Observatorio del Edadismo

HelpAge España

las personas mayores cuentan

Ageism in Spain

Impact analysis based on the WHO Ageism Scale

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Table of contents

INTRODUCTION

The Ageism Observatory of HelpAge International España presents, for the first time, the results of the application of the WHO Ageism Scale in Spain.

In 2026, nearly 10 million people aged 65 and over live in Spain[1], representing 20.4% of the total population—one of the highest rates in Europe. More than 650,000 people are aged over 90, and those aged over 80 represent 6.1% of the population.

This unprecedented demographic reality, combined with a life expectancy of 84.1 years[2], highlights the urgent need to understand and address ageism as a structural barrier to healthy ageing and the full realisation of the rights of older people.

The WHO Ageism Scale enables, for the first time in Spain, the systematic measurement of experiences of stereotypes, prejudice and discrimination based on age—self-directed, interpersonal and institutional—, providing robust and internationally comparable data in countries where the Scale has already been validated (Moldova, Libya, Lebanon, Colombia).

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[1] **Spanish National Research Council (CSIC)**, *Older People in Spain 2025: A Profile. Key Statistical Indicators*, available at: https://envejecimientoenred.csic.es/wp-content/uploads/2025/10/enred-indicadoresbasicos2025.pdf

[2] **National Statistics Institute (INE)**, *Spain in Figures 2025*, available at: https://ine.es/infografias/infografia_espana_cifras2025.pdf

Why is this relevant?

In a context of rapid population ageing, measuring ageism is essential to:

- Highlight a phenomenon affecting one in two people worldwide, limiting health, participation and rights.
- Inform policies that ensure inclusive services, age-friendly environments and intergenerational employment, aligned with the UN Decade of Healthy Ageing (2021–2030).

This report aims to serve as a key tool for policymakers, professionals, media and civil society in building a society for all ages.

10M
People

>65
Age

20,4%
Population

+650.000
People

>90
Age

>80
Age

6,1%
Population

84,1
Life expectancy

Acknowledgements

This report would not have been possible without the institutional collaboration of the World Health Organization (WHO), the University of Edinburgh, IMSERSO and HelpAge International, whose support, together with that of HelpAge International España, enabled the development of the Scale.

Special thanks are extended to all partner organisations of HelpAge International España that facilitated contact with older people across the country: local associations, day care centres, residential care facilities and organisations of older people, which enabled access to their networks and made this representative survey possible.

Our deepest gratitude goes to the more than 200 older participants who generously gave their time and shared their personal experiences of ageism, helping to shed light on a phenomenon that affects their daily lives and those of millions of people in Spain. Their testimony forms the foundation of this work.

Partner organisations:

In collaboration with:

Funded by:

01

What is ageism?

The World Health Organization (WHO) defines ageism as the way we think (stereotypes), feel (prejudice) and act (discrimination) towards others or towards ourselves based on age[3]. It occurs when age is used to categorise and divide people in ways that lead to harm, disadvantage or injustice, and it can affect both younger and older people, although older people experience it more intensely.

Stereotypes **Prejudice** **Discrimination**

To better understand the Ageism Scale and its piloting in Spain, it is important to clarify what is meant by stereotypes, prejudice and discrimination when we talk about age.

[3] World Health Organization (WHO), *Global Report on Ageism*, 2021, available at: https://iris.paho.org/items/5ec40a5d-32a9-4dc6-ad45-97661de2bff7

Stereotypes

Stereotypes are the ideas, beliefs or mental images we hold about a group of people—in this case, people of a certain age—that oversimplify reality[4]. They are socially constructed and used as "shortcuts" for thinking, but they are often rigid generalisations that fail to recognise the diversity of life trajectories, capacities and experiences within the same age group.

In the context of ageism, these **stereotypes may be negative** (for example, automatically associating older age with illness, dependency, inability to learn or lack of productivity), but also seemingly "positive", such as assuming that all older people are wise, kind or selfless.

Both types of stereotypes can be problematic, as they reduce individuals to their age rather than recognising their personal characteristics, and may justify practices that limit their autonomy and social participation, without taking into account the specific circumstances of each older person.

[4] World Health Organization (WHO), *Global Report on Ageism*, 2021, available at: https://iris.paho.org/items/5ec40a5d-32a9-4dc6-ad45-97661de2bff7

Prejudice

Prejudice refers to the evaluations and emotions (rejection, fear, pity, irritation, paternalism) associated with these stereotypes, which shape how we feel towards people of a certain age[5]. Unlike stereotypes, prejudice carries an affective component: it is not only "I think older people are X", but also "they make me feel a certain way" because they are older.

In the context of ageism, prejudice towards older **people may be expressed as excessive pity, fear of ageing or reluctance to share spaces and resources with them**, which in turn influences how policies, services and everyday practices are designed. These prejudices **may also be self-directed**, when older people internalise negative messages about ageing and develop feelings of shame, uselessness or resignation associated with growing older.

Discrimination

Discrimination is the behavioural dimension of ageism: it includes actions, omissions and decisions that treat people unequally on the basis of their age, resulting in disadvantage, exclusion or violations of rights[6]. It can occur across multiple domains (healthcare, employment, social, media and institutional settings) and may take direct forms (such as denying a service or right explicitly on the basis of age) or indirect forms (apparently neutral rules that disproportionately disadvantage certain age groups).

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[5] World Health Organization (WHO), *Global Report on Ageism*, 2021, available at: https://iris.paho.org/items/5ec40a5d-32a9-4dc6-ad45-97661de2bff7

[6] World Health Organization (WHO), *Global Report on Ageism*, 2021, available at: https://iris.paho.org/items/5ec40a5d-32a9-4dc6-ad45-97661de2bff7

In the context of ageism, discrimination **may be interpersonal** (for example, speaking to older people as if they were children, not involving them in decisions that affect them, or assuming they cannot participate in certain activities) **or institutional** (policies that exclude older people from certain treatments, programmes or benefits solely on the basis of their chronological age).

It may also be self-directed ageism, when individuals limit their own decisions, give up opportunities or accept unfair treatment because they believe that "it is no longer their place" or that they do not "deserve" certain resources or forms of treatment due to their age.

Link to the Ageism Scale

The WHO Ageism Scale is specifically designed to capture these three dimensions: what we think (stereotypes), what we feel (prejudice) and how we act (discrimination) in relation to age. Understanding each of these concepts is key to interpreting the Scale items, distinguishing between self-directed, interpersonal and institutional ageism and, in the case of the pilot in Spain, analysing how these manifestations are distributed according to variables such as age, gender, education, health or territorial context.

The WHO Global Report on Ageism shows that ageism is a global and widespread phenomenon: it is estimated that **one in two people worldwide holds ageist attitudes towards older people.** Evidence synthesised by WHO indicates that ageism harms physical and mental health, is associated with greater social isolation and loneliness, poorer wellbeing, increased economic insecurity and reduced life expectancy, in addition to constituting a violation of human rights and a barrier to healthy ageing.

02

What is the Ageism Scale?

The WHO Ageism Scale is a standardised, freely available and evidence-based instrument, designed to measure, in a comparable and rigorous way, the experiences and manifestations of ageism across diverse global contexts, from adolescence to older age.

Developed by the WHO Department of Demographic Change and Healthy Ageing, in collaboration with experts in ageism measurement such as the University of Edinburgh, it forms part of the Global Campaign to Combat Ageism and responds to the need to quantify a previously invisible phenomenon in order to generate robust data to inform policies, interventions and evaluations.

The Scale captures the three essential dimensions of ageism—stereotypes (how we think), prejudice (how we feel) and discrimination (how we act)—and assesses its three levels of manifestation: self-directed (internalised by the individual), interpersonal (in face-to-face relationships) and institutional (through policies, norms or services).

Dimensions:

Levels of manifestation:

It consists of **15 items or statements** that **respondents answer by recalling experiences from the past 12 months**, indicating their level of agreement on a **Likert scale from 1 to 5** (for example: "I feel ashamed of my age", "Other people make me feel excluded because of my age" or "I have been denied opportunities because of my age"). Negative items are scored directly and positive items are reverse-coded, so that higher scores indicate greater exposure to ageism.

The Ageism Experience Scale measures what people experience, while the Perpetration Scale assesses attitudes towards other age groups. The Scale has already been validated in Spanish, Arabic, Russian, Romanian and other languages, and has been applied in humanitarian contexts (Moldova, Libya), polycrisis settings (Lebanon) and age-friendly cities (Colombia), demonstrating its usefulness in analysing intersections with health, loneliness, gender and forced displacement.

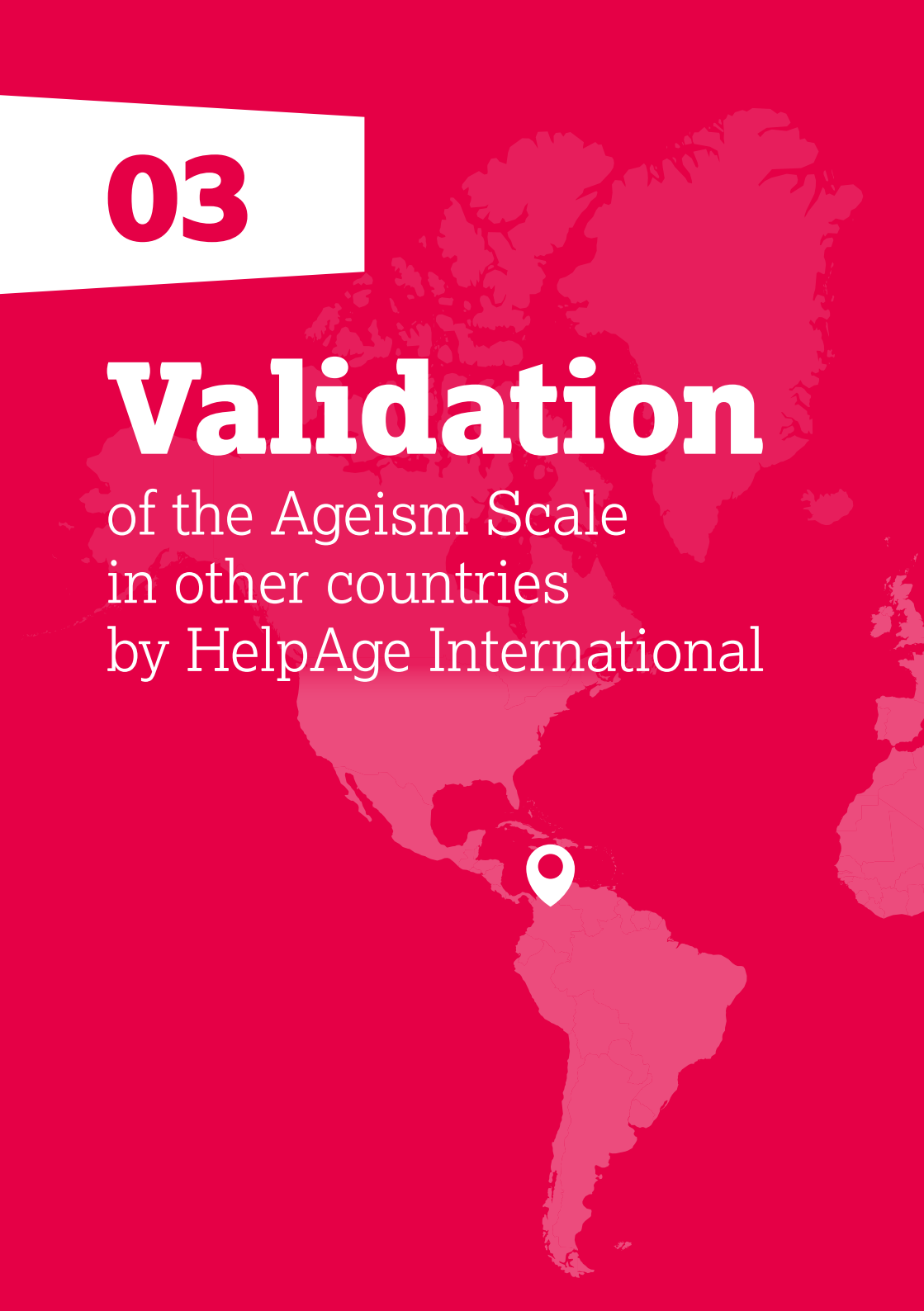
The user manual provides guidance on translation, administration, scoring and interpretation, recommending its use in population surveys, evaluations of intergenerational programmes, policy analysis and interventions to combat ageism. This tool not only makes ageism visible—affecting one in two people worldwide—but also enables the monitoring of change and the evaluation of impact.

All documentation related to the Ageism Scale is available via the QR code.

03

Validation

of the Ageism Scale
in other countries
by HelpAge International



The WHO Ageism Scale has already been tested and validated by HelpAge International, together with partner organisations, in a range of international contexts. Between 2024 and 2025, specific projects were carried out in Moldova, Libya, Lebanon and Colombia, in collaboration with universities and local organisations, providing evidence on how ageism manifests in humanitarian crises, forced displacement, polycrisis settings and in the development of age-friendly cities and communities[7].

These studies have enabled the validation of the Scale across different languages and sociocultural contexts, the analysis of the relationship between ageism, health, wellbeing and social participation, and the identification of how ageism interacts with other factors such as gender, education, income level, disability and refugee status. The accumulated experience in these countries provides an essential comparative framework for situating Spain's results within a global context and for informing public policy and programming recommendations that address ageism from an intersectional and rights-based perspective.

[7] HelpAge International, Understanding Ageism at the Intersections: Insights and Learning to Inform Future Research, Programming and Advocacy 2024/25 Learning Report, available at: https://www.helpage.org/wp-content/uploads/2025/11/FINAL-Learning-Report_HelpAge-2024-25.pdf

Moldova

In Moldova, HelpAge International conducted the validation of the WHO Ageism Experience Scale among **older people from host communities and older refugees from Ukraine**, with the aim **of analysing how displacement and crisis contexts influence experiences of ageism**. The study enabled comparisons across different groups of older people, incorporating variables such as age, educational level, perceived social status and health status, and provided quantitative evidence on the relationship between ageism, loneliness, wellbeing and intergenerational contact.

The findings showed that **older Ukrainian refugees experience significantly higher levels of ageism than Moldovan older people**, particularly in its self-directed and interpersonal forms, and report poorer physical and mental health, higher levels of loneliness and weaker intergenerational contact. It was observed that older age, a subjective perception of "feeling older", lower educational attainment and lower social status are associated with higher levels of ageism. Self-directed ageism was more common among those with lower levels of education; women scored higher in self-directed ageism, while men scored higher in interpersonal and institutional ageism.

From a methodological perspective, the study highlighted **challenges in accessing older men and members of host communities, as well as the need for trauma-sensitive data collection methods**, as some questions related to health and experiences of ageism elicited emotional responses, particularly among refugees. These findings underscore the importance of designing inclusive and targeted humanitarian responses for older refugees that address both institutional and internalised ageism.

Libya

In Libya, the **first psychometric validation in Arabic** of the WHO Ageism Experience and Perpetration Scales was **conducted in a humanitarian disaster context**, working with older people directly affected by the 2023 floods as well as those not affected. The **main objective** was to **analyse how ageism intersects with prolonged exposure to crises and disasters, and what implications this has for the health and wellbeing of older people.**

The Scales demonstrated strong psychometric properties and revealed **notable institutional discrimination,** particularly in relation to housing, social protection and healthcare policies that do not adequately respond to the needs of older people. Higher levels of ageism were associated with poorer health indicators, greater loneliness and lower subjective wellbeing. However, somewhat counterintuitively, the **group affected by the floods showed overall health and wellbeing indicators equal to or better than those of the non-affected group, with the exception of higher levels of post-traumatic stress symptoms.**

This apparent paradox has been interpreted in terms of resilience and post-disaster support, as community solidarity and the humanitarian response appear to have contributed to greater visibility, recognition and participation of older people in affected areas. Fieldwork highlighted the **importance of culturally sensitive translations, the involvement of trusted local facilitators, and the use of questionnaires that take into account the reluctance of some older people to openly criticise institutions, as well as the need for manageable surveys to avoid fatigue and ensure comprehension of all items.**

Lebanon

In the case of Lebanon, **the validation of the Ageism Scale is embedded within a broader longitudinal study on lifelong learning and cognition** (Later Life Learning and Cognition, 3LC), conducted by the American University of Beirut in collaboration with the University for Seniors, Columbia University and the HelpAge International Global Network, in a context of economic, social and conflict-related polycrisis. The project **aims to analyse whether participation of older people in learning activities can reduce experiences of ageism and loneliness, as well as strengthen social support networks** in an environment characterised by prolonged instability and limited social protection.

The research has required continuous adaptation of questionnaire items to the rapidly changing context (currency devaluation, transformations in social protection and employment, impacts of conflict), as well as managing logistical challenges arising from staff displacement and interruptions to fieldwork. In addition, the lack of suitable Arabic-language instruments for this context necessitated significant efforts in translation and training of enumerators in concepts of ageism and ageing, ensuring standardised administration of the Scale under highly unstable conditions.

Despite these challenges, the research has **resonated strongly with participating older people, who have expressed that the study reflects their life trajectories and makes them feel that their experiences are recognised and valued.** The Lebanese experience highlights that conducting rigorous research on ageism in polycrisis contexts requires flexibility, patience and sustained investment, but can foster a strong sense of validation and agency among older participants.

Colombia

In Colombia, **the first validation in Latin America of the WHO Ageism Experience and Perpetration Scales was carried out, using the Colombian Spanish version and, for the first time,** integrating indicators from the WHO Age-friendly Cities and Communities framework. The study was led by the University of Edinburgh in collaboration with four Colombian universities and the Colombian Network for Active and Dignified Ageing, with support from HelpAge International. It was designed with an intergenerational approach, involving university students as enumerators and organisations of older people as key participants.

Older people in Colombia reported moderate levels of ageism, with institutional ageism being the most prevalent. They also perceived their communities as relatively age-friendly, although with differences across territories. Those who perceived their cities as more age-friendly experienced lower levels of ageism and showed better physical and psychological health outcomes, lower levels of loneliness and higher wellbeing. In contrast, those reporting higher levels of ageism—particularly in its self-directed and interpersonal forms—demonstrated lower civic and social participation, fewer employment opportunities and a reduced sense of respect and inclusion.

The study also highlighted significant inequalities: **older people with disabilities, lower levels of education, lower income or lower perceived social status reported higher levels of ageism** and lower satisfaction across several age-friendly city domains, pointing to challenges in accessibility and inclusion. From a methodological perspective, the length of the questionnaire, the need to adapt certain items from the age-friendly framework to the local context and the use of students as enumerators underscored the importance of simplifying tools, strengthening direct training of field staff and continuing to explore the potential of intergenerational approaches to reduce stereotypes and prejudice.

04

Validation

of the Ageism Scale in Spain

Methodology

Data collection was carried out with a sample of 203 people aged 60 and over through face-to-face surveys conducted by two interviewers who were recruited ad hoc for this study and received prior training from both the HelpAge International Spain team and the University of Edinburgh team.

The average age of participants was 72 years, ranging from 60 to 96 years. The majority (61%) were women, reflecting a distribution similar to that of the overall study population (56% women and 44% men). Most participants (72.91%) lived in towns and cities with between 10,001 and 500,000 inhabitants (with 77% of older people living in urban areas), the vast majority were retired (86.21%), and approximately 31.53% reported having a disability. Data were collected across ten autonomous communities.

Data collection: face-to-face surveys

2
Interviewers

15
Ítems

203
Respondents

>60
Age

72
Average age

61%
Women

10
Autonomous communitie

The survey included the following standardised tools to assess experiences, health and social relationships:

Age Discrimination Experience Scale.

This 15-item Scale measures participants' experiences of age-based stereotypes, prejudice and discrimination across different areas of life. It is divided into three subscales: self-directed, interpersonal and institutional discrimination. Items are rated on a Likert scale ranging from "Strongly disagree" to "Strongly agree", with additional options "Don't know" and "Not applicable".

SF-12 v2 Health Survey.

The SF-12 v2 consists of 12 items assessing health-related quality of life: 6 items on physical health (general health, physical functioning, role physical and bodily pain) and 6 on mental health (mental health, vitality, role emotional and social functioning). Higher scores indicate better health status.

WHO-5 Well-Being Index.

This WHO index includes 5 items measuring subjective wellbeing over the previous two weeks, rated on a 6-point Likert scale ("At no time" to "All of the time"). Higher scores indicate greater wellbeing.

UCLA Loneliness Scale (ULS-6).

The 6-item short version of the UCLA Loneliness Scale assesses feelings of social isolation. Participants respond on a 4-point Likert scale (1 = "Never" to 4 = "Often"), where higher scores indicate greater loneliness.

Intergenerational Contact.

The frequency, nature, quality and enjoyment of previous contact with children, adolescents, young adults, middle-aged adults and older people were measured using items on a 5-point Likert scale. Higher scores indicate greater frequency, voluntariness, quality and enjoyment.

Subjective Social Status and Sociodemographic Variables.

A measure of subjective social status (a 10-rung ladder scale reflecting perceived position in society) was included, together with variables such as age, gender, educational level, income, marital status and place of residence, in order to contextualise profiles and analyse intersections.

The involvement of intermediaries from partner organisations fostered greater initial trust and smoother responses. In contrast, in surveys conducted without such intermediaries, higher levels of mistrust were observed ("Why do they want this data?", "What is the purpose?"), which extended the time required to complete the surveys.

Profile of respondents

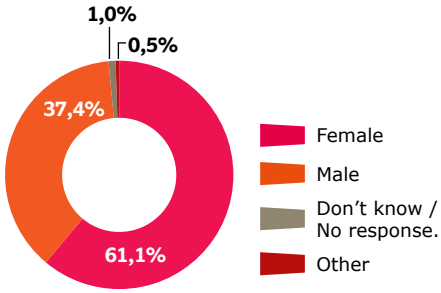
The following charts present the sociodemographic profile of the respondents:

Gender

A total of 124 women (61%) and 76 men (39%) were surveyed. Notably, in this sample, men reported higher levels of ageism on the Scale according to INE data, in contrast to findings from other countries.

The gender distribution (61% women, 39% men) closely reflects that of the older population in Spain: 56% women and 44% men.

Figure 1. Profile of respondents by gender (percentage).



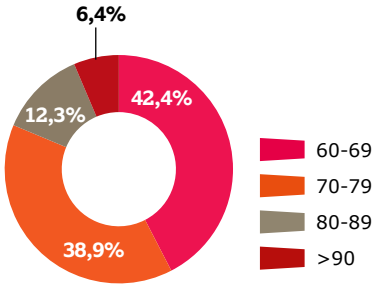
Source: own elaboration.

Age

42% of respondents are aged 60–69, 38% are aged 70–79, 12% are aged 80–89, and only 6% are over 90. These percentages are very similar to those of the older population in Spain: 45% (60–69), 31% (70–79), 17% (80–89) and 4% (over 90).

The average age of respondents is 72 years, and the oldest participant is 96 years old.

Figure 2. Profile of respondents by gender (percentage)).



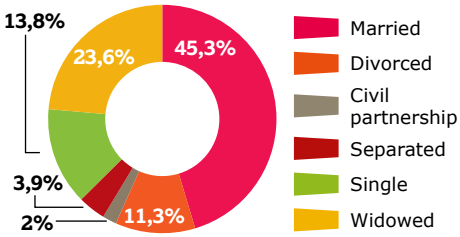
Source: own elaboration.

Marital status

A total of 92 married respondents (45%), 48 widowed (23%), 28 single (14%), 23 divorced (11%), 8 separated (4%) and 4 in a civil partnership (2%) were surveyed.

This distribution shows a slight discrepancy with Eurostat data, where married individuals account for 61%, widowed 25.5%, single 6.9%, and divorced/separated 6.6%.

Figure 3. Profile of respondents by marital status (percentage).



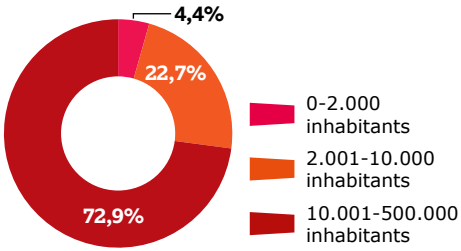
Source: own elaboration.

Size of municipality of residence

Of the respondents, 148 live in municipalities with more than 10,000 inhabitants (72%), 46 in municipalities with between 2,001 and 10,000 inhabitants (22%), and 9 in municipalities with fewer than 2,000 inhabitants (4%).

This distribution is similar to that of older people according to the Spanish National Research Council (CSIC): 77% live in municipalities with more than 10,000 inhabitants, 14% in those with between 2,001 and 10,000, and 7% in rural areas.

Figure 4. Profile of respondents by municipality of residence (percentage).



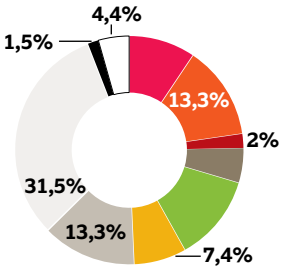
Source: own elaboration.

Autonomous community of residence

Surveys were conducted across 10 autonomous communities and 15 provinces in Spain. The percentages by region are as follows: Andalusia (9.4%), Aragon (13.3%), Asturias (2%), Cantabria (4.9%), Castilla-La Mancha (12.3%), Catalonia (7.4%), Galicia (13.3%), Madrid (31.5%), Murcia (1.5%) and Navarre (4.4%). The provinces included (excluding single-province regions) were Granada, Jaén, Córdoba, Málaga, Cádiz, Zaragoza, Guadalajara, Toledo, Barcelona, Ourense and A Coruña.

These percentages broadly reflect the geographical distribution of people aged 60 and over according to data from the National Statistics Institute (INE), except for the underrepresentation of Catalonia in this sample.

Figure 5. Profile of respondents by Autonomous Community of residence (percentage).



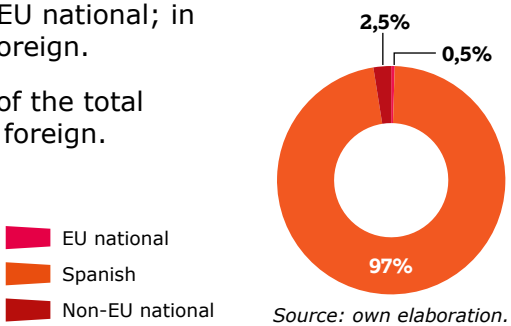
Source: own elaboration.

Nationality

Among respondents, 197 (97%) hold Spanish nationality, 5 (2%) are non-EU nationals and 1 (1%) is an EU national; in total, 3% of the sample is foreign.

According to INE data, 6% of the total older population in Spain is foreign.

Figure 6. Profile of respondents by nationality (percentage).



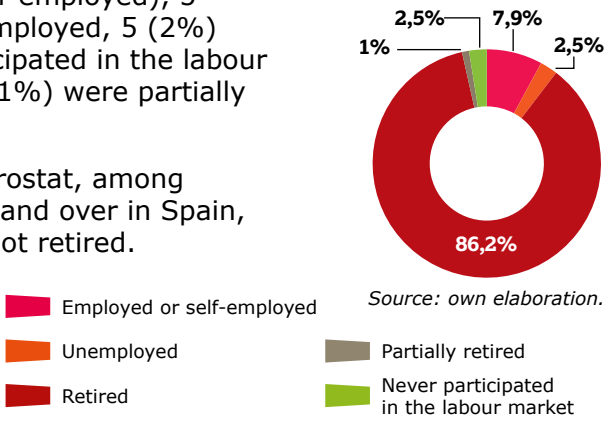
Source: own elaboration.

Labour market status?

A total of 175 respondents were fully retired (86%), 16 (7%) were economically active (either employed or self-employed), 5 (2%) were unemployed, 5 (2%) had never participated in the labour market, and 2 (1%) were partially retired.

According to Eurostat, among people aged 65 and over in Spain, only 1.6% are not retired.

Figure 7. Profile of respondents by labour market status (percentage).



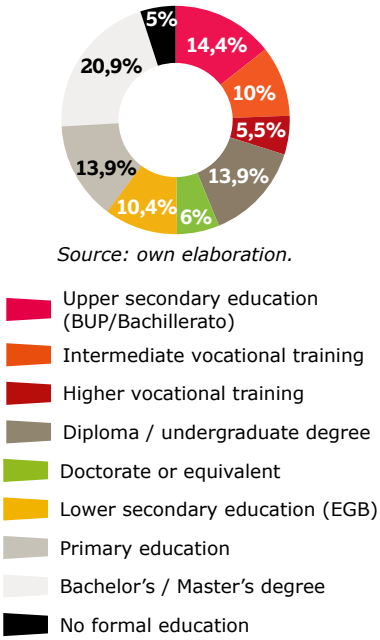
Source: own elaboration.

Level of education

Of the total sample, 42 respondents hold a bachelor's degree or master's degree (20%), 29 have completed upper secondary education (14%), 28 have primary education (13%), 28 hold a diploma or undergraduate degree (13%), 21 have lower secondary education (10%), 20 have completed intermediate vocational training (9.8%), 12 hold a doctorate (5.9%), 11 have higher vocational training (5.4%), and 10 have no formal education (4.9%).

This distribution shows a slight discrepancy with INE data for the overall older population, due to the overrepresentation of individuals with bachelor's or master's degrees in the sample.

Figure 8. Profile of respondents by level of education (percentage).



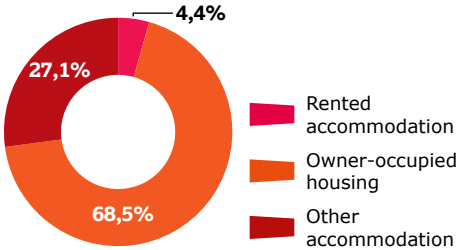
Source: own elaboration.

Place of residence

Among respondents, 139 (68%) live in their own home, 55 (27%) live in accommodation that they do not own (including residential care facilities or with family members), and 9 (4%) live in rented housing.

According to Eurostat, in the general population of older people, 89.1% live in their own home.

Figure 9. Profile of respondents by place of residence (percentage).



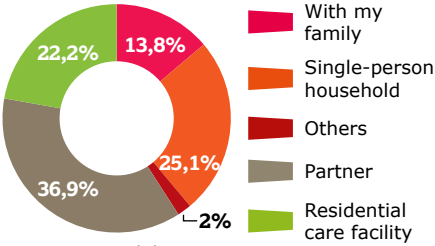
Source: own elaboration.

Who do you live with?

Among respondents, 75 (36%) live with their partner, 51 (25%) live alone, 45 (22%) live in residential care facilities, 28 (13%) live with family members, and 4 (2%) live with other people.

According to the most recent INE data, in the overall older population, 22.8% live alone, 39% live with a partner, 22% live with family members, and 15% live with others.

Figure 10. Profile of respondents by living arrangements (percentage).



Source: own elaboration.

Sample representativeness

The sociodemographic profile of the 203 respondents shows a high level of representativeness in relation to official data from the National Statistics Institute (INE), the Spanish National Research Council (CSIC) and Eurostat for the older population in Spain, with close alignment across the main demographic variables.

The sample consisted of 61% women and 39% men. 42% were aged 60–69, 38% aged 70–79, 12% aged 80–89 and 6% aged 90 or over. 72% lived in municipalities with more than 10,000 inhabitants, 22% in municipalities with between 2,001 and 10,000 inhabitants, and 4% in municipalities with fewer than 2,000 inhabitants. This distribution is consistent with national INE data (56%–44% by gender and 45%–31%–17%–4% by age group; CSIC 77–14–7). The geographical coverage included 10 autonomous communities and 15 provinces, with a slight underrepresentation of Catalonia. 97% held Spanish nationality and 86% were fully retired, in line with INE/Eurostat data.

However, some specific characteristics can be explained by the sampling design. Marital status shows fewer married individuals (45% vs. 61% Eurostat) and a higher proportion of single/divorced individuals, while housing tenure shows lower home ownership (68% vs. 89% Eurostat) and an overrepresentation of people living in residential care facilities (22% vs. approximately 6% INE), likely due to recruitment in public libraries and day centres. Living arrangements (36% with a partner, 25% living alone) are broadly consistent with INE data (39%–23%), although the proportion living in residential care is notable. Finally, the educational profile shows an overrepresentation of higher education qualifications (20% bachelor's/master's), suggesting a bias towards more highly educated participants.

In conclusion, the sample accurately reflects the profile of the older population in Spain, with minor deviations that do not compromise its comparative validity and, in some cases, enrich the qualitative analysis by overrepresenting groups in situations of vulnerability, such as those living in residential care facilities.

05

Results

Older people surveyed reported low to moderate levels of ageism, although they were not completely free from it. This finding suggests that, while the perception of age-based discrimination is not widespread, it remains a persistent reality in their daily lives.

The forms of discrimination identified were diverse, but the most prominent were those related to the institutional sphere, where public policies, regulations and normative frameworks may create subtle barriers that hinder equitable access to benefits, services and the full exercise of rights.

The forms of discrimination identified were diverse, but the most prominent were those related to the institutional sphere.

Within institutional discrimination, respondents indicated that health and social security policies do not always adequately respond to the real needs of older people, particularly in terms of personalised care, accessibility and the recognition of the functional and social diversity within older age groups. They highlighted that regulations tend to treat older people as a homogeneous group, without recognising the significant differences in their economic situation, health status, educational level or disability. This inflexible institutional approach may result in a form of structural ageism, even in the absence of explicit intent to discriminate.

Regulatory frameworks tend to treat older people as a homogeneous group.

Another key finding of the study relates to the perception of the image of older people in the media. Respondents repeatedly pointed out that media outlets—whether television, print or digital—tend to portray them in a stereotypical or unrealistic manner. The most common representations focus on dependency, frailty or isolation, overlooking other aspects such as activity, capacity for learning, social contribution and community participation. This limited portrayal reinforces prejudice and may consolidate a social narrative in which old age is associated with loss and decline, rather than with experience, wisdom or autonomy.

The media portray older people in a stereotypical or unrealistic way.

In contrast, personal experiences related to feelings of shame or self-devaluation due to age were less frequent. The majority of participants reported a positive self-perception, pride in their age and life trajectory. This finding is particularly relevant, as it reflects a notable level of resilience and capacity to cope with social prejudice. However, the presence—even if occasional—of self-blame or internalisation of negative stereotypes shows that ageism can also permeate identity, subtly influencing self-esteem and the way individuals perceive their own ageing process.

One of the most significant findings of the study is the strong relationship between experiences of ageism and indicators of physical, psychological and social health. Individuals who reported experiencing age-based discrimination tended to have poorer health status, both physically and emotionally. Moreover, they reported lower levels of life satisfaction and overall wellbeing. This link demonstrates that ageism not only affects the social sphere, but also has a clinical and emotional impact. The perception of being treated as "less capable" or "less valuable" simply due to age can erode personal motivation, reduce social participation and, over time, contribute to isolation and frailty.

Those reporting higher levels of age-based discrimination showed poorer physical and mental health, as well as lower overall life satisfaction.

The study also identified a significant relationship between ageism and loneliness. Individuals who felt discriminated against or undervalued tended to experience greater feelings of isolation, reinforcing the idea that ageism carries a high emotional cost. However, institutional ageism—for example, administrative or regulatory barriers—did not show as clear a correlation with health and wellbeing indicators as interpersonal or internalised ageism. This may be because discriminatory policies operate in a more indirect and prolonged manner, whereas unfair or disrespectful treatment in everyday life generates an immediate emotional impact.

Interestingly, no direct relationship was found between experiences of ageism and the frequency of intergenerational contact with younger people. This result challenges previous assumptions that greater interaction between generations would reduce negative stereotypes. It suggests that the quality of contact—rather than its frequency—may be the determining factor in shaping positive attitudes towards ageing.

The data analysis also revealed significant individual differences. Individuals who identified themselves as being in a later stage of life, those who were not married, or those with some degree of disability or belonging to a lower socio-economic group reported higher levels of discrimination. This pattern indicates that ageism does not operate in isolation but interacts with other dimensions of inequality and factors that contribute to discriminatory treatment, such as economic status, health or family situation, generating intersectional forms of vulnerability and, therefore, discrimination.

Individuals in a later stage of life, those who were not married, or those with some degree of disability or belonging to a lower socio-economic group reported higher levels of discrimination.

In contrast, a higher level of education proved to be a protective factor against ageism, particularly in its self-directed form. Individuals with higher education were more likely to reject negative stereotypes about ageing, showing a more critical attitude towards prejudice and greater confidence in their abilities. This finding is consistent with previous studies highlighting the role of knowledge and information in shaping a more positive image of ageing.

A higher level of education proved to be a protective factor against ageism, particularly in its self-directed form.

Conversely, variables such as gender, size of the place of residence or housing tenure did not show significant differences, confirming that ageism is a cross-cutting phenomenon that affects the entire older population. However, this does not mean that all individuals experience it in the same way. Although some groups, such as older women, may report lower levels of ageism in certain surveys or contexts, they remain exposed to specific and more subtle forms of discrimination related to the intersection between age and gender. Thus, ageism may take different forms depending on the identity of the individual affected, adapting and manifesting itself in different ways according to social, cultural and role-related factors, highlighting the complexity of this phenomenon.

Variables such as gender, size of the place of residence or housing tenure did not show significant differences, confirming that ageism is a cross-cutting phenomenon that affects the entire older population.

Overall, the findings position ageism as a dual challenge: both social and health-related. It is not merely an issue of perception or social justice, but a factor that can directly affect the quality of life and health of older people. Discrimination, whether explicit or subtle, can exacerbate feelings of devaluation and have cumulative effects on physical and emotional wellbeing.

The findings position ageism as a dual challenge: social and health-related. It is a factor that can directly affect the quality of life and health of older people.

In the Spanish context, the study highlights that ageism manifests primarily in structural forms, through laws, public policies and media representations that do not always reflect the needs of older people.

However, despite these persistent forms of discrimination, a significant level of resilience stands out, reflected in the positive self-perception and pride in their age expressed by many respondents. This suggests that identity in older age is not defined solely by social stigma, but also by accumulated experience, autonomy and the redefinition of one's role within the community. It could be said that older people feel proud of their achievements.

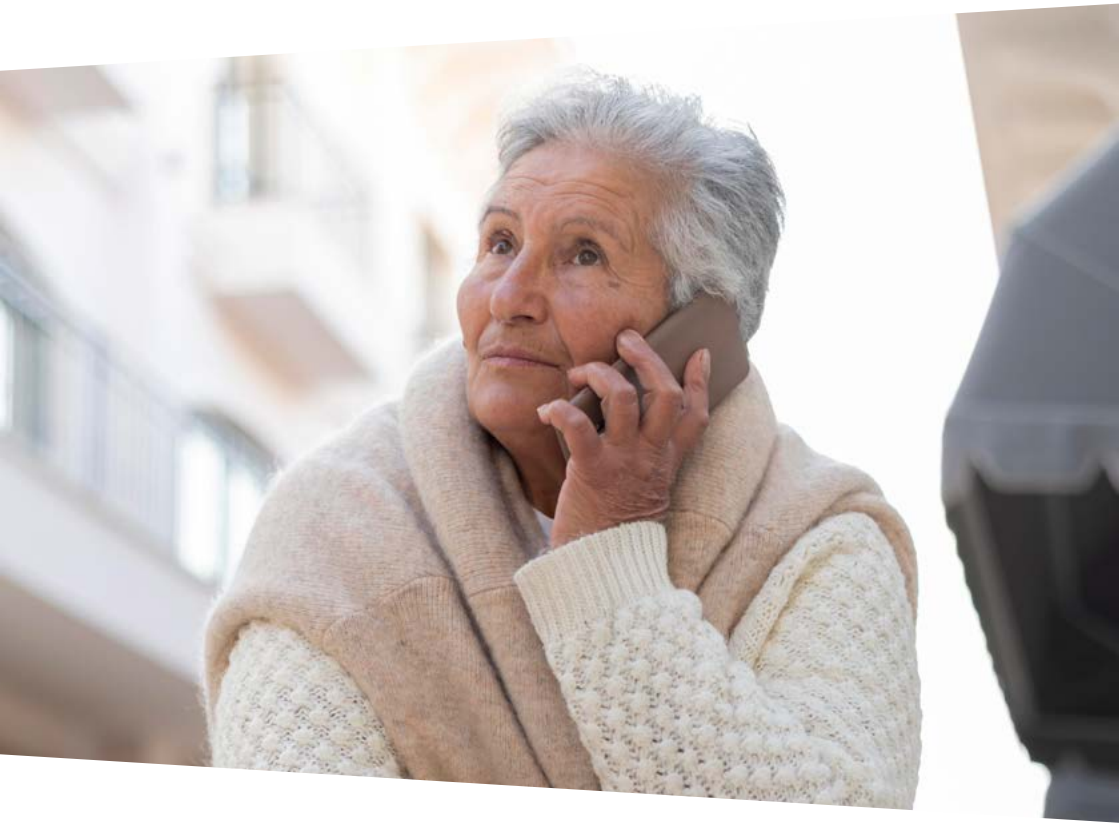
In the face of these persistent forms of discrimination, a notable capacity for resilience emerges, reflected in the positive self-perception and pride in their age expressed by many respondents.

From a sociocultural perspective, age functions as a social axis similar to gender or class, influencing how people are perceived and treated. The experiences captured in the study reveal transformative processes: from the initial internalisation of stereotypes to the reinterpretation of one's life role through experience and resilience. In this transition, the perception of old age moves beyond being exclusively associated with loss and becomes a stage that can be characterised by autonomy, recognition and social contribution.

From a sociocultural perspective, age functions as a social axis similar to gender or class, influencing how people are perceived and treated.

Therefore, the findings call for a rethinking of ageing in more inclusive terms, promoting policies that recognise the diversity of the older population and foster active participation across all areas of society. Addressing ageism involves not only eliminating prejudice, but also building a new narrative of ageing, based on respect, equity and the value of experience. A stage of life where opportunities should not be limited on the basis of age.

Addressing ageism involves not only eliminating prejudice but also building a new narrative of ageing.



06

Direct field observations

During the surveys conducted in Spain, **older participants shared testimonies illustrating concrete experiences of ageism in their daily lives.** These accounts enrich the quantitative data with in-depth qualitative insights that deserve careful consideration. In addition, older people highlighted the importance of face-to-face surveys, as direct interaction and active listening create a safe and trusting environment, improving the quality and reliability of responses.

When interviewing participants, **particular attention was paid to the different domains in which they perceive ageism.** These include the **healthcare, family and residential settings, as well as social attributions and personal beliefs.** The following section outlines these experiences, which help to illustrate the survey's quantitative findings.

In the **healthcare setting,** older people often disengage from family relationships and enter into different power dynamics typical of healthcare environments, particularly in the patient–professional relationship. This can lead to instances of inadequate treatment that are not reciprocal but unilateral, and which objectify older people, introducing age-based biases. The process of dehumanisation from "person" to "patient" perpetuates stereotypes that permeate their identity, reinforcing institutional ageism such as unequal access to diagnoses and treatments based on age rather than individual case. One participant stated: "I don't want to become a piece of furniture", illustrating how external ageist discourse can be internalised.

> "I don't want to become a piece of furniture.

In the **family setting,** characterised by caregiving and close relationships, traditional roles are often reversed, creating what can be described as "inverted dependency" as a defining feature. This intersection between ableism and ageism leads to infantilisation and devaluation, and elevates a biological condition into a social one, affecting more the perceptions of older people themselves than the objective reality. These prejudices impact self-perception and create uncomfortable situations due to the loss of reciprocity. One testimony illustrates this: "A mother can have five children, but five children cannot have one mother."

> **"A mother can have five children, but five children cannot have one mother."**

The distinction between the "physical" and the "emotional/social" is not consistently present in older people's identity narratives. There is a direct relationship between social ties, beliefs and self-perception of age: those who maintain close, high-quality relationships show lower levels of internalised ageism. The loss of partners or friendships accelerates negative self-directed ageist attitudes. Spiritual beliefs, resilience strategies, post-retirement goals and positive attitudes towards death can counteract ageism. In summary, the disruption of previous ways of life, beliefs, contexts and relationships fosters self-directed ageism.

> **When you lose your sense of purpose, that is when you become old.**

> **We are fortunate to live, and fortunate to die.**

Testimonies such as "When you lose your sense of purpose, that is when you become old", "My children have helped me a great deal" or "We are fortunate to live, and fortunate to die" illustrate these dynamics.

Narratives of self-identity vary according to perceptions of age. On the one hand, positive perspectives highlight stereotypes such as accumulated experience and wisdom. On the other, negative perspectives emphasise physical and emotional decline, loss of independence, and issues related to care and social relationships. This example of identity and discourse supports the idea that age is constructed as a social category that affects individual identities, both in self-perception and in how others perceive them.

Notable differences according to residential context.

Differences were observed depending on the residential context. Individuals living alone provided more detailed and dynamic responses; in residential care facilities, responses tended to be shorter and showed lower levels of engagement, partly associated with situations of dependency; and in day centres, intermediate patterns were observed. These findings may be linked to the degree of institutionalisation and the transition to social and physical environments different from the usual context, with possible implications for the reproduction of ageist stereotypes.

These field observations indicate that ageism in Spain is an everyday experience that cuts across health, family, self-esteem, and intergenerational and intra-family relationships. This context calls for concrete responses, ranging from public policies to awareness-raising campaigns.

07

Conclusion

Ageism is a holistic phenomenon that occurs across all social classes and in all areas of life. Its consequences are not limited to issues of social justice, but also translate into a lower quality of life and reduced wellbeing for older people.

Educational level is particularly relevant in relation to self-directed ageism, whereas neither sex nor the territorial context of residence appears to be significant. However, intersectional discrimination becomes evident when other factors come into play, such as disability, gender or residential setting. The social narrative of ageing promoted by the media is challenged, with the institutional sphere and public policies identified as the areas where higher levels of ageism are perceived.

08

Recommen-dations

1

Promote a positive image of ageing.

The media, advertising and culture play a key role in portraying the diversity of older age: active individuals with projects, capacities and valuable contributions to society.

2

Review public policies and regulatory frameworks.

Public authorities must ensure that laws and regulations do not discriminate on the basis of age, particularly in areas such as healthcare, housing, pensions and social services. All public policies should be adapted to the needs of an increasingly long-lived population.

3

Strengthen care and community support policies.

It is essential to promote and develop care policies that foster community networks and local services, enabling older people to remain in their usual environment with adequate support and accompaniment.

4

Support lifelong learning.

Facilitating access to new forms of learning promotes autonomy, self-esteem and social participation, thereby reducing the risk of self-directed ageism.

5 Address ageism as a public health issue.

As with other forms of discrimination, the effects of ageism have a direct impact on physical and mental wellbeing. Therefore, its prevention should be integrated into health policies, active ageing strategies and disease prevention programmes.

6 Raise awareness from an early age.

Introducing education on generational diversity within school curricula can help build a culture of respect across all stages of life.

7 Promote the active participation of older people in decision-making.

Including the voices of older people in debates on public policy, urban planning and community programmes strengthens democracy and enhances the legitimacy of adopted measures. Advisory councils and participatory forums should play a meaningful role in shaping proposals. Older people should be included in all participatory bodies.

8 Strengthen research and the evaluation of public policies.

It is essential to continue generating data on the multiple forms of ageism, their impacts and effective strategies to address them. Investing in social research and policy evaluation will enable evidence-based adjustments, ensuring sustainable interventions with real impact.

09

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Appendix

Psychometric Evaluation and Correlates

of the WHO Ageism Experiences Scale in a Spanish Sample of Older Adults

Method

Participants

This study employed a cross-sectional design. The sample consisted of 203 participants recruited from ten different Autonomous Communities in Spain. Data collection occurred from May to December 2025. A non-probability convenience sampling strategy was utilised, with recruitment through NGO's and entities that work directly with older people. Participants were asked Demographic characteristics included age, gender, education level, subjective social status, subjective life status, town size, marital status, employment status, and property ownership. Participants were also assessed for functional difficulties using the Washington Group Short Set. Characteristics of participants were summarised in Table 1.

Table 1. Own elaboration

Variable	n	%	M	SD
Age	201		72.44	8.00
Gender				
Female	124	61.08%		
Male	76	37.44%		
Prefer not to answer	3	1.48%		
Town Size				
0 to 2,000 inhabitants	9	4.43%		
2,001 to 10,000 inhabitants	46	22.66%		
10,001 to 500,000 inhabitants	148	72.91%		
Education Level	201		6.41	2.09
Marital Status				
Not married	111	54.68%		
Married	92	45.32%		
Property Owner				
No	29	14.29%		
Yes	174	85.71%		

Variable	n	%	M	SD
Employment Status				
Never been in job market	5	2.46%		
Part-time retiree	2	0.99%		
Retired	175	86.21%		
Salaried or self-employed	16	7.88%		
Unemployed	5	2.46%		
Life Stage	203		7.13	1.28
Disability Status				
No disability	139	68.47%		
Has disability	64	31.53%		
SF-12 Physical Health	203		2.21	0.62
SF-12 Mental Health	203		3.21	0.72
Well-being	203		3.42	1.00
Loneliness	203		1.60	0.66
Contact - Children	203		3.31	0.57
Contact - Friends	203		3.29	0.53
Contact - Young People	203		3.57	0.51
Contact - Middle-aged	203		3.66	0.43
Contact - Older Adults	203		3.90	0.37

The study sample consisted of approximately 203 participants with a mean age of 72.44 years. The majority of the sample identified as Female (61.08%), most participants (72.91%) resided in towns with 10,001 to 500,000 inhabitants. A high percentage of the sample were property owners (85.71%) and the vast majority were retired (86.21%). Approximately 31.53% reported having a disability.

Measures

Ageism Experiences Scale.

This 15-item scale assessed participants' experiences with age-based stereotypes, prejudices, and discrimination across various life domains. The scale included three subscales indicating different levels of ageism, which are self-directed ageism, interpersonal ageism, and institutional ageism. Items were rated on a Likert-type scale ranging from "Strongly disagree" to "Strongly agree", with a "don't know and not applicable" options provided.

SF-12 v2 Health Survey.

The SF-12v2 is a 12-item instrument designed to assess health-related quality of life across physical health (6 items, including general health, physical functioning, role physical, and bodily pain) and psychological health (6 items, including mental health, vitality, role emotional, and social functioning) domains. Higher scores indicate better health status.

WHO-5 Well-Being Index.

The World Health Organization's Well-being Index consists of five items assessing subjective well-being over the past two weeks. Responses are recorded on a 6-point Likert scale from "At no time" to "All of the time," with higher scores indicating better well-being.

Loneliness.

The UCLA Loneliness Scale 6 item version (ULS-6) was a shorter version of the UCLA Loneliness Scale. Participants were asked to rate six items on a 4-point Likert-type scale (1 = "never," 2 = "rarely," 3 = "sometimes," 4 = "often"), with higher scores suggested higher loneliness level.

Intergenerational Contact.

The intergenerational contact was measured by asking participants' frequency, nature, quality, and pleasantness of their previous intergenerational contact with children, adolescents, younger adults, middle-aged adults, and older adults. Items were based on 5-point Likert-type scale and were scored such that higher scores indicate more contact frequency, more voluntary, better-quality contact, and more pleasant of intergenerational contact.

Analysis

We first examined the descriptive statistics of the sample and assessed the reliability of the WHO Ageism Scales using McDonald's Omega. Pearson correlation analyses were conducted to explore associations between ageism (both experiences and perpetration) and health-related variables, including physical health, psychological health, well-being, loneliness, and intergenerational contact. Univariate regression analyses were employed to identify demographic predictors of ageism experiences and perpetration. Predictors included age, gender, life stage, education level, disability status, town size, marital status, and property ownership. Overall, the analysis evaluates the psychometric performance of the WHO Ageism Scale in a Spanish sample, investigates demographic predictors of ageism, and examines its associations with key health outcomes.

Results

Description of Ageism Experiences

Descriptive statistics for the individual ageism experience items and their composite subscales are presented in Table 2. Participants generally reported low to moderate levels of ageism across the various dimensions measured. Notably, items 13 (i.e., Policies made by the government (e.g., on housing, social security, healthcare) do not meet the needs of people my age) and 14 (after reverse coding of "People my age are portrayed positively in the media") showed the highest mean scores, indicating these particular forms of ageism (i.e., institutional ageism) were most higher level experienced by the sample. It also worth noting that the third item (I am embarrassed of my age) showed a distribution heavily weighted toward the lower end of the scale.

Table 2. Descriptive Statistics for Ageism Experiences Items

Variable	n	M	SD	Min	Máx	Skew	Kurtosis
ageism_e_1	201	1.78	1.12	1	5.00	1.69	2.19
ageism_e_2	201	1.57	1.06	1	5.00	1.94	2.74
ageism_e_3	203	1.21	0.55	1	5.00	3.54	15.83
ageism_e_4	200	2.00	1.31	1	5.00	1.03	-0.37
ageism_e_5	200	2.09	1.29	1	5.00	0.91	-0.48
ageism_e_6	194	1.86	1.11	1	5.00	1.25	0.53
ageism_e_7	201	1.59	0.97	1	5.00	1.96	3.47
ageism_e_8	199	1.64	0.88	1	4.00	1.44	1.38
ageism_e_9	199	1.65	0.87	1	4.00	1.42	1.42
ageism_e_10	201	2.17	1.32	1	5.00	0.81	-0.76
ageism_e_11	202	1.65	1.09	1	5.00	1.70	1.77
ageism_e_12	203	1.60	0.92	1	5.00	1.71	2.37
ageism_e_13	184	3.74	1.25	1	5.00	-0.71	-0.73
ageism_e_14	191	3.49	1.25	1	5.00	-0.21	-1.28
ageism_e_15	169	1.88	1.18	1	5.00	1.33	0.75
Overall ageism experiences	203	1.98	0.47	1	3.64	0.50	0.27
Self-directed ageism	203	1.73	0.63	1	3.80	0.85	0.39
Interpersonal ageism	203	1.74	0.61	1	3.86	0.79	0.33
Institutional ageism	202	3.08	0.91	1	5.00	0.05	-0.24

Performance of WHO Ageism Experiences Scale in Spanish Sample

The psychometric evaluation of the WHO Ageism Experiences Scale in this sample indicated good model fit and acceptable internal consistency. Confirmatory Factor Analysis (CFA) conducted on the self-directed items demonstrated excellent fit, with a Comparative Fit Index (CFI) and Tucker-Lewis Index (TLI) both exceeding 0.99, and a Standardised Root Mean Square Residual (SRMR) of 0.034. Internal consistency was acceptable, with Cronbach's alpha at 0.66 and McDonald's omega total at 0.67.

Associations between Ageism Experiences and Health and Well-being amogn Older Adults

The relationship between ageism experiences and their health and intergenerational contacts were showed in Table 2.

Table 3. Associations between Ageism Experiences and Health and Well-being Outcomes

Variable	Ageism (Total)	Ageism (Self)	Ageism (Interpersonal)	Ageism (Institutional)
Physical Health	-0.39	-0.46	-0.27	0.00
Psychological Health	-0.42	-0.40	-0.35	-0.04
Well-being	-0.31	-0.27	-0.26	-0.04
Loneliness	0.41	0.35	0.32	0.08
Contact with Children	-0.08	-0.08	-0.10	0.06
Contact with Teens	-0.10	-0.09	-0.13	0.03
Contact with Young Adults	-0.08	-0.06	-0.08	0.01
Contact with Middle-aged	0.01	0.00	-0.04	0.08
Contact with Older Adults	-0.10	-0.11	-0.10	0.04

Results suggested that total ageism scores were significantly negatively correlated with physical health, psychological health, and general well-being. In other words, older adults reporting higher levels of ageism tended to experience poorer health outcomes. Total ageism was also positively associated with loneliness, suggesting that higher levels of perceived ageism corresponded with increased loneliness. Similar patterns were observed for self-directed and interpersonal ageism. In contrast, institutional ageism showed no significant association with health or well-being. Interestingly, ageism experiences were not significantly associated with intergenerational contact among older adults.

Asociaciones entre los factores demográficos y las experiencias de edadismo.

A series of regression analyses was conducted to examine the associations between various demographic predictors and ageism experiences, and three dimensions of ageism. The results are summarised in the Table 3.

Table 4. Associations between demographic variables and ageism experiences

Predictor	Ageism (Total)	Ageism (Self)	Ageism (Interpersonal)	Ageism (Institutional)
Age	0.007 (0.004)	0.020 (0.005)	0.002 (0.005)	-0.011 (0.008)
Gender (Male)	0.073 (0.025)	0.135 (0.092)	-0.072 (0.089)	0.171 (0.132)
Subjective life stage	0.041 (0.069)	0.072 (0.034)	0.095 (0.033)	0.006 (0.050)
Education level	-0.032 (0.013)	-0.085 (0.017)	-0.022 (0.018)	0.044 (0.026)
Town size	-0.031 (0.060)	-0.08 (0.08)	-0.030 (0.078)	-0.012 (0.116)
Disability status (Yes)	0.344 (0.067)	0.508 (0.088)	0.332 (0.090)	0.067 (0.138)
Marital status (Married)	-0.232 (0.064)	-0.240 (0.087)	-0.286 (0.084)	-0.066 (0.129)
Property owner (Yes)	-0.043 (0.095)	-0.147 (0.126)	-0.031 (0.123)	0.231 (0.183)
Subjective Social Status	-0.059 (0.017)	-0.070 (0.023)	-0.070 (0.022)	-0.001 (0.034)

Subjective life stage, marital status, disability status, and subjective social status were significantly correlated with overall ageism, as well as with self-directed and interpersonal ageism. Specifically, individuals who perceived themselves to be at a later life stage, were unmarried at the time of the survey, and reported lower subjective social status tended to report higher levels of ageism experiences. Education level was negatively associated with overall and self-directed ageism, suggesting that individuals with lower levels of education were more likely to report higher levels of overall, particularly self-directed, ageism. No significant association was found between education and interpersonal or institutional ageism. Age was positively associated with self-directed ageism, indicating that older participants were more likely to report self-directed ageism. Gender, town size, and property ownership were not significantly related to ageism experiences among older adults.

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