L'ageismo nei contesti sociosanitari in Europa: una *scoping review*

STEFANO POLI, PAOLA GIANNONI, GIADA MORETTI[1]

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Abstract. Ageism is a widespread, complex form of discrimination negatively affecting older adults' health, well-being, and access to healthcare and social services. In rapidly ageing societies, particularly in Europe, it has become a critical social determinant of health, shaping clinical decision-making, professional practices, organizational routines and health policies. Despite growing research on ageism, evidence remains fragmented, highlighting the need for systematic synthesis. This scoping review maps recent literature on ageism toward older adults in healthcare and social care settings. Searches were conducted in Scopus and PubMed for peer-reviewed articles published between 2021 and 2025, following the COVID-19 emergency. Fifty-five studies in European contexts were included and analysed using Template Analysis with MAXQDA. Findings show that ageism operates across four interrelated levels: internalized/self-ageism, individual/interpersonal, institutional/organizational, and structural/systemic. These levels are associated with a range of specific outcomes: internalized stereotypes, psychological distress, compromised clinical communication, ethical implications, biased service design, health and digital inequalities. While educational and organizational efforts are effective, they remain insufficient. Addressing ageism requires integrated, multilevel strategies, combining education, organizational change, policy interventions, and age-inclusive technological design.

Key words: Ageism, Older adults, Healthcare, Social care, Scoping review.

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1. INTRODUCTION

The concept of ageism, first introduced by Butler (1969), refers to discrimination based on age and was defined as "prejudice by one age group toward other age groups" (Butler, 1969: 243), rooted in fears of ageing, decline, and loss of social value. Although initially conceived as applicable across the lifespan, the term is now predominantly used to describe negative attitudes and practices directed toward older adults. Thus, beyond multidimensional theoretical approaches to generative patterns and predictive factors (Bytheway, 1995; COST, 2015; Snellman, 2016), ageism can be broadly defined as a set of stereotypes, prejudices, and discriminatory practices that negatively affect older people's self-esteem, well-being, and social recognition (WHO, 2021; Paoletti, 2024).

[1] Sebbene l'articolo sia frutto di un lavoro congiunto di tutti gli autori, i contributi individuali sono specificati come segue. Paola Giannoni è autrice dei capitoli 1 (*Introduction*), 3.1 (*Study Characteristics*) e 3.2 (*Qualitative template analysis: types and outcomes of ageism in healthcare*); Giada Moretti è autrice dei capitoli 2 (*Objectives of the scoping review*) e 3.2 (*Qualitative template analysis: types and outcomes of ageism in healthcare*); Stefano Poli è autore dei capitoli 4 (*Discussion*) e 5 (*Conclusion*).

Attention to ageism has grown alongside the rapid demographic shift toward older populations, particularly in Europe, one of the world's oldest regions. As of 2024, individuals aged 65 and over accounted for 21.6% of the EU-27 population, with an old-age dependency ratio of 37% (Eurostat, 2025), and further ageing projected through 2050 (UN, 2024; WHO, 2025). These demographic trends pose significant challenges for health and social care systems, increasing demand for chronic care and long-term support while potentially intensifying ageist practices under conditions of resource constraint (Mikton *et al.* 2021).

In healthcare and social care contexts, ageism operates at multiple levels, shaping clinical interactions, organizational routines, and institutional norms. Empirical evidence shows that age-based stereotypes influence clinical judgment and care pathways, contributing to symptom under-recognition, restricted access to diagnostics or treatments, and age-based prioritization rather than need-based decision-making (Chrisler *et al.* 2016; Chang *et al.* 2020). These mechanisms disproportionately affect older adults with complex or chronic conditions.

Beyond formal care settings, ageism also manifests through everyday interactions and personal beliefs. Older adults may internalize negative age stereotypes, which are associated with poorer mental health, reduced autonomy, lower social participation, and diminished engagement in health-promoting behaviours (Levy, 2017; McDarby *et al.* 2022).

Above all, public discourse and institutional communication often reinforce representations of older adults as uniformly frail or dependent, a tendency particularly amplified during the COVID-19 pandemic, when age-based policies legitimized paternalistic and restrictive practices (Previtali *et al.* 2020; Poli, 2020; Ayalon *et al.* 2021).

Thus, despite the growing body of research on ageism, existing evidence remains fragmented across disciplines, settings, and methodological approaches, with limited integration between theoretical frameworks and empirical operationalization. In particular, studies addressing ageism in healthcare and social care often focus on isolated outcomes or single levels of analysis, while comparatively less attention has been paid to how ageism is measured, translated into professional practices, and addressed through training and organizational interventions, especially in the post-pandemic European context.

Accordingly, this scoping review aims to systematically map recent evidence on ageism toward older adults in healthcare and social care settings, with particular attention to post-pandemic theoretical mainstreams in Europe, and a specific focus on measurement approaches, professional training initiatives, and documented outcomes of ageism, in order to inform future research, policy, and practice.

2. OBJECTIVES OF THE SCOPING REVIEW

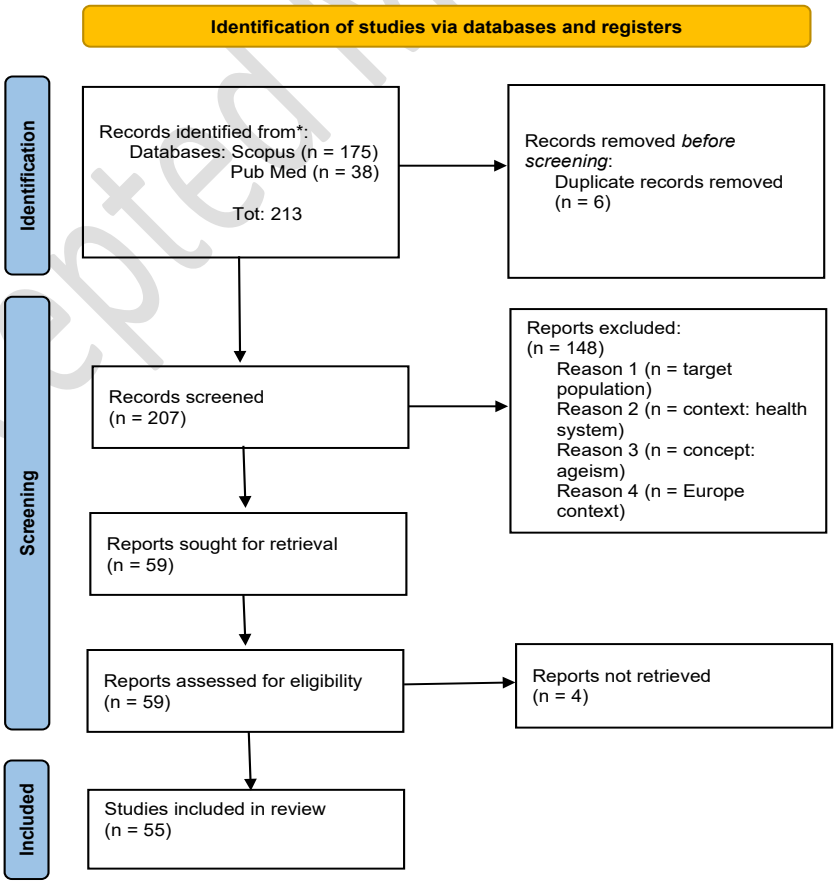
This contribution considers the socio-healthcare domain broadly, encompassing clinical and community-based services, the validation of research and diagnostic instruments, educational contexts (university-level or specialist training) for health professionals, and experimental studies, including those involving artificial intelligence.

The primary objective of the review is to provide a structured and comprehensive classification of recent studies addressing ageism in later life within healthcare and social care sectors. To this end, a scoping review methodology was adopted in accordance with the PRISMA extension for Scoping Reviews (PRISMA-ScR) guidelines (Tricco *et al.* 2018). This approach is particularly suited to mapping heterogeneous bodies of evidence, clarifying key concepts, examining methodological approaches, and identifying research gaps (Peters *et al.* 2017; Munn *et al.* 2018). Moreover, scoping reviews allow for the inclusion and comparison of studies adopting diverse research designs and epistemological perspectives (Pham *et al.* 2014). Relevant studies were identified through searches in the Scopus and PubMed databases. Articles were included if they contained the terms "ageism"

AND "health" AND ("older" OR "elder*"), were published between 2021 and 2025 (following the end of the global pandemic emergency), written in English, published (excluding "in press" articles), available in full text, involved populations aged >60, and were conducted in or explicitly referred to European or North American contexts (given the limited availability of accurate territorial filters in PubMed). A wide range of publication types was considered, including empirical studies, reviews, clinical trials, evaluation and validation studies, and practice-oriented contributions.

The initial search yielded 213 records, of which 6 duplicates were removed. The remaining 207 titles and abstracts were screened, excluding 148 articles that did not meet the predefined classification criteria. Screening and classification were performed by three independent reviewers who assigned binary scores (1 = present; 0 = absent) for three criteria: target population (i.e., recipients of ageist behaviors or internalized ageism), concept (ageism conceptualized as attitudes or practices enacted by healthcare or social care professionals, including studies validating relevant measurement instruments), and context (hospital settings, community-based social care services, or professional training aimed at counteracting ageism) (Grosse & Kokorelias, 2025; Springer *et al.* 2025). Only studies achieving the maximum cumulative score of 9/9 were retained. Geographical relevance was ultimately confirmed through full-text screening, in line with established scoping review practices. Therefore, a final territorial screening was applied, restricting the review to studies conducted in Europe, given its advanced demographic ageing and relevance for the analytical framework adopted.

Figure 1. Flow diagram of the selection of articles included in the study



After the screening process described in Fig. 1, we obtained a final sample of 55 articles, which were deemed eligible and imported into MAXQDA (version 24) and analyzed using Template Analysis (Cardano, 2020). This involved developing an initial codebook through both inductive and deductive processes, which was iteratively refined by integrating or removing concepts during analysis.

For the publication year 2025, contributions available as of December 3, 2025 were considered. For each article, a structured data extraction form was completed to collect publication metadata, intervention setting, clinical area, sample size, methodological approach, and research techniques.

The results of the scoping review are first presented by outlining the descriptive characteristics of the included studies, followed by findings from a template analysis. This method enabled the development of interpretative categories, initially derived deductively from the literature and previous classifications (Springer *et al.* 2025; Cesari *et al.* 2025) and then refined iteratively (Cardano, 2020), providing a structured yet flexible framework to identify recurring patterns, themes, and relationships across studies. The analysis focused on two main dimensions: types of ageism and its outcomes and consequences.

3. RESULTS

3.1. Study Characteristics

All studies included in this scoping review (n=55) refer to the European context. Most studies were published between 2022 and 2024 (n=39), and the main disciplinary fields were nursing (n=17), public health (n=15), and medicine (n=11). Research was conducted in a variety of settings, mainly clinical training (n=20), health systems (n=15), and community services (n=12).

Studies were grouped into four clinical areas: "health professions education and workforce" (n=21) focuses on students, professionals, and training; "clinical care of older adults" (n=14) covers geriatric and long-term care; "health systems, services, and policy" (n=15) includes access, governance, and public health interventions; and "ethical, conceptual, and methodological issues" (n=5) comprises theoretical, ethical, and methodological research.

Regarding healthcare levels, most studies addressed the micro-level (n=25, direct interactions) or macro-level (n=20, systems and policies), with fewer at the meso-level (n=8, organizational processes) or multilevel (n=2). Studies engaged mainly multi-actor collaborations (n=26) and students/trainees (n=18), with other actors including healthcare professionals, organizations/policy makers, society/media, and industry/technology. Quantitative designs were most common (n=23), followed by qualitative (n=9), reviews (n=9), conceptual/theoretical studies (n=9) and mixed methods (n=5).

Table 1 provides a detailed summary of the included studies and their characteristics.

Tab. 1. Characteristics of the studies included in the scoping review (n=55)

	Number of Articles
Publication Year	
2021	7
2022	14
2023	11
2024	14
2025	9
Disciplinary field	
Public Health	15
Medicine	11

Nursing	17
Healthcare Management	7
Psychology	5
Setting	
Community Services	12
Clinical Training	20
Health System	15
Hospital	3
Specialist Services	2
Residential / Long-Term Care	3
Clinical Area	
Health professions education and workforce	21
Clinical care of older adults	14
Health systems, services and policy	15
Ethical, conceptual and methodological issues	5
Healthcare level	
Micro	25
Meso	8
Macro	20
Multilevel	2
Actors	
Multi-actors	26
Students / Trainees	18
Healthcare Professionals	7
Organizations / Institutions / Policy makers	2
Industry / Technology / Research	2
Study Design	
Quantitative	23
Qualitative	9
Mixed Methods	5
Review	9
Conceptual / Theoretical	9

Source: Authors' own elaboration

3.2. Qualitative template analysis: types and outcomes of ageism in healthcare and social care settings

The analysis of the 55 included studies led to the identification of a multi-level structure of ageism and its outcomes. Four interrelated levels emerged inductively from the data: internalized/self-ageism, individual/interpersonal, institutional/organizational and structural/systemic, each associated with specific patterns of outcomes.

Internalized or self-ageism (n=5) captured the process through which older individuals internalize societal and institutional stereotypes, shaping self-perceptions and expectations about ageing. This level was associated with internalized stereotypes and self-stigma (Aytulun & Erden Aki, 2022), psychological well-being and emotional vulnerability, including loneliness and perceived risk (Naughton-Doe *et al.* 2024; Gallistl *et al.* 2024; Bellanova *et al.* 2024), as well as subjective experiences of frailty and health (Chenhuichen *et al.* 2024). These processes contributed to altered health-related behaviors, reduced agency in decision-making, and forms of self-limitation in the relationship with healthcare services.

Individual/interpersonal ageism (n=19) referred to age-based stereotypes, attitudes, and discriminatory practices enacted in everyday interactions within healthcare and educational contexts. At this level, ageism was associated with negative or ambivalent attitudes and stereotypes toward older adults (Lampersberger *et al.* 2023; Pons *et al.* 2025; Elvira-Zorzo & Vega Rodríguez, 2025; Catalao *et al.* 2025), representations of ageing among students and professionals (Heckemann *et al.* 2022; Schüttengruber *et al.* 2022; Cerqueira *et al.* 2023), and implicit or ambivalent forms of ageism (D'hondt *et al.* 2024; Piaton *et al.* 2024). These attitudes influenced educational trajectories and professional orientations (Özdil *et al.* 2021; Knight *et al.* 2022; Castellano-Rioja *et al.* 2022; Nitschke *et al.* 2022 ; Allué-Sierra *et al.* 2023). In this domain, several studies explicitly operationalised ageism using validated scales and measurement tools, aimed at quantifying ageism and assessing explicit or implicit ageist attitudes (Schüttengruber *et al.* 2022; D'hondt *et al.* 2024). Interpersonal ageism also affected clinical communication and the quality of care in direct one-to-one interactions, shaping patient–professional relationships, decision-making processes, and experiences of healthcare. In particular, studies highlighted age-based assumptions in clinical interactions and care practices (Martínez-Angulo *et al.* 2023a; Martínez-Angulo *et al.* 2023b), exclusion or marginalization of older patients in preventive pathways such as screening (Gram *et al.* 2023), and the role of age-related anxieties and stereotypes among healthcare trainees in influencing attitudes toward older patients and care delivery (Draper *et al.* 2024).

Institutional/organizational ageism (n=9) concerned age-based dynamics embedded in organizational structures, professional practices, and educational systems within healthcare settings. At this level, ageism was associated with organizational practices and workforce outcomes, including the influence of age stereotypes on professional well-being, motivation, and intention to leave the workplace (Helaß *et al.* 2024), as well as the role of age-related beliefs in shaping burnout and quality of working life in long-term care contexts (López-Frutos *et al.* 2022). Institutional ageism also emerged in relation to education and training processes, highlighting how formal learning environments can both reproduce and mitigate ageist attitudes. Studies documented the impact of educational interventions and training models on attitudes toward ageing and older patients (Başer & Hisar, 2024; Bouwmeester Stjernetun *et al.* 2024a; Bouwmeester Stjernetun *et al.* 2024b), professional identity and career orientation toward geriatrics (Pearson *et al.* 2025), and the development of competencies and awareness related to ageism in healthcare practice (Fitzpatrick *et al.* 2021; Fernandes *et al.* 2022), including the validation of scales for measuring ageist attitudes in students (Piaton *et al.* 2023).

Structural/systemic ageism (n=22) referred to age-based inequalities produced and legitimized at the macro-social level through healthcare systems, public policies, ethical frameworks, and socio-cultural norms. At this level, ageism was associated with health inequities and unequal access to care, including disparities in diagnostic testing and service availability (Trevisan *et al.* 2021; Miralles *et al.* 2021), missed or delayed healthcare during crises and policy responses (Settels & Leist, 2022; Rodriguez-Rodriguez *et al.* 2022), age-based resource allocation and prioritization (Pinho & Araújo, 2022; McDonald, 2022), and clinical outcomes shaped by age-related decision-making and prescribing practices (Paar *et al.* 2024; Fumagalli *et al.* 2025). Structural ageism also emerged as a driver of global mental health inequities (Teaster & Giwa, 2023) and vulnerabilities among specific populations, such as older adults with rare diseases (Uwitonze *et al.* 2024). Beyond material inequalities, structural ageism was reflected in ethical, normative, and symbolic dimensions of ageing, including debates on dignity, vulnerability, and epistemic justice in healthcare (Langmann, 2023; Bortolotti, 2025; Langmann *et al.* 2025), intersectional forms of age-based disadvantage related to gender and social inequalities (Bows *et al.* 2024; Costa *et al.* 2025), and age discrimination in public health and legal frameworks (Nitschke *et al.* 2021; Lloyd-Sherlock *et al.* 2022). Finally, studies highlighted the emergence of digital ageism and its implications for service design and technological innovation in healthcare. Research showed how stereotypes about older adults' digital

abilities shape professional attitudes and technological practices (Mannheim *et al.* 2021), while broader socio-technical transformations in healthcare risk reinforcing inequalities and exclusion of older populations (Stypińska & Franke, 2023). Other contributions emphasized how implicit ageist assumptions can influence participatory design processes and the co-creation of services for older users (Comincioli *et al.* 2022), as well as how regulatory and technological frameworks may embed or mitigate algorithmic bias and age-based discrimination in digital health systems (Van Kolfschooten, 2023).

Overall, these findings illustrate how ageism operates across multiple interconnected levels, generating heterogeneous but systematically related outcomes. A detailed synthesis of types of ageism, associated outcomes, and mapped studies is provided in Table 2.

Tab. 2. Types of ageism and associated specific outcomes: evidence from the scoping review (n=55)

Type	*Specific outcome*	*Studies*
Internalized / Self Ageism	Internalized stereotypes and self-stigma	Aytulun & Erden Aki, 2022
	Psychological well-being	Naughton-Doe *et al.* 2024; Gallistl *et al.* 2024; Chenhuichen *et al.* 2024; Bellanova *et al.* 2024
Individual / Interpersonal Ageism	Attitudes and stereotypes toward older adults	Özdil *et al.* 2021; Knight *et al.* 2022; Heckemann *et al.* 2022; Schüttengruber *et al.* 2022; Castellano-Rioja *et al.* 2022; Nitschke *et al.* 2022; Cerqueira *et al.*, 2023; Allué-Sierra *et al.* 2023; Lampersberger *et al.* 2023; Piaton *et al.* 2024; D'hondt *et al.* 2024; Gümüşler Başaran *et al.* 2024; Pons *et al.* 2025; Elvira-Zorzo & Vega Rodríguez, 2025; Catalao *et al.* 2025
	Clinical communication and care quality	Gram *et al.* 2023; Martínez-Angulo *et al.* 2023a; Martínez-Angulo *et al.* 2023b; Draper *et al.* 2024
Institutional / Organizational Ageism	Organizational practices and workforce outcomes in hospital and socio-healthcare settings	López-Frutos *et al.* 2022; Helaß *et al.* 2024
	Education and training effects	Fitzpatrick *et al.* 2021; Fernandes *et al.* 2022; Piaton *et al.* 2023; Bouwmeester Stjernetun *et al.* 2024a; Bouwmeester Stjernetun *et al.* 2024b; Başer & Hisar, 2024; Pearson *et al.* 2025
Structural / Systemic Ageism	Health inequities and access to care	Trevisan *et al.* 2021; Miralles *et al.* 2021; Crosignani *et al.* 2021; Pinho & Araújo, 2022; McDonald, 2022; Rodriguez-Rodriguez *et al.* 2022; Settels & Leist, 2022; Teaster & Giwa, 2023; Uwitonze *et al.* 2024; Paar *et al.* 2024; Fumagalli *et al.* 2025

	Ethical, normative and symbolic outcomes	Nitschke et al., 2021; Lloyd-Sherlock et al., 2022; Langmann, 2023; Bows et al., 2024 ; Bortolotti, 2025; Costa *et al.* 2025; Langmann *et al.* 2025
	Digital ageism and service design	Mannheim *et al.* 2021; Comincioli *et al.* 2022; Stypińska & Franke, 2023; Van Kolfschooten, 2023

Source: Authors' own elaboration

4. DISCUSSION

This scoping review provides a comprehensive and policy-relevant synthesis of recent European research on ageism toward older adults in healthcare and social care contexts. By systematically mapping 55 studies published between 2021 and 2025, the review highlights the multidimensional and multi-level nature of ageism and its consequences, showing how age-based discrimination is not confined to individual attitudes but is embedded in professional practices, organizational arrangements, and structural features of healthcare systems. The analytical framework emerging from the review, distinguishing internalized, interpersonal, institutional, and structural forms of ageism, offers a useful lens for understanding how these dimensions interact and generate cumulative effects on health outcomes, access to care, and professional conduct.

One important contribution of this review lies in its attention to internalized or self-ageism, which, although addressed by a limited number of studies, emerges as a significant pathway through which broader social and institutional ageism affects older adults' well-being. The evidence suggests that internalized stereotypes shape self-perceptions of health, frailty, and vulnerability, influencing help-seeking behaviors, engagement with healthcare services, and participation in decision-making. From a policy perspective, these findings point to the need for public health strategies that counter negative societal narratives about ageing and promote more diverse and empowering representations of later life. Interventions aimed at improving older adults' health literacy and agency should therefore be understood not only as individual-level initiatives but also as components of broader efforts to address ageism as a social determinant of health.

At the interpersonal level, the review confirms that ageist attitudes and stereotypes remain widespread among healthcare students and professionals, with tangible implications for clinical communication, care quality, and professional trajectories. A substantial portion of the literature focuses on educational settings, underscoring the formative role of health professions training in shaping representations of ageing and older patients. Notably, many studies highlight implicit and ambivalent forms of ageism, suggesting that discrimination may persist even in contexts where explicit attitudes appear neutral or positive. This has important implications for policy and regulation in health education: curricula should systematically integrate ageing and ageism as cross-cutting themes, emphasizing reflective practice, ethical reasoning, and sustained exposure to older adults in varied care settings. Regulatory bodies and accreditation agencies may play a key role in promoting minimum standards for age-inclusive education across health professions.

Institutional and organizational ageism represents a critical meso-level dimension connecting individual attitudes with system-level outcomes. The reviewed studies show how age-based stereotypes are embedded in organizational cultures, workforce management practices, and service delivery models, particularly in hospital and long-term care contexts. These dynamics affect not only older patients but also healthcare workers, contributing to burnout, reduced job satisfaction, and intentions to leave among staff working with older populations. At the same time, the evidence indicates that organizationally supported training and educational interventions can mitigate ageist attitudes and strengthen professional competencies. From a policy standpoint, this suggests the

importance of embedding age-inclusivity into organizational governance, quality assurance frameworks, and workforce strategies, rather than treating ageism solely as an individual ethical issue.

Structural and systemic ageism emerges as the most extensively documented level in the reviewed literature, reflecting growing concern about age-based inequities in healthcare access, resource allocation, and policy responses. The findings illustrate how ageism is institutionalized through healthcare policies, legal frameworks, and crisis management strategies, particularly during the COVID-19 pandemic. Age-based thresholds for diagnostics, preventive services, or intensive treatments exemplify how chronological age is often used as a proxy for vulnerability, efficiency, or social worth, rather than clinical need or individual preference. These practices raise critical ethical and governance issues and underscore the need for policy instruments that explicitly address ageism within health systems. Integrating age-sensitive equity assessments into health policy design and evaluation could represent a concrete step toward reducing structural ageism and ensuring that resource allocation decisions are transparent, proportionate, and justifiable.

An emerging and particularly policy-relevant theme concerns digital ageism and technological innovation in healthcare. Several studies highlight the risk that digital health tools, artificial intelligence, and algorithmic decision-making may reproduce or amplify age-based biases if older adults are inadequately represented in design, testing, and implementation processes. Assumptions about limited digital competence among older people can lead to exclusionary service models and reinforce existing inequalities. These findings point to the need for regulatory and governance frameworks that explicitly consider age-related bias in digital health technologies, as well as for participatory approaches that involve older adults in co-design and evaluation. Addressing digital ageism is especially urgent given the rapid expansion of digital healthcare and its growing role in shaping access, quality, and continuity of care.

From a methodological perspective, the predominance of quantitative and cross-sectional designs highlights the need for more longitudinal, mixed-methods, and intervention-based research capable of capturing how ageism evolves over time and across institutional contexts. Greater conceptual and measurement consistency would also strengthen the evidence base and support more effective policy translation. While this review deliberately focused on the European context, the structural mechanisms identified are likely to operate across different welfare regimes, suggesting the value of comparative and transnational research to inform policy learning.

Several limitations should be acknowledged. The restriction to English-language publications and to two major databases may have led to the exclusion of relevant studies, and, consistent with scoping review methodology, no formal quality appraisal was conducted. Moreover, the heterogeneity of ageism conceptualizations and outcome measures limits direct comparability across studies. Nevertheless, the review provides a robust and timely synthesis of a rapidly expanding field, offering a policy-relevant framework for understanding how ageism shapes healthcare systems and outcomes.

Overall, the findings indicate that tackling ageism in healthcare requires coordinated, multi-level policy action. Interventions focused solely on individual attitudes are unlikely to produce sustainable change if organizational routines and structural incentives remain unaltered. Conversely, system-level reforms that overlook everyday clinical interactions risk remaining symbolic. An integrated approach, linking education, organizational governance, health system design, and regulatory oversight, is therefore essential to promote equitable, age-inclusive, and person-centered healthcare systems in ageing societies.

5. CONCLUSION

This scoping review highlights ageism as a pervasive and structurally embedded phenomenon in healthcare and social care systems, with far-reaching implications for older adults' health, well-being, and social inclusion. By synthesizing recent European evidence, the study demonstrates that ageism operates across interconnected levels, from internalized beliefs to systemic policies, producing cumulative and mutually reinforcing effects. Addressing ageism, therefore, requires moving beyond isolated interventions toward integrated, multi-level strategies that simultaneously target individual attitudes, professional practices, organizational cultures, and policy frameworks.

The findings underscore the importance of early and continuous education on ageing and ageism within health professions training, as well as the need for organizational commitment to age-inclusive practices in workforce management and service delivery. At the policy level, greater attention is needed to ensure that healthcare systems do not rely on chronological age as a proxy for vulnerability or value, particularly in contexts of resource scarcity and technological innovation. Finally, the emerging evidence on digital ageism calls for inclusive design, ethical oversight, and regulatory safeguards to prevent the reproduction of age-based inequalities in digital health.

Overall, this review contributes to consolidating ageism as a key social determinant of health and provides a conceptual and empirical basis for future research and action aimed at promoting equity, dignity, and justice across the life-course and within increasingly complex and digitalized health systems

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