different areas and fields of action, as well as the advantages of interdependencies between different ages.

In the healthcare sector, it is vital to strengthen the awareness and critical thinking of actors and health systems regarding the manifestations of ageism that occur in these contexts to reinforce the equity and quality of services provided to people of all ages.

Table 2 outlines the previously mentioned initiatives, focusing on policy, research, and practice, aimed at addressing ageism at both the individual and societal/institutional levels.

Domains	Actions
Policy	• Developing or reinforcing international and national legislation focused on age discrimination in different sectors, such as healthcare systems and healthcare services. • Implementing national and international campaigns aimed at raising awareness of age-based stereotypes and their detrimental effects. • Formulating policies that promote intergenerational collaboration and solidarity.
Research	• Expanding research on factors that contribute to or determine the genesis and persistence of ageism. • Examining the effectiveness of interventions aimed at changing both individual and societal age stereotypes. • Exploring specific strategies that address internal biases versus institutional manifestations of ageism. • Examining the effect of interventions addressing the risks of internalised ageism in self-perceptions of older people.
Practice	• Promoting educational programmes in the community targeting both younger and older individuals to enhance awareness about the nature and consequences of ageism. • Establishing collaborative initiatives that promote intergenerational contact to highlight the strengths and capabilities of people in different age groups. • Integrating content about ageist stereotypes, prejudice and discrimination into the curricula of healthcare education.

Table 2.
Actions to combat ageism at the individual and societal levels.

This literature review provides a comprehensive examination of ageism and its impact on the health outcomes of older adults. It presents a framework for understanding key concepts and processes related to ageist bias. The review explores a wide range of research findings from different continents, highlighting the pervasive nature of ageism and its implications for individuals and society.

Due to its objectives, the scope and methodological approach of this review are more flexible than those used in other types of reviews (e.g., scoping reviews). As a result, the selection of literature may be influenced by the author's theoretical positioning, which may affect the interpretation of findings.

Moreover, the review identifies relevant factors that have produced inconclusive research results (e.g., age or years of education) and those that are contextually and/or culturally dependent (e.g., norms and legislation). This suggests the need for further research and the adoption of a more systematic approach.

I hope this work helps to improve the understanding of the factors contributing to ageism and raises awareness of its negative impact on the active ageing of older persons. Additionally, it may contribute to developing actions that combat ageist manifestations at both the individual and societal levels.

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