POLICY REPORT ON AGEISM AND INTERGENERATIONAL SOLIDARITY IN EUROPE

RESEARCH FINDINGS AND POLICY RECOMMENDATIONS FOR POLICYMAKERS, INSTITUTIONS, EXPERTS, CIVIL SOCIETY MEDIA

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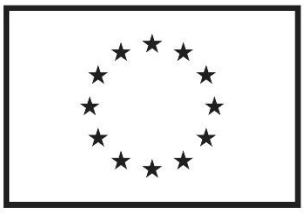

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1 INTRODUCTION

European societies are undergoing profound demographic transformation. Increasing life expectancy and declining fertility rates are reshaping the age structure of populations across the continent, leading to a growing share of older persons in society. While these demographic shifts reflect important social achievements — including improvements in health, living conditions and social protection — they also expose structural inequalities and persistent stereotypes associated with ageing.

Among the most pervasive of these challenges is **ageism**, a form of discrimination based on age that affects people across the life course but has particularly harmful consequences for older persons. Ageism manifests through stereotypes about ageing, prejudices toward older people, and discriminatory practices embedded in institutions, policies and everyday social interactions. Despite the diversity, contributions and experiences of older persons, public narratives often portray ageing primarily in terms of dependency, decline or social burden.

Research increasingly demonstrates that ageism is not merely a matter of attitudes but a structural phenomenon with significant social consequences. It affects access to healthcare, employment opportunities, social participation, and protection from violence and abuse. Ageist assumptions may influence policy decisions, institutional practices and resource allocation, shaping the ways in which societies respond to demographic ageing. At the same time, internalised ageism — the adoption of negative stereotypes about ageing by individuals themselves — can affect health outcomes, well-being and life expectancy.

Addressing ageism therefore requires action at multiple levels: legal frameworks, public policies, institutional practices, social norms and cultural representations. International organisations, including the World Health Organization (WHO), the United Nations and the European Union, have increasingly recognised ageism as a major barrier to healthy ageing, human rights and social cohesion. Global initiatives such as the **UN Decade of Healthy Ageing (2021–2030)** and the **Global Report on Ageism** call for coordinated efforts to change how societies think, feel and act towards age and ageing.

In this broader context, cultural and participatory approaches are gaining increasing attention as tools for challenging discriminatory narratives and fostering social dialogue. Artistic expression — particularly forms that encourage public participation and reflection — can create spaces in which lived experiences of discrimination become visible and open to debate. Theatre, in particular, has long been used as a medium for social critique and civic engagement.

The project Age Against the Machine – European Solidarity Network for Older Citizens' Rights was developed in response to these challenges by Lazar Jovanov and Branka Bajić on behalf of the Novi Sad – European Capital of Culture Foundation. The project brought together partners

from several European countries to explore ageism and the position of older persons through an innovative combination of research, artistic practice and public engagement.

In addition to the Novi Sad – European Capital of Culture Foundation, the project consortium is consisted of the following partners: the Red Cross of Serbia, the University of Évora (Portugal), Dispari Teatro (Cuneo, Italy), Teatr Brama (Goleniów, Poland), Nordisk Teaterlaboratorium (Holstebro, Denmark), and Trupa Drž' ne daj (Novi Sad, Serbia). The project (ID 101138625) was co-funded by the European Union under the CERV programme – Networks of Towns.

By fostering intergenerational collaboration and using applied theatre methods, the project sought to stimulate dialogue about age discrimination, promote solidarity across generations, and empower older persons to participate more actively in discussions about policies that affect their lives. Overall aim was to increase the awareness, knowledge, and interest of the European citizens and decision-makers regarding ageism and the position of the older population.

Age Against the Machine project combined several complementary components. In each participating country, interdisciplinary and intergenerational groups engaged in research processes examining public policies, media representations and lived experiences related to ageing. These processes culminated in the development of theatrical performances addressing different aspects of ageism, including access to services, labour market discrimination, gender inequalities, and participation in public life. The performances were presented during national and international festivals, accompanied by discussions with audiences, policymakers and civil society representatives.

A total of 12 activities were realized within the project (7 international and 5 national):

- One kick-off training in Novi Sad, Serbia;
- 5 premieres of interactive intergenerational community performances (Poland, Serbia, Portugal, Denmark, Italy);
- *5 Age Against the Machine* festivals in following European cities: Holstebro, Cuneo, Evora, Goleniów, Novi Sad;
- 1 *Age Against the Machine* conference in Belgrade.

Aside from these activities, partner's network produced following:

- 5 flash mob actions in public spaces, recorded and distributed online;
- 5 short (one minute lasting) video animations, for the digital campaign.

In addition to the artistic process, the project incorporated a research component aimed at better understanding perceptions of ageing and experiences of ageism, led by Nataša Todorović[1] and Milutin Vračević[2], on behalf of the Red Cross Serbia. A survey based on the **WHO Ageism Scale** was conducted among audiences attending project performances in participating countries. This survey provided valuable insights into public attitudes towards ageing, intergenerational perceptions and experiences of discrimination.

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This report brings together the results of these different strands of the project. It seeks to contribute to the growing body of knowledge on ageism while also demonstrating the potential of participatory cultural approaches as tools for public advocacy and social change.

The report is structured as follows. The first part outlines the conceptual and policy context of ageism, including its prevalence, consequences and societal implications. The second part presents the methodology and approach of the *Age Against the Machine* project. The third part includes country-based reports developed by project partners, highlighting key findings and national-level recommendations emerging from the research and theatre processes. The fourth part presents the findings of the survey conducted among theatre audiences using the WHO ageism questionnaire. Finally, the report concludes with reflections on the use of theatre as a tool for challenging ageism and strengthening public dialogue about ageing in Europe.

By combining research evidence, artistic practice and public engagement, the *Age Against the Machine* project demonstrates how cultural initiatives can contribute to a broader societal conversation about ageing, dignity and equality across generations.

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2. AGEISM: CONCEPTS, EXPLANATORY MODELS AND SOCIETAL IMPACT

2.1 DEFINING AGEISM

Age is one of the most visible characteristics through which people categorize and interpret the social world. While age is a biological and chronological reality, its meaning and significance are shaped by cultural norms, social expectations and institutional arrangements. The ways societies define and interpret age influence how individuals experience different stages of life and how they are treated within social, economic and political systems.

The concept of **ageism** was first introduced by Robert Butler in 1969 to describe systematic stereotyping and discrimination against individuals or groups based on their age. Today, ageism is widely understood as a multidimensional phenomenon encompassing **stereotypes, prejudice and discrimination directed toward people on the basis of age**. Stereotypes refer to the beliefs we hold about people of different ages, prejudice refers to the emotions or attitudes associated with those beliefs, and discrimination refers to actions or practices that disadvantage individuals because of their age.

Ageism can occur across the life course, affecting both younger and older people, although its consequences are often particularly severe for older persons. Importantly, ageism can operate at multiple levels of social interaction. The World Health Organization identifies three principal forms:

- **Institutional ageism**, embedded in laws, policies and institutional practices that restrict opportunities based on age.
- **Interpersonal ageism**, occurring in everyday interactions between individuals.
- **Self-directed ageism**, when individuals internalize age-based stereotypes and apply them to themselves.

Ageism may also operate both consciously and unconsciously. Explicit forms involve deliberate attitudes or actions, whereas implicit forms arise from unconscious biases that shape behavior without conscious intent. These implicit mechanisms often make ageism particularly difficult to recognize and challenge.

Despite increasing attention in public policy and research, ageism remains one of the most socially tolerated forms of discrimination. Studies indicate that negative age stereotypes emerge early in childhood and are reinforced throughout the life course through cultural narratives, institutional practices and media representations.

2.2 AGEISM AS A SOCIALLY CONSTRUCTED PHENOMENON

Ageism cannot be fully understood as an individual attitude alone; it is deeply embedded in broader cultural and social structures. A useful perspective for understanding ageism comes from **social constructionism**, which emphasizes that categories such as "old age" are not fixed biological realities but social meanings shaped by historical and cultural contexts.

Language and discourse play a central role in constructing these meanings. The ways societies talk about ageing influence how older persons are perceived and how they are treated within institutions and public policy. Discourses that portray older persons as dependent, frail or socially burdensome can reinforce negative stereotypes and legitimize exclusion from social participation.

These discursive constructions can have real consequences. When particular narratives about ageing become dominant, they shape social expectations, policy priorities and institutional practices. For example, framing ageing primarily as a problem of dependency and decline can lead to policies focused narrowly on care and protection, while overlooking the diversity, capabilities and contributions of older persons.

Ageism therefore operates not only through individual prejudice but also through broader systems of meaning that structure social relations across generations.

2.3 EXPLANATORY MODELS OF AGEISM

Scholars from sociology, psychology and gerontology have proposed several theoretical explanations for the emergence and persistence of ageism. These explanations highlight the complex interplay between individual attitudes, cultural norms and structural factors.

One important perspective focuses on **stereotype embodiment**, which suggests that age stereotypes absorbed throughout life can eventually be internalized and influence individuals' own perceptions of ageing. These internalized beliefs can affect behaviour, health outcomes and well-being later in life.

Another explanation draws on **terror management theory**, which proposes that negative attitudes toward older persons may be partly driven by psychological anxiety about ageing and mortality. Because older persons are often perceived as symbols of physical decline and mortality, distancing oneself from old age may serve as a psychological defence mechanism.

Ageism may also be explained through **intergroup competition theories**, which emphasize perceived competition over resources between age groups. In contexts where economic or social resources are scarce, older persons may be portrayed as consuming disproportionate resources, particularly in areas such as pensions, healthcare and social protection.

Empirical research suggests that multiple determinants contribute to the development of ageist attitudes. These include individual characteristics such as age, education and personal experiences with older persons, as well as broader societal factors such as media representation, labour market structures and demographic change.

Importantly, the quality and frequency of **intergenerational contact** appears to be one of the strongest factors influencing attitudes toward older persons. Positive interaction between generations can challenge stereotypes and reduce prejudice, while social segregation between age groups may reinforce negative perceptions.

2.4 MANIFESTATIONS OF AGEISM IN CONTEMPORARY SOCIETIES

Ageism manifests across many domains of social life. Research indicates that it affects institutions such as healthcare systems, labour markets, media representations and technological development.

In healthcare, ageist assumptions may influence clinical decisions, leading to underdiagnosis, undertreatment or exclusion of older persons from clinical trials. In labour markets, older workers may face discrimination in hiring, promotion and professional development opportunities. Media representations often portray older persons through narrow stereotypes, reinforcing images of dependency or decline while underrepresenting their diversity and contributions.

Ageism can also shape technological innovation. Research on digital technologies, for example, shows that assumptions about older persons' abilities and needs can influence design processes, sometimes leading to technologies that reinforce stereotypes or exclude older users from meaningful participation.

These patterns demonstrate that ageism is not only a matter of attitudes but also a structural phenomenon embedded within institutional systems and social practices.

2.5 THE SOCIETAL CONSEQUENCES OF AGEISM

The impacts of ageism extend far beyond individual experiences of discrimination. Evidence shows that ageism has significant consequences for health, economic participation and social cohesion.

Ageism has been associated with poorer physical and mental health outcomes, increased social isolation and reduced quality of life. It can influence how individuals seek and receive healthcare, as well as how health professionals interpret symptoms and treatment needs.

At the societal level, ageism can also generate substantial economic costs. Studies have shown that age discrimination in labour markets contributes to unemployment, underemployment and early retirement among older workers, reducing overall economic productivity. Ageism in healthcare has likewise been linked to increased healthcare costs due to delayed diagnosis and inadequate treatment.

Perhaps most importantly, ageism undermines **intergenerational solidarity**, which is essential for societies facing demographic ageing. Narratives that frame older persons primarily as a burden risk weakening social cohesion and reinforcing divisions between generations.

Addressing ageism is therefore not only a matter of protecting the rights and dignity of older persons but also a broader societal imperative for building inclusive and sustainable societies.

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3. INTERNATIONAL AND REGIONAL POLICY FRAMEWORKS ON AGEING AND AGE EQUALITY

3.1 GLOBAL FRAMEWORKS ON AGEING AND AGE EQUALITY

Population ageing has become one of the most significant demographic transformations of the twenty-first century, prompting the development of international policy frameworks aimed at addressing the social, economic and human rights implications of longevity. Within the United Nations system, ageing has increasingly been recognised not only as a demographic phenomenon but also as a matter of human rights, social inclusion and sustainable development.

A central global policy framework in this area is the **Madrid International Plan of Action on Ageing (MIPAA)**, adopted in 2002 during the Second World Assembly on Ageing. The Plan of Action emphasises the need to integrate ageing into all social and economic policies and promotes three priority directions: the participation of older persons in development, the promotion of health and well-being in older age, and the creation of supportive environments that enable dignity and independence in later life. The implementation of MIPAA has been monitored through regional review mechanisms coordinated by the United Nations Economic Commission for Europe (UNECE), which has further developed policy guidelines addressing issues such as long-term care, labour market participation, and social inclusion of older persons.

In parallel, ageing has increasingly been framed within the broader human rights system. The **United Nations Open-Ended Working Group on Ageing (OEWGA)** was established by the UN General Assembly in 2010 to strengthen the protection of the human rights of older persons and to consider gaps in existing international frameworks.[2] Discussions within this forum have highlighted persistent forms of discrimination and structural inequalities affecting older persons, including barriers to access to healthcare, social protection, employment, and justice. The ongoing debates have also raised the possibility of developing a dedicated international convention on the rights of older persons.

Global policy discussions on ageing have also been influenced by the **World Health Organization's approach to healthy ageing**, which emphasises the importance of functional ability, supportive environments, and age-friendly communities.[3] The WHO framework highlights the role of health systems, long-term care services, and social participation in enabling people to live longer and healthier lives. Together, these international frameworks establish ageing as a multidimensional policy issue encompassing health, social protection, economic participation, and human rights.

3.2 AGE DISCRIMINATION AND AGEISM AS EMERGING POLICY CHALLENGES

While demographic ageing has become widely recognised as a policy priority, increasing attention has also been given to the phenomenon of **ageism**, understood as stereotypes, prejudice and discrimination directed toward individuals based on their age. Ageism can affect people at different stages of life but has particularly significant implications for older persons, influencing their access to employment, healthcare, housing, and social participation.

Research conducted at the international level has demonstrated that age discrimination remains widespread across multiple sectors. Age-based stereotypes often portray older persons as dependent, economically inactive or resistant to change, which can shape institutional practices and public attitudes. These perceptions may influence decisions related to recruitment, healthcare provision, eligibility for services, and the design of public policies. In many cases, such forms of discrimination are embedded in institutional frameworks through age-based eligibility criteria, mandatory retirement policies, or limited access to training and education opportunities.

Ageism also has broader societal consequences. Studies have linked age discrimination to negative outcomes in terms of employment opportunities, economic security, health status, and social participation. In addition, internalised age stereotypes may affect individuals' self-perception and behaviour, potentially limiting their aspirations and engagement in social and economic activities. Addressing ageism therefore requires not only legal protection against discrimination but also broader societal efforts to challenge stereotypes and promote positive representations of ageing.

3.3 REGIONAL POLICY RESPONSES IN EUROPE

Within Europe, demographic ageing has become a central policy issue due to declining fertility rates, increasing life expectancy, and changes in labour market structures. European institutions have increasingly recognised the need to adapt economic, social, and health policies to respond to these demographic changes.

The European Union has developed a range of legislative and policy initiatives addressing equality and demographic change. Age discrimination in employment is prohibited under Directive 2000/78/EC, which establishes a general framework for equal treatment in employment and occupation. At the same time, broader policy commitments are articulated through the **European Pillar of Social Rights**, which promotes equal opportunities, access to social protection, and the right to quality long-term care and social services across the life course.

In response to the demographic transformation of European societies, the European Commission launched the **Green Paper on Ageing** in 2021 to stimulate a debate on how policies related to employment, pensions, healthcare and long-term care should adapt to longer life expectancy.[6] The document highlights the importance of strengthening intergenerational solidarity, promoting longer and healthier working lives, and ensuring sustainable social protection systems in ageing societies.

Despite these policy developments, evidence suggests that age discrimination remains a persistent challenge across European societies. A recent study prepared for the European Commission found that age discrimination affects individuals across multiple sectors and stages of life. Employment remains the area most frequently associated with age discrimination, with more than half of Europeans believing that age disadvantages candidates during recruitment processes. Age-related discrimination is also reported in healthcare, housing, and access to services, particularly among older persons aged 75 and above. The study identifies institutional

barriers, interpersonal stereotypes, and internalised forms of ageism that continue to influence opportunities and participation across the life course.

Together, these findings highlight that, while the European Union has established an important normative framework addressing equality and demographic ageing, significant challenges remain in translating these commitments into effective policies and practices that ensure equal opportunities for people of all ages.

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4. COUNTRY ANALYSES

DENMARK

1. INTRODUCTION: FRAMING AGEISM AND INTERGENERATIONAL SOLIDARITY IN ITALY

Denmark is frequently celebrated as one of the happiest countries in the world, with high levels of social trust, low corruption, and a comprehensive welfare state that guarantees access to health, education, and social protection. Yet beneath this positive international image lies a paradox: a substantial proportion of Danes experience loneliness, and many also report facing age-based discrimination.

According to the Danish National Health Profile (2021), more than 600,000 adults—around one in eight—regularly feel lonely. Loneliness has become such a widespread issue that policymakers, civil society, and researchers increasingly describe it as a **"silent epidemic"**. Loneliness does not merely affect mood or personal wellbeing: it has been identified by the World Health Organization (WHO) as a measurable determinant of health, on par with other major risk factors such as smoking and obesity. People who are chronically lonely are at increased risk of developing cardiovascular disease, dementia, depression, and even premature mortality.

At the same time, research from the European Social Survey (ESS) and Eurobarometer confirms that ageism—stereotyping, prejudice, or discrimination on the basis of age—is a real and persistent issue in Denmark. The ESS (Round 9, 2021) found that 35% of Danes reported personal experiences of ageism, while Eurobarometer (2022) indicated that 40% of the population perceives age discrimination as widespread. These figures reveal that despite Denmark's strong welfare protections, negative stereotypes and exclusion remain powerful social forces.

The link between **ageism and loneliness** is critical. Ageism not only isolates people through exclusion from workplaces, digital systems, or social activities, but also makes it harder for individuals to admit to loneliness or seek help. Older adults who internalise negative stereotypes about ageing—such as being seen as dependent, frail, or burdensome—may withdraw from society earlier than necessary. Research by Professor Becca Levy (Yale School of Public Health) shows how these beliefs directly affect health: individuals with more positive attitudes toward ageing live on average 7.5 years longer than those with negative views. Her findings confirm that ageism is not only a social barrier but a measurable health risk, influencing both mental wellbeing and longevity.

Younger people, conversely, may internalise stereotypes that older adults are irrelevant or obsolete, reducing their willingness to connect across generations. In both cases, ageism deepens the cycle of disconnection.

Why Ageism and Loneliness Must Be Addressed Together

1. **Loneliness and Ageism as Health Risks**
   Loneliness increases the risks of chronic disease and accelerates cognitive decline. Ageism, meanwhile, is associated with worse mental health, delayed healthcare use, and higher mortality. When these two forces interact, the negative health effects multiply.

2. **Life-Course Relevance**
   Both loneliness and ageism affect people across the life course. Adolescents excluded in school may carry scars into adulthood. Young workers stereotyped as inexperienced may feel undervalued, reducing their social engagement. Older adults who live alone and face discrimination may experience both physical and emotional decline.

3. **Structural and Policy Dimensions**
   Neither loneliness nor ageism can be solved by individual resilience alone. They are shaped by policies on education, employment, housing, digitalisation, and health. Denmark's rapid shift to digital-by-default public services, for example, has unintentionally deepened exclusion for older adults who lack digital literacy.

4. **Economic and Societal Costs**
   Loneliness is estimated to cost Denmark up to 193 billion DKK annually (≈7% of GDP), through increased healthcare use, lost productivity, and greater demand for social services. Ageism reduces labour market efficiency, discourages older adults from working longer, and increases pension burdens. Together, they threaten social cohesion and economic sustainability.

Denmark's Policy Response and the Need for Integration

Recognising the scale of the problem, Denmark launched its first **National Strategy Against Loneliness** in 2023. Developed by a partnership of 115 organisations, including the Danish Red Cross and Ældre Sagen, the strategy sets an ambitious goal: halving the prevalence of loneliness among adults by 2040. It focuses on five key domains:

- Home and living,
- Daycare/school/education,
- Leisure and communities,
- Working life and employment,
- Health and care.

Current policies often treat loneliness in isolation, without fully integrating the role of ageism. Tackling one without the other risks failure. If loneliness is addressed but ageism persists, many

older adults will still avoid services due to stigma. Similarly, if ageism is tackled in workplaces but loneliness among youth remains unaddressed, intergenerational tensions will continue.

For Denmark to succeed, the fight against loneliness must be explicitly tied to anti-ageism strategies at both the national and EU level. This requires recognizing loneliness as a determinant of health, building indicators into national health monitoring, and ensuring that interventions are not one-size-fits-all but sensitive to age, gender, disability, and socioeconomic background.

SECTION 2: EVIDENCE ON LONELINESS AND AGEISM IN DENMARK

PREVALENCE OF LONELINESS

The **Danish National Health Profile (2021)** provides one of the clearest pictures of the problem. According to this nationally representative survey, around **12% of Danish adults—about 600,000 people—experience frequent loneliness**. This is not a marginal number. In a country of 5.9 million, it means that entire communities are affected by disconnection, despite the presence of strong welfare systems, free healthcare, and extensive social protection.

The data also reveal important patterns across age groups:

- **Young adults (16–24 years old)** report particularly high and growing rates of loneliness. In fact, loneliness among this age group has more than doubled in the last decade. This rise coincides with major societal changes: the spread of social media, increasing pressure in education, and more precarious transitions into the labour market.
- **Older adults (75+)**, especially women, show some of the highest prevalence rates. Denmark has one of the highest proportions of older people living alone in Europe, which reflects cultural values of independence but also increases risks of isolation after widowhood or with declining health.
- **Middle-aged adults** also report loneliness, particularly those in the "sandwich generation" balancing childrearing and eldercare. These groups often withdraw socially due to lack of time, creating hidden isolation.

This age-distributed pattern is critical: loneliness is not limited to one generation but emerges across the entire life course. That makes Denmark's challenge systemic rather than sectoral.

NORDIC AND EUROPEAN RESEARCH EVIDENCE

Comparative research across Europe confirms that loneliness in Denmark cannot be dismissed as an outlier or statistical anomaly.

- **Hansen & Slagsvold (2016)** examined late-life loneliness across 11 European countries and found that **10–20% of older adults in Northern Europe, including Denmark, report**

severe loneliness. This is despite the presence of universal pensions and healthcare. The finding highlights that material security alone cannot eliminate feelings of exclusion or invisibility.

- **Dahlberg et al. (2022)** studied loneliness and social exclusion in the Nordic countries, showing that structural factors—such as poor health, low income, or lack of digital literacy—explain nearly **9% of the variance in loneliness**. In practical terms, this means that the most vulnerable groups in Denmark (people with disabilities, low-income pensioners, migrants) are at sharply higher risk.
- **Nielsen & Hansen (2023, Scandinavian Journal of Public Health)** demonstrated that loneliness is so closely linked to poor mental and physical health that it should be treated as a **determinant of health**, not merely as a wellbeing issue. Their research connects loneliness to increased rates of depression, cardiovascular disease, and cognitive decline. This reinforces the argument that national health strategies should treat loneliness like other health risk factors—measured, tracked, and funded.

Taken together, these studies show that loneliness is **real, measurable, and preventable**, but only if it is recognised as a structural challenge rather than a private burden.

EVIDENCE ON AGEISM

Loneliness in Denmark is compounded by the persistence of **ageism**—prejudice or discrimination based on age. The evidence here is also strong:

- The **European Social Survey (ESS) Round 9 (2021)** found that **35% of Danes personally experienced ageism**. This could take the form of being dismissed at work, overlooked in healthcare, or treated with less respect in social life.
- The **ESS Round 10 (2022/23)**, with a sample of **2,872 respondents**, confirmed that these experiences are not rare. Conducted by VIVE (the Danish Center for Social Science Research), this survey demonstrated that discrimination based on age is still perceived as widespread and systemic.
- The **Eurobarometer 2022 survey** showed that **40% of Danes believe age discrimination is widespread**. Perception matters because if people believe society devalues them due to age, they may be less willing to seek support when lonely or depressed.

This evidence indicates that ageism is not a minor problem but a lived reality for large sections of the Danish population.

THE INTERSECTION BETWEEN AGEISM AND LONELINESS

Ageism and loneliness are mutually reinforcing:

- **Stigma and invisibility**: Older adults may avoid admitting loneliness because they fear being seen as "weak" or "burdensome." This silence delays interventions and worsens outcomes.
- **Barriers to participation**: Youth face stereotypes of being unreliable or fragile, while older adults are sometimes seen as obsolete in workplaces or communities. Both dynamics reduce social inclusion.
- **Internalised ageism**: Perhaps most harmful, negative stereotypes can be absorbed by individuals themselves. When older adults internalise the idea that ageing means decline, they withdraw from society prematurely, reinforcing loneliness.

This cycle creates a structural trap. It means that without addressing ageism, loneliness policies will not reach their full potential, and without tackling loneliness, ageism will continue to be normalised.

UNEVEN DISTRIBUTION ACROSS GROUPS

Finally, evidence from **Age Platform Europe (2023)** reminds us that not all Danes face the same risks:

- **People with disabilities and chronic illnesses** often have fewer opportunities for participation.
- **Women over 75 living alone** represent a fast-growing high-risk group.
- **Migrants and ethnic minorities** face language barriers and cultural exclusion.
- **Informal carers** are at heightened risk of isolation because their care duties reduce their ability to maintain social networks.
- **Digitally excluded citizens** face growing isolation in Denmark's "digital-by-default" environment, where essential services often require online access.

These vulnerabilities show why loneliness and ageism must be analysed together, and why policy responses must be intersectional.

SECTION 3: A LIFE-COURSE LENS

Looking at loneliness and ageism through a life-course perspective helps us understand that these are not problems that suddenly emerge in old age. Instead, they are built over time, beginning in childhood and adolescence, compounding in young adulthood and mid-life, and becoming especially acute in later years. This perspective highlights how experiences at one stage ripple into the next, creating cumulative disadvantages that eventually become visible in old age statistics. In Denmark, where independence and self-reliance are strongly valued, this

dynamic is particularly important: cultural norms may unintentionally reinforce disconnection across the life span.

ADOLESCENCE

Adolescence is a period of rapid social development. Friendships, peer networks, and school belonging play a central role in shaping self-esteem and mental health. Evidence from the Danish National Birth Cohort shows that adolescents who feel excluded or isolated are significantly more likely to experience depression, anxiety, and social withdrawal in later life. The consequences are not temporary: early loneliness increases the likelihood of dropping out of school, struggling to enter the labour market, and experiencing long-term mental health challenges.

What makes adolescent loneliness especially concerning in Denmark is its **steep rise** over the past decade. While Denmark performs well in education outcomes, competitive pressures, digital social comparison through social media, and housing costs in urban areas have created new stressors. Adolescents who cannot find their place in peer groups often carry the scars into adulthood, undermining future social and economic participation.

Addressing loneliness during adolescence is therefore not only a matter of wellbeing but also an investment in future productivity and health. School-based interventions, peer mentoring schemes, and community youth clubs have shown promise, but they need to be scaled systematically across municipalities.

YOUNG ADULTHOOD

The transition to adulthood is marked by moving out of the parental home, pursuing higher education or vocational training, and entering the labour market. In Denmark, this stage is characterised by both opportunities and risks. University students often benefit from strong peer networks, but young adults outside higher education—those in apprenticeships, insecure jobs, or unemployed—face a much higher risk of loneliness.

Precarious employment compounds the challenge. Many young people encounter short-term contracts, internships with limited stability, or difficulty affording independent housing in urban centres. These factors undermine social stability and foster dependence on family support. While family support can buffer loneliness, it can also create tension, as parents worry about "failed launches" and young adults feel over-controlled.

From a policy perspective, the issue is not only social but also economic. Persistent loneliness in young adulthood is linked to lower civic trust and weaker democratic engagement. This is particularly concerning in Denmark, a country that relies heavily on active citizenship and volunteerism to sustain its welfare society.

MID-LIFE

Mid-life is often described as the period when loneliness is "hidden." Adults in their 40s and 50s may not openly report loneliness, but many experience it due to time poverty. The so-called sandwich generation is responsible for caring for both children and ageing parents, often while

managing demanding careers. This dual burden reduces opportunities for leisure, socialising, and civic engagement.

Women, in particular, shoulder the heavier share of informal caregiving, which deepens gender inequalities in health, pensions, and career progression. Loneliness in mid-life has consequences not only for individuals but for society: burned-out workers are less productive, more likely to exit the labour market early, and less able to contribute to community organisations.

This stage demonstrates how loneliness is not merely a psychological state but a structural problem with ripple effects on economic growth, gender equality, and pension sustainability. If left unaddressed, mid-life loneliness translates into higher public expenditures later, when carers themselves require health and social support.

OLDER ADULTHOOD

Older adulthood is the life stage most commonly associated with loneliness, and in Denmark the risk is especially pronounced due to demographic and cultural factors. More than 20% of the population is now over 65, and the proportion is rising steadily. Among those over 75, especially women, living alone is the norm rather than the exception. While independence is culturally celebrated, it can easily slide into isolation when combined with bereavement, reduced mobility, or chronic illness.

One of the most pressing challenges is digital exclusion. Denmark is a leader in digitalisation, but its "digital-by-default" approach to public services means that older adults with limited digital literacy face barriers in everyday tasks such as booking medical appointments, banking, or applying for social benefits. This is not just inconvenient; it actively creates structural loneliness, as individuals are excluded from basic interactions with society.

Loneliness in older adulthood has profound health impacts. Studies show strong links between chronic loneliness and dementia, depression, and higher mortality rates. It also increases the likelihood of entering residential care earlier, which places pressure on municipal budgets. For Denmark, ensuring that older adults can maintain social connection is therefore both a human rights imperative and a financial necessity.

CONCLUSION OF THE LIFE-COURSE PERSPECTIVE

Viewing loneliness and ageism through a life-course lens makes it clear that interventions cannot be limited to old age. Each stage of life contributes to the next:

- Exclusion in adolescence undermines educational attainment and labour market participation.
- Loneliness in young adulthood erodes civic trust and future resilience.
- Mid-life isolation weakens families, reduces productivity, and deepens gender inequality.

- In older age, these accumulated disadvantages manifest as poor health, social withdrawal, and increased dependence on public services.

Only by addressing loneliness and ageism as interconnected, lifelong challenges can Denmark reduce the social, economic, and health costs they impose.

SECTION 4: SOCIETAL COSTS OF LONELINESS AND AGEISM IN DENMARK

When policymakers are asked to prioritise loneliness and ageism, their first question is often: *what does this cost society?* In Denmark, where public policies are evidence-driven and budgets are tightly monitored, demonstrating the economic and social costs is essential to building political momentum. The good news is that research is increasingly available to show just how expensive loneliness and ageism are—not only in human suffering, but in kroner and øre.

OVERALL ECONOMIC BURDEN

A landmark study by Copenhagen Economics (2022), developed with Economists Without Borders and Impactly, estimated that loneliness costs Denmark around 193 billion DKK annually—equivalent to about 7% of GDP

This figure is staggering. It is larger than Denmark's entire annual budget for education. It signals that loneliness is not a marginal social issue but one of the country's most pressing public challenges, on par with obesity or smoking in terms of societal burden.

HEALTHCARE COSTS

Loneliness is a health risk. People who are chronically lonely:

- Visit general practitioners more often.
- Use hospital and psychiatric services more frequently.
- Enter residential care or nursing homes earlier than peers with stronger social ties.

For Denmark, this translates into billions of kroner in preventable healthcare spending. For example, lonely older adults are at increased risk of dementia, cardiovascular disease, and depression—all conditions that are expensive to manage and require long-term care. The U.S. Surgeon General's Advisory (2023) stressed that the mortality risk of social disconnection is comparable to smoking up to 15 cigarettes a day.

LABOUR MARKET AND PRODUCTIVITY COSTS

Loneliness also reduces economic output. Workers who experience loneliness are more likely to:

- Take sick leave, increasing absenteeism.
- Be less engaged while at work (so-called "presenteeism").

- Leave the labour market earlier due to stress, burnout, or poor mental health.

For the mid-life "sandwich generation", loneliness caused by care burdens directly impacts productivity. Carers who cannot balance work and family often cut hours or exit jobs prematurely, reducing tax revenue and pension contributions. This undermines Denmark's labour supply at a time when the population is ageing and every worker counts.

PENSION SYSTEM AND EARLY RETIREMENT

The pension system is another area of cost. Loneliness and ageism push people out of the workforce earlier, reducing the number of years they contribute and increasing the number of years they rely on public pensions. At the same time, younger workers who face stereotypes of inexperience may delay stable entry into the labour market, creating gaps in their own future pension rights.

This "double squeeze" increases long-term pension liabilities and threatens the sustainability of the welfare model. In short, loneliness and ageism undermine intergenerational solidarity by weakening both contributions and entitlements.

MUNICIPAL AND SOCIAL CARE COSTS

Municipalities bear much of the direct cost of loneliness. When family support weakens—because of disconnection, stress, or geographic distance—municipalities must step in with home care, visiting nurses, or residential services. The costs are significant:

- A single nursing home placement costs far more than community-based support.
- Earlier institutionalisation due to loneliness can therefore multiply municipal budgets unnecessarily.

Ensuring people remain socially connected and supported in their communities is not only more humane but also more cost-effective.

CIVIC AND DEMOCRATIC COSTS

Denmark relies heavily on volunteerism and civic participation. From sports clubs to elder associations, volunteers sustain much of the country's social fabric. Loneliness erodes this tradition: people who feel disconnected are less likely to volunteer, vote, or participate in community organisations.

This weakens social cohesion, reduces trust in institutions, and ultimately increases the demand for state-run programmes to fill the gaps. The civic cost of loneliness is therefore not just about individuals, but about the weakening of Denmark's democratic model of society.

INTERGENERATIONAL RIPPLE EFFECTS

Loneliness does not stay contained within an individual's life stage. It spills over into families, communities, and even national systems, creating ripple effects that accumulate across

generations. These ripple effects are crucial for understanding why investment in prevention is not just compassionate but also economically rational.

ADOLESCENTS

Young people who grow up lonely are at higher risk of depression, anxiety, and social withdrawal. But the effects go further: lonely adolescents are more likely to underperform in school, disengage from group activities, and drop out of education. This creates long-term consequences for Denmark's knowledge economy, as fewer young people complete vocational training or higher education. In the long run, this means fewer skilled workers, lower productivity, and reduced tax revenues. It also places additional strain on social safety nets, as early disadvantages make young people more dependent on public support later in life.

YOUNG ADULTS

When loneliness persists into young adulthood, it undermines the development of stable identities, friendships, and careers. Research shows that lonely young adults are less trusting of institutions and less likely to participate in democratic processes such as voting or volunteering. In Denmark—where civil society and volunteer-based organisations play a huge role in sustaining welfare services—this disengagement weakens the very model of the welfare state. A generation that feels excluded is less prepared to take on responsibility for others, creating a feedback loop of disconnection and mistrust.

MID-LIFE ADULTS

For adults in mid-life, loneliness often emerges through "time poverty." Carers who balance jobs, children, and ageing parents withdraw from social life, leaving them isolated. The ripple effect here is twofold: families under stress pass on insecurity to children, and workplaces lose valuable productivity when employees struggle with exhaustion or burnout. In Denmark's case, this can also deepen gender inequality. Women who shoulder most informal care work face interrupted careers and smaller pensions, which in turn feed into higher poverty risks in later life. This not only costs families but also increases long-term demand for public pension supplements and social services.

OLDER ADULTS

For older adults, loneliness accelerates decline in both health and independence. The ripple effects extend to families, who lose grandparents as active supporters of childcare and household support. Communities also lose the contributions of older volunteers, who often form the backbone of local associations, cultural life, and civic organisations. As older adults withdraw, families are left with heavier care burdens, municipalities face rising long-term care costs, and society loses valuable intergenerational connection. In a demographic context where the share of older adults in Denmark will continue to grow, ignoring this ripple effect is particularly costly.

ADVOCACY TAKEAWAY: Framing loneliness and ageism in terms of ripple effects helps policymakers see that today's inaction multiplies tomorrow's costs. It is not only about supporting lonely individuals now; it is about preventing systemic weaknesses in labour markets, pensions, healthcare, and democratic participation.

5. CITY AND COMMUNITY DESIGN

Loneliness is not only shaped by individual circumstances but also by the design of cities and communities. The environments in which people live—their housing, transport options, access to services, and opportunities for social interaction—play a decisive role in either reducing or exacerbating social isolation. In Denmark, municipalities are central actors, since they are responsible for many aspects of welfare delivery, community planning, and health promotion.

HOUSING MODELS: Denmark has pioneered several intergenerational housing projects, such as the *Aarhus student–senior co-housing initiative*, where students live at reduced rents in exchange for offering companionship and practical support to older residents. Evaluations show these arrangements not only reduce loneliness but also break down age stereotypes and provide mutual benefits. However, such models remain pilot-based and limited in scale.

COMMUNITY SPACES: Initiatives like community cafés in Copenhagen and small town "contact houses" offer older adults safe, inclusive spaces for daily social interaction. Evidence indicates that even modest investments in such hubs can substantially reduce loneliness among older populations. Yet provision is uneven, often depending on enthusiastic local NGOs or specific municipal priorities rather than a national framework.

TRANSPORT AND ACCESSIBILITY: The design of transport systems also matters. Older adults in rural municipalities often face challenges in reaching community centres, health facilities, or social activities. Without affordable, accessible transport, even the best-designed programmes remain underused.

DIGITALISATION AND INFRASTRUCTURE: Denmark's "digital-by-default" strategy offers efficiency but risks excluding those who lack digital literacy. Municipalities can mitigate this by ensuring hybrid service delivery—both digital and face-to-face—and by investing in digital literacy training. Ensuring older adults can still access banks, healthcare, and municipal services offline is essential to avoid structural loneliness.

POLICY FRAMEWORKS: The WHO *Age-Friendly Cities and Communities* framework (https://extranet.who.int/agefriendlyworld/) offers a comprehensive guide for scaling these initiatives nationally. Denmark is well-placed to lead in this area, but it requires stronger national coordination so that best practices are shared and systematically implemented across municipalities rather than left as isolated pilots.

6. POLICY STATUS AND RECOMMENDATIONS: DENMARK

The Danish National Strategy Against Loneliness (2023) is a groundbreaking initiative that fundamentally reframes how we approach loneliness. It moves beyond seeing loneliness as a private, personal problem and instead positions it as a major public health challenge. For far too long, loneliness, especially among older persons, has been dismissed as a "soft" social issue or an inevitable part of aging. Denmark's strategy firmly rejects this outdated view.

By defining loneliness as a measurable health determinant, the Danish policy highlights its profound and costly impact on our society. Chronic loneliness leads to tangible, negative consequences for public health, such as an increased risk of heart disease, dementia, and depression, placing a heavy burden on our healthcare system. It also erodes our social cohesion by weakening community ties and trust. On an economic level, loneliness affects productivity and workforce participation.

This strategy compels us to rethink how we address ageism and social isolation. Rather than relying on individual responsibility or isolated programs, it drives coordinated action across government departments, civil society, and the private sector. The strategy is based on a data-driven understanding of the problem and sets an ambitious goal of halving loneliness by 2040. It explicitly acknowledges that older persons are a high-risk group and integrates specific initiatives to address their needs, moving beyond vague platitudes to concrete actions like mandatory preventive home visits.

1. LONELINESS AS A HEALTH DETERMINANT & MONITORING

Current State: Loneliness is formally recognised in Denmark as a major public health concern, comparable to smoking or obesity. The 2023 Strategy sets a clear target: halving loneliness among the adult population by 2040. Data shows that over 600,000 Danes (about one in eight adults) report feeling lonely regularly.

Accountability: Accountability is ensured through the inclusion of the Three-Item Loneliness Scale (T-ILS) in the Danish National Health Survey, in use since 2017. This provides robust, standardised, and disaggregated data, enabling government to link prevalence trends directly to resource allocation and targeted interventions.

Advocacy Priority: Push for loneliness data to be integrated into preventive health budgets and for the Ministry of Health to report annually to Parliament, ensuring that progress is tied to concrete funding lines.

2. EXPAND SCHOOL-BASED INTERVENTIONS

Current State: Youth loneliness has more than doubled in the last decade, with clear evidence of its connection to depression, anxiety, and poorer educational outcomes. The Danish National Youth Study (2019) confirmed that disconnectedness in schools is one of the strongest predictors of later mental health problems.

Interventions: The National Strategy is scaling measures within schools, moving beyond fragmented pilots. These include peer support, mentoring systems, and the use of digital tools (EdTech) to survey students' wellbeing and guide class-level interventions that strengthen connectedness.

Advocacy Priority: Secure long-term funding to make these interventions universal across all schools, ensuring continuity rather than short-term projects. Stress the cost-effectiveness of prevention: addressing loneliness in adolescence reduces health and labour market costs for decades ahead.

3. SUPPORT FOR INFORMAL CARERS

Current State: While municipalities must provide respite or substitute services for carers of people with severe impairments, Denmark lacks a national law fully defining and protecting the rights of informal carers. This gap leaves carers—especially the "sandwich generation" and women—financially and socially vulnerable.

Policy Goal: Introduce structural financial protections to mitigate these inequalities:

- **Universal Pension Credits** to compensate for career breaks caused by caregiving.
- **Flexible Work Arrangements** to safeguard long-term labour market attachment.
- **Guaranteed Respite Services** to reduce stress and prevent burnout.

Advocacy Priority: Position these reforms as an extension of Denmark's commitments under the EU Work–Life Balance Directive (2019/1158). Highlight the gender equality dimension: without reforms, women face disproportionate pension gaps and higher risks of old-age poverty.

4. GUARANTEE OFFLINE ACCESS TO SERVICES

Current State: Denmark's "digital-by-default" approach is efficient but creates new vulnerabilities. Tools such as Digital Post are mandatory for citizens, yet older adults, migrants, and people with disabilities often lack the digital literacy to use them. This results in "digital loneliness," where exclusion from essential services deepens social isolation.

Policy Goal: Establish the principle of hybrid access to all critical services—healthcare, banking, and social benefits—so that offline options remain available.

Advocacy Priority: Frame this demand in line with the European Declaration on Digital Rights and Principles (2022), which guarantees inclusive access to digitalisation. Advocacy should emphasise that offline access is not about slowing down innovation, but about protecting equality and preventing structural exclusion.

5. STRENGTHEN MUNICIPAL FUNDING AND COORDINATION

Current State: Municipalities are the primary delivery agents for loneliness interventions. They run housing initiatives, community hubs, and outreach services, but current funding is fragmented and grant-based. In 2024, over DKK 29 million was allocated for research on ageing and care and DKK 19.7 million for loneliness research, but these remain short-term and project-based.

Policy Goal: Transition from reliance on project grants to a national co-funding framework. This would allow municipalities to scale proven interventions (e.g., Aarhus' intergenerational housing or Realdania's senior co-housing) systematically across the country. EU Cohesion Funds could provide complementary financing, ensuring sustainability beyond Danish budgets.

Advocacy Priority: Campaign for national "loneliness compacts" between government and municipalities, with guaranteed long-term funding. Stress the return on investment: strong local

interventions reduce healthcare costs, delay institutionalisation, and strengthen civic engagement.

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ITALY

1. INTRODUCTION: FRAMING AGEISM AND INTERGENERATIONAL SOLIDARITY IN ITALY

1.1 OVERVIEW: DEMOGRAPHIC SITUATION AND INTERGENERATIONAL RAMIFICATIONS

Italy is undergoing a significant demographic and social transformation. With a total population of 58.93 million, it has one of the oldest populations in the world and one of the lowest fertility rates (1.18). The median age is now 46.8 years, and one in four residents is aged 65 or older.

These profound demographic shifts redefine how generations coexist and cooperate, leading to two main ramifications for intergenerational relations:

1. Structural Conflict and Strain: The rapidly shrinking working-age base relative to the growing dependent older population creates significant pressure on shared resources [2]. This fiscal imbalance often frames intergenerational relations as a zero-sum game, fostering narratives of conflict over pensions and public debt.

2. Necessity of Solidarity and Cooperation: Due to demographic ageing, public services are under strain and cannot effectively accommodate increased demand. Italy thus relies heavily on intergenerational transfers within families for care and financial support This reliance forces cooperation and solidarity through familial reciprocity—where parents subsidize adult children, who, in turn, provide care for aging parents [4, 5].

Ageism—defined as stereotyping, prejudice, or discrimination based on age—cuts across these challenges [6]. It affects both older and younger people, shaping access to employment, housing, and social participation.

1.2 THE LIFE-COURSE APPROACH

A life-course approach recognises that ageism is not an isolated experience at one point in life but a cumulative process [8]. Early-life inequalities—such as precarious work or low social protection—compound over time, increasing risks of insecurity, isolation, and discrimination in later life [8]. Conversely, societies that invest across all stages of life reap compounding benefits: better health, stronger communities, and greater intergenerational trust.

Italy's demographic structure amplifies the need for this approach.

- Children and youth represent a shrinking share of the population, yet bear the cost of supporting ageing systems.
- Working-age adults face dual pressures from labour-market instability and care responsibilities.
- Older adults, though healthier and better educated than past cohorts, encounter barriers to participation and recognition.

1.3 INTERGENERATIONAL SOLIDARITY AND POLICY RELEVANCE

Historically, Italy's welfare state has relied heavily on intergenerational transfers within families. Reinforcing intergenerational solidarity requires modernizing this social contract. It means:

- Valuing care work through pension credits and flexible employment policies.
- Ensuring equal labour-market entry and retention opportunities across age groups.
- Creating shared spaces and services that connect, rather than segregate, generations.

1.4 DATA-DRIVEN FRAMING

Empirical evidence confirms the magnitude of the issue:

- Youth unemployment remains high, and NEET rates exceed 19.3 %—the highest in Europe.
- Employment among older workers (55–64) stands at only 61.5 %, below the EU average.
- 50 % of Italians perceive age discrimination as widespread.

2. DEMOGRAPHIC AND STRUCTURAL DYNAMICS UNDERPINNING AGEISM

2.1 DEMOGRAPHIC DYNAMICS AND FUTURE RAMIFICATIONS

The median age is currently 46.8 years. Demographic Projections show that by 2050, the dependency ratio is projected to reach 76 dependents per 100 workers. This fiscal imbalance often frames intergenerational relations as a zero-sum game, fostering narratives of conflict.

2.2 SOCIOECONOMIC STRUCTURE AND CUMULATIVE INEQUALITY

- Youth Marginalization: Protracted transitions have led to high NEET rates. This delayed economic independence pushes young adults to remain in the family home longer, often relying on parental transfers.
- Elderly Exclusion and Health Disparities: Ageism in healthcare settings can lead to the under-treatment or dismissal of symptoms. The over-reliance on informal, family-based care strains mid-life adults. During crises, reliance on familial support places a significant strain on households.
- Intergenerational Wealth Gap: The transfer of wealth primarily occurs *inter-familially* (from parents to children). This reliance reinforces existing inequalities, particularly in accessing housing.

2.3 POLICY AND INSTITUTIONAL INERTIA

- Pension Focus vs. Life-Course Investment: Policy debate is often dominated by the costs of the pension system, diverting resources from critical early-life and working-life investments.
- Regional Divide: Demographic challenges are more pronounced in Southern Italy. The uneven capacity of regional welfare systems means the burden of age-related care falls disproportionately on private families in areas with fewer public services.

3. SOCIETAL COSTS OF AGEISM AND WEAK INTERGENERATIONAL SOLIDARITY IN ITALY

3.1 ECONOMIC COSTS: LABOUR MARKET AND PRODUCTIVITY LOSSES

- Under-utilisation of older workers: Only 61.5% of adults aged 55–64 are employed.
- Youth exclusion: The high NEET rate (19.3%) means delayed social-security contributions.

Together, these dynamics suppress potential GDP by an estimated €70–90 billion annually.

3.2 HEALTH-SYSTEM COSTS

- Loneliness and Health: Loneliness increases risks of cardiovascular disease by 30% and depression by 45%.
- Ageism in Care: Ageism in healthcare contributes to reduced healthy life expectancy.

3.3 SOCIAL-PROTECTION AND FISCAL PRESSURES

Italy spends approximately 16.2% of GDP on public pensions. This trajectory implies higher tax burdens on younger workers and shrinking fiscal space for other public investments.

3.4 CIVIC AND DEMOCRATIC COSTS

Perceived unfairness between generations correlates with lower voting participation among youth and reduced volunteering among older adults.

3.5 INTERGENERATIONAL RIPPLE EFFECTS

The combined economic, health, and social costs of ageism are conservatively estimated at 5–7% of GDP annually.

4. POLICY IDEAS AND ACTIONS FROM INTERGENERATIONAL WORK

The intergenerational analysis highlights the need for policies that balance the needs of older and younger citizens.

4.1 MAKING WORK AND PENSIONS FAIRER FOR EVERYONE

- Better Job Chances for All Ages: Policies must align with the European Pillar of Social Rights (Principle 4 on employment support) to cut high youth NEET rates. Simultaneously, policies must support Active Ageing (EU Green Paper on Ageing) to improve the low employment rate of older workers.
- Invest in Skills across the Life-Course: Policy must fund continuous training and upskilling accessible to all ages.
- Fairer Retirement Rules: The debate on pensions must ensure financial security for older adults while promoting the UN 2030 Agenda goal of "leaving no one behind".

4.2 IMPROVING HOMES, CARE, AND FAMILY SUPPORT

- Support for Caregivers and Work-Life Balance: Policy actions must advocate for a significant expansion of affordable, quality formal care services (LTC and childcare) to reduce the heavy burden on family members. This aligns with the EU Work-Life Balance Directive.
- Affordable Housing Solutions: Policy must promote solutions like affordable co-housing and mixed-age communities to help young people gain financial independence.
- Dignity in Long-Term Care: Policy must uphold the European Charter of Social Rights (Article 23) by setting national standards for quality, accessibility, and affordability of institutional and home-based care.

4.3 STRENGTHENING VOICE AND FAIR TREATMENT FOR ALL AGES

- Fighting Systemic Ageism: Policy needs to prioritize legal and educational reform to take age discrimination seriously, including combating prejudice within the healthcare system, as highlighted by the WHO Global Report on Ageism.

- Making Political Life Inclusive: Actions must promote civic participation across all ages [16]. Policy should ensure that decision-making platforms meaningfully include the diverse voices of older adults.

5. POLICY IMPLICATIONS AND ADVOCACY RECOMMENDATIONS

This section suggests targeted policy changes and specific advocacy actions for local partners, focusing on the Cuneo area in Piedmont.

5.1 POLICY IDEAS AT NATIONAL AND REGIONAL LEVELS

A. HARMONIZING LABOUR AND SKILLS POLICY: The Piedmont Region should prioritize EU structural funds (ESF+) for intergenerational skills-transfer initiatives in key local sectors (e.g., manufacturing, tourism). This directly supports the OECD's Active Ageing Strategy by integrating older workers and addressing the high NEET rates among youth.

B. STRENGTHENING FORMAL CARE AND SUPPORT SYSTEMS: The Cuneo social services should expand home-care programs (ADI) to integrate respite services for family caregivers. Policy should grant tax relief or municipal credits to families that hire certified formal caregivers, reducing the dependence on unpaid labour, a measure essential for realizing the objectives of the EU Work-Life Balance Directive.

C. PROMOTING AFFORDABLE AND INTERGENERATIONAL HOUSING: The Piedmont Region should allocate municipal property for projects that offer subsidized housing to young people in exchange for community service or light support (e.g., digital literacy) for older residents. This action addresses the European Pillar of Social Rights (Principle 19: Housing assistance) by fostering intergenerational cohesion and reducing youth dependency.

5.2 ADVOCACY RECOMMENDATIONS FOR CUNEO (LOCAL PARTNER)

The local partner in Cuneo can use community-based advocacy to push for these policies, linking performances to existing national and European frameworks.

- LABOUR INCLUSION ADVOCACY: Initiative: "Reverse Mentoring" Forum Theatre. Action: Stage performances in local business associations (e.g., *Confcommercio* Cuneo) to propose and test solutions for workplace ageism and intergenerational team-building. This directly supports OECD recommendations for inclusive employment practices.

- CARE AND HEALTH ADVOCACY: Initiative: "Invisible Care" Campaign. Action: Focus Invisible Theatre or flashmobs in primary care centers (*ASL Distretti*) to raise awareness of the hidden stress on informal caregivers and the need for respite care services. This aligns with the WHO Global Report on Ageism, which calls for combating ageism in healthcare settings.

- CIVIC PARTICIPATION ADVOCACY: Initiative: "City Voices" Legislative Theatre. Action: Engage citizens in a theatre piece that dramatizes a specific local ordinance (e.g., housing subsidies or public transport access). Invite municipal councilors to debate

changes to the proposed ordinance. This reinforces the CNEL's focus on increasing civic and democratic participation across age groups.

- STEREOTYPE CHALLENGE ADVOCACY: Initiative: Digital/Media Intervention. Action: Create short video "interventions" challenging ageist or youth-stereotyping phrases found in local media. Partner with local schools (*scuole superiori*) to screen these videos and lead intergenerational discussions. This is a direct measure supporting the WHO Global Report on Ageism's strategy to change public discourse and educational norms.

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PORTUGAL

SECTION 1: INTRODUCTION: : AGEISM, GENDER AND THE LIFE COURSE IN PORTUGAL

1.1 DEMOGRAPHIC SNAPSHOT AND STRUCTURAL CONTEXT

Portugal is facing deep demographic change that redefines how generations relate and how inequality is distributed over time.

- As of 2024, Portugal's population stands at **10.64 million**, with a median age of 47.3 years—among the highest in the EU.
- About **24 %** of residents are 65 or older, while fertility has fallen to 1.40 children per woman.
- Life expectancy at birth has reached **82.8 years**, but healthy life expectancy remains roughly 69–70 years, revealing persistent morbidity in older age.
- Women make up **52 %** of the total population, and their over-representation in the oldest cohorts exposes the gendered dimension of ageing.

These shifts are accelerating the dependency ratio, shrinking the working-age base, and increasing pressure on health, care and pension systems. Intergenerational transfers—financial and emotional—remain crucial to maintaining family stability and public welfare.

1.2 INTERSECTIONAL RISKS: AGE, GENDER AND VULNERABILITY

Ageism and gender discrimination overlap in multiple ways across the life course:

- For **young women**, care burdens and labour-market segmentation mean interrupted careers and lower earnings.
- For **middle-aged adults**, particularly women in caregiving roles, unpaid care limits economic independence and pension accumulation.
- For **older women**, longevity combines with economic precarity and social isolation, heightening exposure to poverty, neglect and abuse.
- For **younger men**, cultural expectations of stability and provision collide with precarious employment and housing inaccessibility.
- For **older men**, stoicism and stigma may inhibit help-seeking for mental health or violence.

ABUSE AND VIOLENCE AS LIFE-COURSE RISKS

Violence and abuse intersect with age and gender throughout life:

- **Children and adolescents** may experience abuse or neglect that leaves long-term mental-health scars and social disadvantage.
- **Young adults**, especially women, face high rates of dating and intimate-partner violence.
- **Mid-life carers** can experience role strain or coercive control within families when supporting dependents.
- **Older persons**, particularly older women living alone, are vulnerable to physical, psychological, financial and digital abuse.

The **2023 INE Survey on Safety in Public and Private Spaces** found over 1.4 million Portuguese aged 18–74 had experienced violence (3), and community-based studies suggest up to **27 %** of older adults are at risk of elder abuse (4).

These figures demonstrate that violence is not confined to any single generation—it is a continuum that reflects structural inequality, ageist stereotypes, and gendered power dynamics. Addressing it therefore demands a life-course, intergenerational, and gender-responsive policy framework.

1.3 WHY INTERGENERATIONAL SOLIDARITY AND GENDER-AGE INCLUSION MATTER

With a declining birth rate and an expanding older population, Portugal's social fabric increasingly depends on reciprocity between generations.

However, when age and gender biases shape who is seen as productive, deserving or credible, solidarity erodes.

- Stereotypes that portray older persons as burdens undermine respect and care investment.
- Stereotypes that frame younger generations as unstable or entitled reduce opportunities for their economic participation.
- Gendered assumptions assign women lifelong caregiving roles and exclude men from them.

In short, ageism and gender inequality mutually reinforce social disconnection. Tackling them together is essential not only for fairness but for the sustainability of Portugal's welfare and labour systems.

SECTION 2: EVIDENCE OF AGEISM, GENDER INEQUALITY, AND ABUSE ACROSS THE LIFE COURSE IN PORTUGAL

2.1 LIFE-COURSE INEQUALITY AND THE GENDERED SHAPE OF AGEISM

Ageism in Portugal intersects deeply with gender inequality. Discrimination linked to age is not an isolated event; it accumulates over time through educational, professional, and caregiving pathways.

From youth to old age, gender norms and labour structures combine to produce unequal outcomes:

- **Early adulthood:** limited childcare and rigid working hours push many women into flexible or informal work.
- **Mid-life:** the dual care burden—raising children and supporting older parents—reduces women's labour-market continuity and health.
- **Later life:** accumulated pay and pension gaps leave older women with less financial independence and greater risk of poverty or social exclusion.

Across these stages, ageism reinforces inequality. Younger women are stereotyped as unreliable future mothers; older women as less adaptable or less deserving of training. Men, by contrast, face expectations of stability and provision but less institutional support when they become carers or experience job loss in mid-life.

2.2 LIFE AND CAREER CHOICES, GENDER PAY GAP, AND LATER-LIFE INEQUALITY

Women in Portugal continue to adjust or interrupt their careers to accommodate caregiving responsibilities, especially during their thirties and forties. These interruptions create long-term wage penalties, which later compound into lower pensions. According to the European Institute for Gender Equality (EIGE), Portugal's gender pay gap is around 11–12 %, while its gender pension gap exceeds 25 %, among the widest in Southern Europe.

Although Portugal's overall female employment rate is high, women remain concentrated in lower-paid sectors such as education, retail, and caregiving. They are under-represented in

technical, scientific, and leadership roles. These occupational patterns perpetuate what economists describe as structural incentives—systems that reward continuous full-time work and penalise flexibility.

Claudia Goldin's research demonstrates that gender pay gaps widen after childbirth, especially in jobs where advancement depends on long, inflexible hours. In Portugal, this logic plays out clearly: women are twice as likely as men to work part-time or on temporary contracts, and their average retirement income is substantially lower.

As people age, these inequalities become self-reinforcing. Older women face both gender-based and age-based discrimination, while younger women internalise expectations of limited advancement, which affects educational and career choices. The result is a feedback loop: the same structures that restrict young women's options today produce older women's vulnerability tomorrow.

2.3 THE MIDDLE-AGE GENERATION: WORK, CARE AND WELL-BEING

Portugal's middle-age population (roughly 40–59 years) plays a pivotal role in sustaining intergenerational welfare. This group, comprising over **40 %** of the total population (7), includes both the "sandwich generation" caring for elderly parents and dependent children and the country's most productive labour force.

- Workers aged 50 and over represent one in three employees, generating over **38 %** of national earnings.
- Employment participation for this group remains high by EU standards, but job quality is uneven, and ageism affects promotion and retraining opportunities.
- Many mid-life adults, particularly women, reduce their hours or leave work altogether to care for relatives, leading to lost productivity and reduced future pension entitlements.

This generation's well-being is therefore central to social stability. Their physical and mental health, access to flexible work, and inclusion in up-skilling policies determine not only their own quality of life but also the sustainability of Portugal's welfare and pension systems. Yet, policy frameworks rarely integrate their dual role as earners and caregivers—leaving them exposed to burnout, loneliness, and economic insecurity in later years.

2.4 AGEISM IN LABOUR MARKETS AND SOCIAL PARTICIPATION

Ageism shapes employment and civic life in multiple directions:

- **Older workers** face stereotypes of reduced adaptability, discouraging retraining or re-employment after redundancy.
- **Younger workers** experience "reverse ageism": their temporary contracts and underemployment reinforce the image of being unreliable or inexperienced.
- **Mid-life adults**, especially women, navigate the greatest strain—balancing professional demands with caregiving, often without adequate institutional support.

The **Eurobarometer 2022** found that **50 %** of Portuguese respondents believe age discrimination is widespread, while the European Social Survey 2021 recorded **37 %** reporting personal experience of it.

This erodes trust and participation. Older adults disconnected from digital or civic spaces volunteer less and use fewer community resources, while younger adults, alienated by economic insecurity, lose faith in collective institutions. Together, these trends weaken the intergenerational contract.

2.5 ABUSE AND VIOLENCE ACROSS THE LIFE COURSE

Violence and abuse are persistent across generations and gender lines:

- **Children and adolescents:** INE data show that about **2.3 %** of adults report childhood sexual abuse, with rates higher among girls (**3.5 %**) (10).
- **Young adults:** more than half of adolescents report some form of dating or intimate-partner violence.
- **Mid-life carers:** emotional strain and role conflict expose many to coercive control or psychological abuse within families.
- **Older adults:** national studies estimate **12–27 %** experience abuse or neglect, most often psychological or financial.

Women face the greatest lifetime risk of violence, but men—particularly older men living alone—are also affected and often invisible in data. Violence reflects structural inequalities of power that accumulate through gender and age hierarchies, reinforcing social isolation and dependency.

2.6 CROSS-CUTTING IMPLICATIONS

- **Integrate life-course policy design:** link youth, working-age, and older-age measures under one equality framework.
- **Mainstream gender in ageing policy:** track all indicators (employment, care, pension, health) by sex and age.
- **Recognise middle-age carers:** introduce flexible work, respite care, and pension credits.
- **Prevent violence across ages:** implement age- and gender-sensitive prevention, awareness, and service training.
- **Support inclusive participation:** guarantee digital and civic access for all ages, especially those facing compounded disadvantage.
-

SECTION 3: SOCIETAL COSTS AND ECONOMIC IMPACT

3.1 THE ECONOMIC WEIGHT OF AGE AND GENDER INEQUALITY

Ageism and gender discrimination in Portugal impose measurable costs on the economy, the healthcare system, and the social protection network. While these costs are often hidden under "family responsibility" or "personal choice," they translate into lost productivity, lower tax revenue, and higher expenditure on health, pensions, and social care.

According to **Eurofound and OECD analyses**, the combination of low fertility, early retirement, and under-utilisation of older workers could cost Southern European economies up to **2–3 % of GDP annually by 2030** if unaddressed. In Portugal, this is compounded by structural gender gaps: women's lower participation in full-time employment and reduced lifetime earnings shrink the national contribution base while increasing the number of citizens dependent on social transfers.

3.2 LABOUR-MARKET AND PRODUCTIVITY LOSSES

The economic contribution of older workers is underestimated. Data from the **International Longevity Centre (ILC, 2024)** show that Portuguese workers aged **50+ generate 38 % of national earnings**, yet age discrimination shortens their working lives by discouraging retraining and late-career transitions.

Simultaneously, mid-life carers—mostly women aged 40–59—frequently reduce working hours or exit employment altogether. The **European Institute for Gender Equality (EIGE)** estimates that the **unpaid care economy in Portugal represents roughly 12 % of GDP** with women contributing over 70 % of total unpaid hours.

These dynamics feed a cycle:

- **Reduced labour participation** → lower tax revenue and pension contributions.
- **Gender pay and pension gaps** → increased old-age poverty and demand for non-contributory benefits.
- **Workforce stagnation** → slower innovation and productivity growth.

Addressing ageism is therefore not only a human-rights imperative but an economic necessity.

3.3 HEALTH AND CARE EXPENDITURE

Loneliness, workplace exclusion, and caregiving stress all increase demand for healthcare. Mid-life carers experience higher rates of anxiety, hypertension, and burnout, which raise health-insurance and absenteeism costs.

For older adults, ageism in healthcare—such as under-diagnosis or limited rehabilitation offers—reduces healthy life expectancy and increases long-term care expenditure.

Portugal's Ministry of Health estimates that chronic conditions linked to social isolation and stress account for nearly **15 % of primary-care visits**. Moreover, delayed retirement due to insufficient income lengthens exposure to physically demanding work, increasing occupational-injury costs.

3.4 THE COST OF VIOLENCE AND ABUSE

Gender- and age-based violence has severe fiscal and social consequences.

- A 2023 study by the **Commission for Citizenship and Gender Equality (CIG)** estimated the annual cost of domestic violence at **€1.2 billion**, including health, policing, justice, and productivity losses.
- Elder abuse, though under-reported, results in costly hospitalisations and emergency care. Based on conservative extrapolation from European averages (**Eurostat 2023**), these cases may represent an additional **€200–250 million annually** in hidden costs.

These figures highlight how violence is not merely a social issue but a systemic economic drain linked to gender and age inequality.

3.5 INTERGENERATIONAL AND ENVIRONMENTAL SPILL-OVERS

Intergenerational dynamics influence not only welfare but also housing and environmental costs.

- **Housing:** age-segregated property ownership—where older adults hold most assets and younger people rent precariously—creates barriers to mobility and intergenerational exchange. This imbalance increases urban segregation and intergenerational resentment.
- **Climate and wellbeing:** young people report high "eco-anxiety," while older adults face heat vulnerability and fuel poverty. Both phenomena increase healthcare and adaptation costs. Viewing climate resilience through an intergenerational lens—ensuring energy-efficient housing, green transport, and age-inclusive cities—can mitigate these social divides.

3.6 THE BROADER SOCIAL COST

Beyond economic metrics, the cumulative effect of ageism and gender inequality weakens social trust, participation, and civic solidarity. When discrimination leads to early withdrawal from work or community life, collective productivity and innovation decline. The OECD Better Life Index 2024 highlights that Portugal's social-trust indicator remains below the EU-15 average—a reflection of intergenerational insecurity and perceived unfairness in opportunity distribution.

SECTION 4: COMMUNITY SUPPORT, CONTINUUM OF CARE, AND FAMILY CAREGIVERS

4.1 PREVENTION AND EARLY SUPPORT

The first line of protection against exclusion and dependency is prevention.

Local *Centros de Convívio*, *Universidades Sénior*, and *Associações de Reformados* help maintain older persons' social participation, yet their reach remains uneven. Rural municipalities, in particular, struggle with transport barriers and staff shortages.

Integrating social-isolation screening into primary-care visits could detect risks earlier. Community health teams (*equipas de proximidade*) are strategically placed to link older persons with volunteers and social services before problems escalate.

A gendered lens is critical: older women, often widowed or lifelong caregivers, have smaller social networks and lower digital literacy, increasing the risk of chronic isolation. Proactive outreach—home visits, neighbourhood groups, and telephone companionship schemes—should therefore prioritise women living alone.

4.2 HOME- AND COMMUNITY-BASED CARE

Home-care services (*Serviço de Apoio Domiciliário*) are at the heart of Portugal's aging-in-place model. However, national coverage remains inadequate: over 35 000 older persons are on waiting lists, and many municipalities depend on short-term funding from local charities.

Expanding the professional home-care workforce with proper wages and training—especially in rural areas—would reduce pressure on families and improve quality of life.

Municipal innovations demonstrate potential. Cascais and Évora have launched integrated programmes combining home-meal delivery, digital-skills training, and tele-assistance—creating both care continuity and community contact (24). Scaling such approaches nationally would multiply social and economic returns.

4.3 EMERGENCY AND PROTECTIVE CARE

Community networks are also essential during crises such as heatwaves or public-health emergencies. Older women living alone face higher mortality during extreme heat due to poor housing and limited mobility. Embedding heat-health preparedness into existing municipal social-care services prevents duplication and ensures swift responses.

Good practices include:

- Red Cross community outreach combining social visits with environmental risk monitoring.
- Municipal buddy systems activated during DGS heat alerts.
- Temporary cooling spaces in community centres doubling as hubs for social participation.

This integrated approach turns emergency planning into everyday community care.

4.4 FAMILY CAREGIVERS – THE INVISIBLE BACKBONE

Over **60 % of long-term care in Portugal is provided informally by family members**—mostly women aged 45–64 (20). These caregivers fill structural gaps but face economic and social penalties: lost earnings, interrupted pensions, and heightened stress.

The **Informal Carers Statute** (*Lei n.º 100/2019*) formally recognises their role but suffers from inconsistent implementation and low public awareness. To make recognition meaningful, Portugal should guarantee:

- Pension credits and allowances for caregiving periods.
- Paid leave and flexible-work options, aligned with the EU Work-Life Balance Directive (26).
- Respite services through *Centros de Dia* or mobile support teams.
- Psychosocial assistance via primary-care networks and peer groups.

Such supports would reduce burnout, promote gender equality, and delay costly institutionalisation.

4.5 LONG-TERM AND PALLIATIVE CARE

Portugal's *Rede Nacional de Cuidados Continuados Integrados* (RNCCI) links hospitals, municipalities, and NGOs to provide post-acute and long-term care. Yet service density varies sharply: rural Algarve and Alentejo remain underserved (25). Integrating palliative, rehabilitative, and psychosocial care under a single governance framework would secure continuity for dependent older persons—two-thirds of whom are women.

4.6 BUILDING A LIFE-COURSE INFRASTRUCTURE

A resilient continuum of care requires coordinated governance and community ownership:

- Integrated local networks connecting health, housing (28), and social services.
- Gender- and age-responsive budgeting to direct funds where needs are greatest (mid-life women, older single households).
- Digital inclusion with **offline guarantees** for those excluded from e-services.
- Intergenerational community hubs providing shared spaces and reciprocal learning (27).

Embedding care and connection in everyday life transforms vulnerability into participation and dependency into empowerment.

SECTION 5: POLICY IMPLICATIONS AND ADVOCACY RECOMMENDATIONS

5.1 STRATEGIC ALIGNMENT

Portugal already possesses strong strategic instruments that can be leveraged rather than reinvented. The advocacy task is to make age and gender equality measurable, funded, and cross-ministerially coordinated.

Current frameworks:

- **ENIND 2030** (National Strategy for Equality and Non-Discrimination) – umbrella for gender, prevention of violence, and discrimination (30).
- **National Strategy for Active and Healthy Ageing (2023–2030)** – emphasises autonomy and participation but needs a stronger gender lens (31).
- **RNCCI** (National Network for Integrated Continuous Care) – key to operationalising community-based and home-based care (32).
- **National Plan to Combat Domestic Violence (2022-2025)** – includes older women but lacks intersectional monitoring (33).
- **European Care Strategy (2022)** – provides EU-level funding logic and benchmarks for formal and informal care (34).

5.2 MAIN POLICY IMPLICATIONS

RECOGNISE AGE AND GENDER AS CROSS-CUTTING DETERMINANTS

Ageism and gender discrimination are mutually reinforcing. Policy implication: integrate both into all national equality, health, and social policies using gender- and age-responsive budgeting.

- Mandate ministries to include age-gender impact assessments in annual budget submissions.
- Establish age- and gender-disaggregated indicators for loneliness, care needs, and violence.

GUARANTEE THE CONTINUUM OF CARE

Fragmented funding produces service gaps that increase family stress and institutionalisation. Policy implication: embed the continuum of care—from prevention to palliative—into the next Social Protection Strategy, coordinated by the Ministry of Labour and Social Solidarity (MTSSS) and RNCCI.

- Scale integrated municipal networks combining health, housing, and social services.
- Expand mobile multidisciplinary teams in rural municipalities.

SUPPORT AND PROTECT INFORMAL CAREGIVERS

Family carers sustain the system but remain under-supported. Policy implication: strengthen implementation of the *Estatuto do Cuidador Informal* (Lei n.º 100/2019) by:

- Simplifying registration and benefit procedures.
- Ensuring national parity in caregiver allowances.
- Introducing pension credits, paid leave, and portable rights for cross-border workers.
- Linking caregiver data to ENIND 2030 monitoring.

PREVENT ABUSE AND VIOLENCE ACROSS THE LIFE COURSE

Older women experience specific forms of domestic and financial abuse that remain hidden within families. Policy implication: integrate elder-abuse prevention into the National Plan to Combat Domestic Violence (2022-2025).

- Train health, police, and social-service professionals in age-sensitive detection.
- Establish anonymous reporting and safe-referral pathways in community health centres.
- Fund local NGO shelters with capacity for older survivors.

EMBED COMMUNITY RESILIENCE AND SAFETY

Community-based care must include emergency preparedness. Policy implication: integrate age- and gender-sensitive risk mapping into the *Plano Nacional de Saúde e Alterações Climáticas*.

- Use community centres as cooling and social hubs during heatwaves.
- Finance small-scale municipal grants for home-safety improvements.

PROMOTE ECONOMIC AND DIGITAL INCLUSION

Digitalisation can widen inequalities. Policy implication: guarantee hybrid (online/offline) access to public services and targeted digital-skills programmes for older women.

- Enforce digital-accessibility standards through the *Agência para a Modernização Administrativa*.
- Include digital-literacy modules in the *Programa EFA* (*Educação e Formação de Adultos*) for women 55+.

STRENGTHEN DATA AND ACCOUNTABILITY

Without metrics, progress remains rhetorical. Policy implication: establish a National Coordinating Mechanism on Age and Gender Equality—a technical body under CIG and MTSSS—to:

- Harmonise indicators across ENIND 2030, RNCCI, and Active Ageing Strategy.
- Produce annual public scorecards on gender-age equality and care sustainability.

- Channel EU cohesion and ESF+ funds towards under-served municipalities.

5.3 ADVOCACY PRIORITIES FOR CIVIL SOCIETY AND PARTNERS

- **Mainstream** the gender-age perspective in every reform (pensions, care, violence prevention, digital inclusion).
- **Monitor** the implementation of the Informal Carers Statute, pushing for equitable access and simplified procedures (35).
- **Advocate** for sustainable funding—transition from pilot projects to multi-year national co-funding mechanisms tied to EU programmes (34).
- **Promote** intergenerational dialogue through municipal councils, schools, and employers to combat stereotypes about both older and younger workers.
- **Elevate** abuse prevention—frame elder abuse as gender-based violence to ensure political visibility and resource allocation.
- **Strengthen** community partnerships—link Red Cross branches, parish councils, and senior universities into shared referral pathways.

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POLAND

1. INTRODUCTION: AGEISM AND THE AGEING BODY IN POLAND

1.1 DEMOGRAPHIC SNAPSHOT AND STRUCTURAL CONTEXT

Poland is undergoing a rapid demographic transformation that is reshaping social relations, welfare expectations, and the organisation of care across generations. As of 2024, the population stands at approximately 36.8 million and continues to decline. The median age is now around 42.7 years, placing Poland among the fastest-ageing countries in the European Union. Approximately one-fifth of the population is already aged 65 or older, and projections indicate that this share will exceed 30 per cent by 2050. Fertility rates remain persistently low at 1.29 births per woman, far below replacement level. While life expectancy is roughly 78 years, healthy life expectancy remains significantly lower, indicating substantial morbidity and functional limitations in later life. Women constitute the majority of the oldest age groups due to longer female longevity, reflecting gendered life-course patterns of work, health and caregiving.

These demographic trends increase pressure on pension sustainability, healthcare provision, and long-term care infrastructure. At the same time, intergenerational financial and caregiving transfers continue to form the foundation of support for older persons, particularly within families. However, demographic ageing in Poland is not understood only in economic terms. It is deeply shaped by cultural narratives that associate ageing with physical decline, diminishing social value, and withdrawal from visibility in public life. As a result, the ageing process becomes interpreted through the body, where physical changes are read socially as loss rather than continuity.

1.2 AGEISM IN POLAND THROUGH BODY IMAGE PERCEPTION AND EMBODIED SELF-RESTRICTION

Ageism in Poland operates not only through institutional or labour market discrimination but also through body-mediated norms that shape how individuals understand and present themselves in older age. Research on stereotype embodiment demonstrates that cultural beliefs about ageing are internalised across the life course and become expressed physiologically, influencing posture, mobility, confidence, and even cognitive and physical health outcomes.

In the Polish cultural context, the ageing body is frequently framed as something that must be concealed, disciplined, or made less visible. Body image changes—such as shifts in gait, muscle tone, weight distribution or skin appearance—are interpreted socially rather than neutrally. This can lead to body image distortions, where older adults adjust behaviour to pre-empt judgement: limiting expressive movement, avoiding eye contact, restricting clothing choices, or reducing presence in public space.

For women, these dynamics are reinforced by norms linking femininity to youthfulness, modesty and restraint, which can result in withdrawal from social visibility, self-expression and intimacy as the body changes. For men, cultural expectations of strength and autonomy encourage the suppression of vulnerability and discourage help-seeking, contributing to preventable declines in physical and mental health. In both cases, ageism becomes internalised, leading individuals to regulate their own bodies in anticipation of social disapproval.

Thus, the ageing body is not only shaped by biological processes but by social forces that determine which bodies are seen as legitimate, beautiful, deserving of space, or permitted to express pleasure or desire.

1.3 INTERSECTIONAL RISKS: GENDER, IDENTITY AND SOCIAL POSITION

These embodied dynamics are not uniform across the population. They intersect with gender, socioeconomic status, geography and identity. Older women are disproportionately affected by low pensions, cumulative unpaid caregiving, widowhood and limited social networks, which intensify vulnerability to body-related self-restriction and invisibility. Older men often experience social isolation differently: emotional expression and acknowledgement of dependency may be discouraged due to masculine norms, resulting in silent declines in wellbeing.

In rural and small-town settings, social monitoring is especially strong, and conformity to age-appropriate behaviour, dress and appearance is reinforced through informal community judgement. For LGBTQ+ older adults, the body may become a site of concealment rather than expression, as visibility can risk social exclusion. These patterns demonstrate that the ageing body is governed through cultural expectations that regulate not only what bodies can do, but what bodies should do.

1.4 WHY INTERGENERATIONAL SOLIDARITY REQUIRES A BODY-CENTRED PERSPECTIVE

Intergenerational solidarity in Poland is often addressed through economic policy debates on pensions, labour force participation and family care. However, these systems depend on the quality of intergenerational perception and recognition. When ageing is associated primarily with decline, fragility and shame, younger people come to fear their own ageing, and older people withdraw from public participation. This reduces opportunities for shared experience, empathy and collective responsibility.

A body-centred approach reframes ageing as a continuous and meaningful dimension of the life course. It enables older persons to reclaim presence, expression, sexuality, intimacy and movement, and it allows younger generations to develop a more realistic and affirmative understanding of ageing. This shift is essential not only for dignity and wellbeing but for sustaining social cohesion in an ageing society.

In this context, arts-based and performative methodologies—especially theatre—are strategically important. Theatre works directly through gesture, posture, breath and presence, making visible the often invisible processes of internalised ageism. It can expose the social forces that shape the ageing body and open space for reclaiming agency, voice and relational connection. Used in this way, theatre becomes not only cultural expression but a mechanism for political and social change, supporting both personal empowerment and public advocacy.

2. EVIDENCE AND MANIFESTATIONS OF EMBODIED AGEISM IN POLAND

2.1 CONCEPTUAL MECHANISMS: FROM SOCIAL STEREOTYPES TO BODILY SELF-REGULATION

A robust body of research shows that age-related stereotypes are not only external labels; they are internalised and then embodied in ways that influence cognition, affect, physiology and behaviour across the life course. In the Stereotype Embodiment framework, older people's own age beliefs measurably alter balance, gait, cardiovascular reactivity, memory, health behaviours and recovery, helping to explain why "subtle" ageism can produce concrete differences in late-life health and participation. These mechanisms are central for Poland because they connect cultural scripts about "how an older body should look and act" to everyday self-restriction in public space, families, and services.

Evidence from integrative reviews further underlines that appearance and body image are pivotal vectors through which ageism is experienced, especially by women. Changes in skin, posture, weight distribution and mobility are read socially as "decline," prompting self-monitoring (e.g., clothing choices, gesture minimisation, voice lowering) and avoidance of situations that expose the body to scrutiny—responses that can reduce social participation and accelerate frailty.

2.2 WHAT POLISH STUDIES SHOW ABOUT AGEIST ATTITUDES AND PERCEPTIONS

Polish population and student studies consistently document negative attitudes toward older age, with stereotypic beliefs about dependence and reduced competence. These attitudes track closely with international definitions of ageism and are relevant to how older adults perceive their own ageing bodies. Findings indicate that ageist beliefs are present among younger and mid-life cohorts, and that perceived social image of "old age" relates to self-esteem and expectations for capabilities in older adulthood—conditions that foster internalised body image distortions later on.

At the European level, the contextual backdrop is a rapidly ageing population: by 1 January 2024, 21.6% of EU residents were aged 65+, with a median age of 44.7 years—trends that shape everyday contact between generations and the salience of age-coded body norms in public and institutional settings.

2.3 SETTINGS WHERE THE AGEING BODY IS JUDGED AND GOVERNED

2.3.1 HEALTHCARE AND REHABILITATION

International evidence shows that ageism in healthcare ranges from diagnostic overshadowing (attributing symptoms to "normal ageing") to reduced offer of prevention, screening and rehabilitation. These practices transmit powerful signals to patients about the (de)valued status of ageing bodies, which can amplify self-restriction (e.g., patients under-reporting pain or limiting questions). Given Poland's below-OECD-average life expectancy and the need to expand long-term care and rehabilitation capacity, addressing clinical ageism is both a human-rights and efficiency imperative.

2.3.2 WORKPLACE AND EMPLOYABILITY

When late-career capability is equated with youthful appearance and speed, body-coded hiring and retention practices emerge (e.g., "energetic image," presumed digital slowness). Stereotype-consistent cues are then internalised by older workers, who may mute participation in meetings, avoid up-skilling contexts that expose perceived deficits, or accept peripheral roles to "fit" expectations. These embodied dynamics contribute to premature withdrawal from work and lower healthy-working-life expectancy in ageing labour markets like Poland's.

2.3.3 PUBLIC SPACE AND SERVICES

In transport, retail or administrative offices, the ageing body often becomes a public object open to unsolicited advice, infantilising speech or impatience with slow movement. Anticipation of such reactions fosters pre-emptive shrinking—reduced eye contact, quiet speech, neutral clothing—especially among older women. EU-wide demographic ageing increases the frequency of such intergenerational encounters, making body-based norms a daily governance mechanism of inclusion/exclusion.

2.3.4 FAMILY, INTIMACY AND SEXUALITY

Reviews document that appearance-centric and desexualising stereotypes shape older adults' intimate self-concepts, particularly women's, who report withdrawing from expressive clothing, dance, and sexual initiative to avoid social disapproval. Men, guided by control/strength norms, may hide vulnerability and forgo help, increasing risks of loneliness and untreated conditions. These patterns link directly to mental-health outcomes and quality of life.

2.4 HEALTH AND SYSTEM IMPACTS OF EMBODIED AGEISM

The health consequences of internalised ageism include lower physical activity, reduced adherence to therapy, heightened stress responses and poorer functional outcomes. Such pathways help explain persistent gaps in healthy life expectancy, even where overall life expectancy improves. For Poland, OECD/EC monitoring emphasises the need to lift healthy years and address system bottlenecks (primary care, long-term care), areas where reducing clinical and self-directed ageism can deliver measurable gains.

At the population level, the combination of ageing demographics and embodied ageism increases the social cost of isolation, delays preventive care, and shortens productive

engagement—effects that compound pressures on pensions, health and municipal care budgets. EU demography data provide the structural lens for these spill-overs and underline why interventions must target perceptions and bodies, not only services.

2.5 WHAT WORKS: PRINCIPLES FROM INTERNATIONAL GUIDANCE

The WHO Global Report on Ageism identifies three interventions with strongest evidence: policy and law, educational programmes, and intergenerational contact—all relevant to shifting how ageing bodies are seen and treated. For healthcare, education that challenges implicit bias and communication norms can reduce diagnostic overshadowing; for workplaces, policy clarity combined with age-inclusive training and visual communications reduces body-coded hiring. Intergenerational formats that centre shared physical presence (e.g., movement, craft, co-performance) are particularly powerful for recalibrating body-image expectations across ages.

2.6 IMPLICATIONS FOR THE PLAY (ADVOCACY BRIDGE)

Objective: make the invisible rules of body-coded ageing visible, and invite audiences to test alternatives.

- Healthcare scene: A routine visit where the clinician addresses a daughter instead of the patient; audience interventions shift gaze, seating and voice to centre the older woman's body and speech. (Counters diagnostic overshadowing.)
- Workplace scene: Late-career employee volunteers for a digital task but self-limits due to anticipated ridicule; audience proposes micro-changes (turn-taking, visual aids, coaching pair) that de-link competence from youthful image.
- Public-space tableau: Bus/queue images show shrinking gestures and averted eyes; audience experiments with posture, colour, pace to rehearse dignified presence and respectful interaction.

These scenes translate the evidence base into embodied policy messages the audience can feel—and therefore remember.

3. SOCIETAL AND SYSTEM-LEVEL IMPLICATIONS OF EMBODIED AGEISM IN POLAND

Ageism in Poland does not manifest solely through discriminatory attitudes or institutional exclusion; it is also expressed through the ways older people experience, evaluate, and manage their bodies within social space. The internalisation of cultural expectations about what ageing bodies should look like, how they should move, and what they are permitted to express or desire has profound consequences for health, labour participation, well-being and social cohesion. The process by which stereotypes are absorbed and enacted physically over time has been described as **embodiment**, a mechanism that shapes posture, movement, voice, confidence, and self-perception across the life course.

3.1 HEALTH AND WELL-BEING

Research consistently shows that internalised ageism influences both mental and physical health. Older adults who believe that ageing inevitably involves decline are less likely to engage in physical activity, rehabilitation or preventive care. This contributes to earlier onset of frailty and functional limitations.[2] When the ageing body becomes a site of shame or inadequacy, movement becomes restricted and cautious, which in turn accelerates the very decline that is feared.

Healthcare interactions reinforce these patterns. Ageist assumptions from clinicians, such as attributing symptoms to "normal ageing," discourage older adults from seeking treatment and undermines their trust in the system.[3] Individuals may avoid care, delay diagnosis or minimise symptoms — leading to more advanced and complex health conditions when they eventually present for support. This dynamic is reflected in Poland's gap between life expectancy and healthy life expectancy, which remains wider than the EU average.[4] The embodied experience of ageism thus becomes not only a personal burden but a measurable public health cost.

3.2 MENTAL HEALTH AND SOCIAL PARTICIPATION

The social meanings attached to ageing bodies shape patterns of participation. When older adults feel that their bodies are being judged, monitored, or evaluated, they may avoid public settings where their physical presence is visible. Withdrawal from cultural venues, parks, cafés, and intergenerational gatherings gradually leads to isolation. This decline in participation is not primarily due to incapacity, but to internalised norms of restraint and reduction of presence.[5] Isolation, in turn, increases the risk of depression, anxiety, and cognitive decline.[2] The body retreats first, and the mind follows.

3.3 LABOUR MARKET CONSEQUENCES

In the workplace, ageism is often communicated through bodily codes — energy, speed, appearance, posture, and tone are treated as signals of competence and adaptability. Older workers may internalise these standards and voluntarily step back from opportunities, training, leadership roles or professional visibility. In Poland, where women's employment trajectories are already shaped by caregiving interruptions, embodied ageism compounds earlier inequalities, contributing to lower pensions and higher poverty in later life. Early labour market exit is therefore not only an administrative or economic issue but also an embodied psychological process shaped by cultural expectations of what ageing bodies should do and be.

3.4 FAMILY AND INFORMAL CARE SYSTEMS

Poland relies heavily on family-based caregiving, particularly provided by women aged 50+. Embodied ageism affects both caregivers and care recipients. Caregivers often suppress signs of fatigue, pain or emotional distress to maintain an image of competence, while care recipients may avoid expressing needs to avoid appearing dependent or burdensome. This mutual silence leads to burnout and can result in earlier institutionalisation — precisely the outcome families seek to avoid. The management of ageing and care thus becomes an emotional and bodily negotiation of what can be shown and what must be hidden.

3.5 SOCIAL COHESION AND INTERGENERATIONAL RELATIONS

At a societal level, embodied ageism erodes intergenerational connection. When ageing is framed primarily as decline, younger people distance themselves from older adults and from their own future selves. The withdrawal of older adults from public visibility reduces opportunities for shared recognition, empathy and cooperation. For a country experiencing rapid demographic ageing, this absence of intergenerational engagement reduces social cohesion and weakens public support for shared welfare responsibility.

4. POLICY FRAMING: CULTURAL MEANING, THE AGEING BODY, AND THE LONG HORIZON OF SOCIAL CHANGE

Addressing ageism in Poland requires more than reforming systems of care, employment, or social protection. These systems operate within cultural environments that shape how ageing is understood and how ageing bodies are treated in daily life. Cultural narratives do not merely reflect policy conditions; they actively shape them, influencing which issues appear urgent and which forms of support are seen as legitimate. For this reason, meaningful policy change must also be a cultural shift—one that **repositions the ageing body not as a symbol of loss, but as part of a shared human continuum.**

The theatre element of this project makes visible the subtle, embodied forms of ageism that often remain unnoticed but are deeply felt. By presenting these dynamics through performance, it opens a space for recognition and reflection that is both social and emotional. This shared recognition lays the groundwork for public and institutional conversations that would otherwise be difficult to start.

4.1 REFRAMING AGEING AS A SHARED LIFE-COURSE PROCESS

Public discourse in Poland continues to frame ageing primarily in terms of decline and dependency. Such framings obscure the universal nature of ageing and reinforce the perception that older persons are outside or beyond the main flow of social life. Reframing ageing as a continuous life-course process supports approaches that prioritise participation, autonomy, and intergenerational inclusion, **aligning with international policy directions** on healthy ageing and age equality.

4.2 THE CENTRALITY OF THE BODY IN POLICY-RELEVANT FORMS OF AGEISM

The ageing body is where structural ageism becomes personal. Expectations that older adults should appear modest, quiet, or physically small shape how they occupy space, seek care, and participate socially These internalised norms have measurable impacts on health and service use: reduced physical activity accelerates frailty; delayed help-seeking contributes to late-stage diagnoses; withdrawal from social settings increases loneliness and cognitive risk. The body, therefore, is not peripheral in ageing policy—it is foundational.

4.3 CULTURAL INTERVENTIONS AS PRECONDITIONS FOR POLICY PROGRESS

Policies that expand services or benefits cannot achieve their intended outcomes if cultural norms discourage older adults from making use of them. Addressing embodied ageism is thus a **prerequisite for effective health, social care, and labour policies**. Cultural and creative interventions create the conditions in which institutional reforms become socially acceptable and politically sustainable.

4.4 THEATRE AS A CIVIC TOOL FOR CULTURAL SHIFT

Theatre works directly through gesture, presence, and interpersonal recognition. It allows older individuals to reclaim expressive bodily agency and allows audiences to witness how ageing is socially regulated. This shared emotional encounter destabilises ageist norms at their source: in perception, expectation, and identity. In doing so, it supports the development of intergenerational solidarity, which is essential for future welfare and care system resilience.

4.5 THE LONG HORIZON OF CHANGE

Cultural change develops gradually, through repetition, conversation, and shared experience. The work presented in this project should therefore be understood as contributing to the enabling conditions for long-term policy transformation. While policy reforms may take years to materialise, the shift in how societies imagine ageing begins in spaces where older bodies are seen, heard, and recognised as fully human and fully present.

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Public discourse in Poland continues to frame ageing primarily in terms of decline and dependency. Such framings obscure the universal nature of ageing and reinforce the perception that older persons are outside or beyond the main flow of social life. Reframing

ageing as a continuous life-course process supports approaches that prioritise participation, autonomy, and intergenerational inclusion, **aligning with international policy directions** on healthy ageing and age equality.

5.2 THE CENTRALITY OF THE BODY IN POLICY-RELEVANT FORMS OF AGEISM

The ageing body is where structural ageism becomes personal. Expectations that older adults should appear modest, quiet, or physically small shape how they occupy space, seek care, and participate socially. These internalised norms have measurable impacts on health and service use: reduced physical activity accelerates frailty; delayed help-seeking contributes to late-stage diagnoses; withdrawal from social settings increases loneliness and cognitive risk. The body, therefore, is not peripheral in ageing policy—it is foundational.

5.3 CULTURAL INTERVENTIONS AS PRECONDITIONS FOR POLICY PROGRESS

Policies that expand services or benefits cannot achieve their intended outcomes if cultural norms discourage older adults from making use of them. Addressing embodied ageism is thus a **prerequisite for effective health, social care, and labour policies**. Cultural and creative interventions create the conditions in which institutional reforms become socially acceptable and politically sustainable.

5.4 THEATRE AS A CIVIC TOOL FOR CULTURAL SHIFT

Theatre works directly through gesture, presence, and interpersonal recognition. It allows older individuals to reclaim expressive bodily agency and allows audiences to witness how ageing is socially regulated. This shared emotional encounter destabilises ageist norms at their source: in perception, expectation, and identity. In doing so, it supports the development of intergenerational solidarity, which is essential for future welfare and care system resilience.

5.5 THE LONG HORIZON OF CHANGE

Cultural change develops gradually, through repetition, conversation, and shared experience. The work presented in this project should therefore be understood as contributing to the enabling conditions for long-term policy transformation. While policy reforms may take years to materialise, the shift in how societies imagine ageing begins in spaces where older bodies are seen, heard, and recognised as fully human and fully present.

6. LOCAL ADVOCACY APPROACHES LINKED TO POLICY AND FUNDING MECHANISMS

Advocacy at municipal and regional level can be strengthened by aligning cultural and intergenerational work with existing local policy frameworks and funding streams. This situates theatre-based work as a direct contributor to recognised priorities, rather than as an external request for change.

1. ALIGN CULTURAL VISIBILITY OF AGEING WITH LOCAL SENIOR POLICY STRATEGIES

Every municipality in Poland is encouraged to adopt a *Gmina Program Wsparcia Seniorów* (Municipal Senior Support Program) as part of the national Social Policy for Older Persons 2024–2030, which prioritises social participation, reduction of isolation, and intergenerational inclusion.

- **Advocacy use:** The theatre's cultural visibility work can be framed as implementation of participation and community integration objectives already present in municipal senior policy.
- **Potential funding basis:** The Act on Public Benefit and Volunteer Work allows municipalities to allocate small, renewable public-purpose grants to local NGOs and cultural actors supporting community well-being.

2. CONNECT EMBODIED PARTICIPATION TO REGIONAL "HEALTHY AND ACTIVE AGEING" PRIORITIES

The Zachodniopomorskie Regional Social Policy Strategy identifies prevention of loneliness, community activation, and ageing in place as key regional challenges.

- **Advocacy use:** Movement-based, expression-based, and intergenerational cultural practices can be presented as low-cost, community-rooted prevention measures that reduce pressure on health and care systems.
- **Potential funding:** Regional Social Policy Center (ROPS) community activity grants.

3. LINK INTERGENERATIONAL CONTACT TO LOCAL SENIOR COUNCIL STRUCTURES

Most municipalities have, or are forming, Senior Councils (*Rady Seniorów*) to provide advisory input to local government. These bodies shape local policy climate even when they lack executive power.

- **Advocacy use:** Inviting council members to rehearsals, public conversations, or shared reflection sessions can gradually introduce embodiment and representation issues into local policy discussion without formal lobbying.

4. USE EU-LEVEL FRAMEWORKS TO LEGITIMIZE CULTURAL APPROACHES

European and international frameworks already recognise participation, visibility, and representation as core ageing policy principles, including:

- **WHO Decade of Healthy Ageing (2021–2030)** — participation as a right
- **EU Care Strategy (2022)** — community-based support and dignity in care
- **UNECE Mainstreaming Ageing Guidelines** — intergenerational inclusion and age-respectful environments

- **Advocacy use:** Referencing these frameworks gives cultural work institutional legitimacy, without requiring engagement in EU-level advocacy.

5. POSITION CULTURAL WORK AS MUNICIPAL SOCIAL INFRASTRUCTURE

The argument becomes: **Theatre is not leisure activity; it is social infrastructure that sustains community connection, intergenerational relations, belonging, and emotional resilience.**

This framing supports:

- multi-year collaboration agreements,
- integration into municipal cultural planning,
- recognition as a stable civic partner, not a project applicant.

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SERBIA

SECTION 1 — INTRODUCTION

1.1 DEMOGRAPHIC SNAPSHOT AND STRUCTURAL CONDITIONS UNDERPINNING AGEISM IN SERBIA

Serbia is among the most rapidly ageing societies in Europe. According to the 2022 Census, **22.1% of the population is aged 65+**, placing Serbia within the top tier of "old" societies globally . This demographic picture is shaped by persistent low fertility, negative migration flows of working-age adults, and gradual improvements in longevity. Serbia's median age has reached **44.3 years**, making age-related needs an increasingly central policy concern.

Ageing in Serbia is strongly **gendered**: women represent **56.9%** of the 65+ population, and an even greater share of persons aged 80+ (1). Due to lower lifetime earnings, interrupted careers and unpaid caregiving roles, older women disproportionately experience poverty and greater need for long-term care, a pattern also reflected in Red Cross of Serbia (RCS) research.

Geographical disparities deepen vulnerability. Rural and depopulating regions in Southern and Eastern Serbia have significantly higher shares of older residents but fewer services. One-person older households — **13.4% of all households**, of which **over two-thirds are women** — are at distinct risk due to isolation, low income and limited mobility.

This demographic context is essential to understanding policy ageism: older persons are often framed as "dependants" or "cost-drivers," which influences how public resources are allocated and how policy priorities are defined.

1.2 POVERTY, HEALTH INEQUALITIES, AND SOCIAL EXCLUSION AS OUTCOMES OF POLICY AGEISM

Older persons in Serbia experience some of the **highest poverty rates of any age group**. The at-risk-of-poverty rate for persons 65+ is **23.5%**, and for older women **25.3%**, confirming that old-age poverty is both widespread and gendered. One-person households aged 65+ have a poverty rate of **34.2%**, making them one of the most vulnerable household types in the country.

Even average pensions do not cover the minimal consumption basket, reflecting structural inadequacy in income protection in later life. Out-of-pocket payments (OOP) for care, medicines and health services further intensify deprivation and expose families to financial hardship.

Health inequalities compound these risks. National data show that between **30% and 45%** of older persons experience mobility, sensory, or functional limitations, while about **10%** require support with daily living activities. Access to rehabilitation, geriatric services and community-based care is limited, inequitable, and often unaffordable. These gaps reflect implicit ageist assumptions that functional decline is "natural" and therefore less deserving of public investment.

Social exclusion affects nearly **one-third** of older persons in Serbia, driven by poverty, poor transport, digital exclusion, and shrinking social networks. Such exclusion reinforces stereotypes of older adults as passive or isolated, which in turn shapes institutional responses.

1.3 INTERGENERATIONAL PRESSURES AND POLICY CHOICES SHAPED BY AGEIST ASSUMPTIONS

Serbia's demographic and socioeconomic conditions place high pressures on intergenerational relations. Younger adults face precarious labour markets and rising housing costs, while middle-aged adults carry extensive unpaid caregiving responsibilities. The state's reliance on family-based care — especially care provided by women aged 45–64 — reflects and reinforces the ageist assumption that older persons are primarily the responsibility of their relatives, not the social protection or health system.

This underinvestment creates a cascade of economic and emotional pressures that families internalise, often resulting in subtle forms of resentment or frustration. International research shows that when public systems fail to support older adults adequately, implicit narratives portraying older persons as a "burden" grow stronger. These narratives then influence future policy decisions, creating a self-reinforcing cycle between **societal ageism and policy ageism** .

1.4 WIDESPREAD SOCIETAL AGEISM AND ITS INFLUENCE ON PUBLIC POLICY

Studies by the Commissioner for the Protection of Equality demonstrate that older persons in Serbia experience discrimination in healthcare, social services, banks, local administration and

everyday interactions. Reports describe dismissive communication, diagnostic overshadowing, administrative barriers and assumptions of incapacity — all examples of **societal ageism** that directly affect service quality.

The WHO Global Report on Ageism and international research by Ayalon and Tesch-Römer show that societal ageism often becomes embedded in public policy. This pattern is visible in Serbia's:

- persistent underfunding of long-term care,
- fragmented community support systems,
- weak implementation of social protection rights,
- digitalisation policies that exclude older adults,
- reliance on unpaid caregiving.

These are not isolated shortcomings but systemic expressions of ageism: older persons' rights and needs are acknowledged rhetorically but not supported through adequate, equitable and accessible measures.

1.5 WHY ADDRESSING AGEISM IN PUBLIC POLICY IS A STRUCTURAL IMPERATIVE

The consequences of ageist policy structures are visible across Serbia's demographic, economic and social landscape. Poverty in older age, unpaid care burdens, lack of LTC services, and inequitable access to healthcare affect not only older persons but entire households and communities.

Addressing ageism thus requires a shift from treating older persons as passive recipients of welfare to recognising them as **rights-holders**. This shift must be embedded in:

- resource allocation,
- LTC system design,
- pension and social protection reform,
- health system organisation,
- emergency planning,
- digital inclusion,
- and governance structures that include older adults in decision-making.

Reducing ageism is not simply a matter of correcting attitudes; it is a foundational requirement for building a fair, sustainable and rights-based policy system in Serbia (9,12,13).

SECTION 2 — EVIDENCE OF AGEISM AND INEQUALITY IN PUBLIC POLICIES IN SERBIA

2.1 STRUCTURAL AGEISM AS A DRIVER OF POLICY CHOICES

Ageism in Serbia is not confined to interpersonal attitudes. It is embedded in **how institutions distribute resources, define responsibilities and assign value to older persons' needs**. International research shows that negative assumptions about ageing often translate into lower public investment and weaker policy attention (1,2). This connection between societal ageism and institutional ageism is well documented globally (1,3) and is visible in Serbia across four systems central to ageing:

- long-term care (LTC),
- social protection,
- healthcare,
- digitalisation and administrative services.

Across these domains, older persons in Serbia experience limited service availability, unequal territorial access, affordability barriers, administrative complexity and low institutional responsiveness — all features that reflect **structural ageism**.

2.2 AGEISM IN LONG-TERM CARE: UNDERINVESTMENT, FRAGMENTATION AND RELIANCE ON UNPAID LABOUR

Serbia still does not have a unified LTC system; instead it relies on a fragmented mix of health and social-protection measures. This fragmentation creates inequity and reinforces the implicit policy assumption that older persons' care needs should be met primarily by family members, particularly women — a finding strongly supported by national evidence.

2.2.1 FRAGMENTED SYSTEM AS A MANIFESTATION OF POLICY NEGLECT

Community-based services such as *pomoć u kući*, day care or respite care exist only in parts of the country. According to LTC access research, **less than half of municipalities** provide home assistance, and even where available, the service is typically limited to **one or two visits per week**. Day centres and respite services are rare, often dependent on project funding rather than stable public financing.

Fragmented provision reflects longstanding assumptions that older persons do not require autonomy-oriented services and that families will fill the gap — an institutional expression of ageism.

2.2.2 OVERRELIANCE ON INFORMAL CARE AS INSTITUTIONALISED AGEISM

More than **80% of all care** is provided by family members, predominantly women aged 45–64. The state does not provide universal caregiver allowances, pension credits, or comprehensive psychosocial support, even though the mental-health burden on carers is substantial.

This reliance on unpaid care mirrors international patterns of structural ageism, where older persons' dependency is treated as a private family matter rather than a public responsibility. In Serbia, this pattern is intensified by limited municipal budgets and inconsistent service availability.

2.2.3 INSTITUTIONAL CARE AS THE "DEFAULT" FOR THOSE WHO CAN AFFORD IT

Because community support is insufficient, many older persons enter residential institutions earlier than necessary. Private institutions, however, are unaffordable for large segments of the population, whose pension levels rarely cover even basic living costs (4). Public facilities have waiting lists and geographic limitations (6).

This dynamic reveals an ageist policy logic: support for ageing in place is weak, while institutionalisation—although more expensive—remains the path of least resistance.

2.3 AGEISM IN SOCIAL PROTECTION: LIMITED INCOME SUPPORT, ADMINISTRATIVE BARRIERS AND WEAK TARGETING

Older persons' elevated poverty risk is well documented. Serbia's at-risk-of-poverty rate for persons 65+ is **23.5%**, rising to **34.2%** for one-person older households. Yet income-support mechanisms do not adequately address the specific vulnerabilities of older adults.

2.3.1 INCOME SUPPORT MECHANISMS POORLY ALIGNED WITH NEEDS

Financial social assistance has restrictive eligibility rules (property tests, asset thresholds) incompatible with the profiles of many older adults. As a result, those facing poverty, especially older women and rural residents, are often formally "ineligible."

This misalignment reflects the assumption that older persons possess assets or family support and therefore require less public intervention — a form of policy ageism consistent with global findings.

2.3.2 LACK OF DEDICATED LTC-RELATED FINANCIAL PROTECTION

Serbia provides *Pomoć i nega drugog lica* and *Dodatak za tuđu negu i pomoć*, but these benefits:

- were designed primarily as disability supports,
- do not cover the actual cost of long-term care,
- are not linked to community services,
- and do not support family caregivers.

Given that OOP payments for health and care significantly increase poverty among older persons and their households, the absence of systemic financial protection represents a critical rights gap.

2.3.3 IMPLEMENTATION GAP: PROVISIONS EXIST BUT REMAIN INACCESSIBLE

Many municipalities formally adopt social-protection strategies that include services for older persons, but a large number **never allocate funding for implementation**. The discrepancy between legal obligations and real-world service availability constitutes another expression of institutional ageism: rights exist on paper but not in practice.

2.4 AGEISM IN HEALTHCARE: UNEQUAL ACCESS, DIAGNOSTIC OVERSHADOWING AND LACK OF GERIATRIC FOCUS

Health systems often reproduce ageist biases through clinical decision-making and resource allocation. In Serbia, this is visible in limited access to geriatric expertise, delayed rehabilitation, and the widespread perception that functional decline is "normal for age," leading to diagnostic overshadowing.

2.4.1 TERRITORIAL INEQUITIES AND AFFORDABILITY BARRIERS

Older persons in rural and less-developed regions face longer travel distances, higher transport costs and limited availability of specialist services. OOP spending on medicines, diagnostics and medical devices is high relative to pension income, pushing many into financial hardship.

2.4.2 WEAK INTEGRATION BETWEEN HEALTH AND SOCIAL SERVICES

Older persons with complex needs often bounce between *dom zdravlja*, hospitals, and social-protection institutions without coordinated pathways. The absence of integrated care perpetuates neglect, delays functional recovery and increases institutionalisation risk — all consistent with global patterns of structural healthcare ageism.

2.5 AGEISM IN DIGITALISATION AND PUBLIC ADMINISTRATION

Serbia's rapid digitalisation of public services has brought efficiency gains, but it also widened barriers for older adults, many of whom lack digital skills or access to devices.
When essential rights — such as scheduling medical appointments, applying for social benefits or accessing banking services — are shifted primarily to digital platforms without adequate non-digital alternatives, older persons face **administrative exclusion**.

Such exclusion constitutes a form of discrimination recognised in international human rights frameworks. The Commissioner for the Protection of Equality has documented numerous complaints related to inaccessible administrative procedures and public services for older citizens.

2.6 THE IMPLEMENTATION GAP AS A CORE EXPRESSION OF POLICY AGEISM

Across LTC, social protection, healthcare and digitalisation, the **implementation gap** is one of Serbia's most persistent policy problems. Strategies and regulations often acknowledge older persons' vulnerabilities, yet:

- services are not funded,

- entitlements are not operationalised,
- municipalities lack resources,
- monitoring is weak,
- and accountability mechanisms are minimal (4–6,8).

This gap reveals a crucial truth: **ageism is not only about what is written in laws — it is about what governments choose to implement, fund and prioritise**.

Ageism becomes structural when laws exist but older persons cannot exercise the rights they contain.

2.7 CROSS-CUTTING POLICY DOMAINS INTENSIFYING AGEISM AND INEQUALITY

2.7.1 ABUSE OF OLDER PERSONS: A GENDERED BLIND SPOT IN PUBLIC POLICY

Abuse of older persons remains insufficiently recognised within Serbia's public policy framework. Despite growing international and national evidence, elder abuse is predominantly addressed as a private or family matter rather than as a structural outcome of dependency, poverty and weak institutional protection. This framing reflects policy ageism, whereby violence and neglect affecting older persons remain marginal across health, social protection and gender-equality systems.

Older women face heightened exposure to abuse due to longer life expectancy, higher prevalence of disability, lower income security and greater reliance on informal care. National evidence indicates that gender-based violence against older women is under-reported and weakly addressed, with protection mechanisms insufficiently adapted to age-related barriers in disclosure and access to services. International evidence similarly shows limited integration between gender-based violence policies and ageing frameworks, leaving older women insufficiently covered by either system.

Health and social services play a key role in identifying abuse, yet ageist assumptions frequently limit detection and response. Indicators of neglect, psychological abuse or financial exploitation are often normalised as "age-related" or reframed as family issues, contributing to under-reporting and delayed intervention. Fragmented and procedurally demanding reporting mechanisms further increase the risk of withdrawal from the process and continued exposure to harm.

Available evidence links exposure to abuse with poverty, care dependence and social isolation, particularly among older women living alone and in rural areas *(19)*. In the absence of accessible, age-appropriate and continuous institutional support, abuse of older persons reflects predictable outcomes of policy arrangements that fail to ensure coordinated protection.

2.7.2 PENSION POLICIES AS A STRUCTURAL AMPLIFIER OF AGEISM AND GENDER INEQUALITY

Pension policy represents a key mechanism through which structural ageism accumulates across the life course. In Serbia, formally neutral pension rules insufficiently account for gendered labour-market trajectories, unpaid caregiving and health-related work interruptions, resulting in persistent income insecurity in older age. Pension adequacy remains weakly aligned with the actual costs of ageing, particularly for women.

Older women face significantly higher poverty risks due to lower lifetime earnings and interrupted employment histories. Pension design continues to rely on assumptions of continuous, full-time employment, reproducing inequalities that reflect cumulative disadvantage rather than individual choice*)*. The gradual equalisation of statutory retirement age, while formally promoting equality, does not address unequal starting positions and may reinforce gendered ageism.

Recent regulatory updates specify that from 1 January 2026 women become eligible for old-age pensions at age 64 with at least 15 years of insurance coverage, while the eligibility age for men remains 65, with further equalisation planned by 2032. Early-retirement penalties continue to disproportionately affect individuals whose labour-market exits are driven by caregiving responsibilities, deteriorating health or limited age-friendly employment opportunities. Combined with high health- and care-related out-of-pocket expenditures, insufficient pension income increases reliance on family support and heightens vulnerability to neglect and exclusion. Pension policy thus operates as a cross-cutting amplifier of ageism across care, health and social-protection systems.

2.7.3 HEALTH SERVICES WITHIN THE LONG-TERM CARE CONTINUUM: EMERGENCY CARE AS A PRESSURE POINT

Health services play a central role within the long-term care (LTC) continuum by shaping responses to functional decline, chronic illness and acute deterioration. As shown above, limited community-based LTC provision and weak integration between health and social services result in gaps in continuous support, increasing reliance on crisis-driven care.

When preventive, rehabilitative and home-based services are insufficient, health services increasingly function as substitutes rather than complements to long-term support. Older persons with unmet care needs often enter the system through emergency calls or hospital admissions rather than coordinated care pathways, reflecting a reactive policy approach consistent with structural ageism.

Emergency medical services provide a clear indicator of these dynamics. Recurrent emergency calls and avoidable hospitalisations frequently signal the absence of accessible community care, home support or caregiver relief. In 2025, Serbia adopted a new *Pravilnik o načinu i organizaciji obavljanja hitne medicinske pomoći*, standardising the organisation of prehospital emergency care. However, weak coordination between emergency services, primary care, rehabilitation and social protection continues to contribute to repeated crisis episodes, accelerated functional decline and increased institutionalisation risk.

From a policy perspective, emergency care functions as a pressure point where failures in prevention, integration and long-term support converge, reinforcing inequality across the care continuum.

SECTION 3 — SOCIETAL AND ECONOMIC COSTS OF AGEISM IN SERBIA

3.1 AGEISM AS AN ECONOMIC LIABILITY: HOW POLICY UNDERINVESTMENT GENERATES COSTS

Ageism embedded in public policies does not only produce inequality — it also generates *significant economic losses*. International evidence shows that structural ageism reduces productivity, increases healthcare expenditure and suppresses social participation. In Serbia, the absence of a coordinated LTC system, underfunded community services and insufficient financial protection expose older adults and their families to high costs that the state ultimately absorbs through emergency care, hospitalisation and premature institutionalisation.

Serbia's demographic profile intensifies these pressures: high shares of older persons, strong rural ageing and widespread poverty among older women create a context where ageist policy choices have **direct fiscal consequences**.

3.2 POVERTY IN OLDER AGE: A MAJOR SOCIAL AND ECONOMIC BURDEN

3.2.1 HIGH PREVALENCE OF INCOME POVERTY AMONG OLDER PERSONS

Older persons in Serbia face the highest poverty risk of any age group. According to national research, **23.5% of persons aged 65+** are at risk of poverty, with the risk reaching **34.2% among one-person 65+ households**, the most vulnerable household type in the country. Older women, due to unequal lifetime earnings and caregiving interruptions, face even higher rates: **25.3% live below the poverty threshold**.

Even average pensions often do not cover the minimal consumption basket, meaning that poverty is structurally built into the income protection system (8). This is an expression of **policy ageism**, where income in older age is not aligned with actual living costs or needs.

3.2.2 OOP SPENDING PUSHES OLDER PERSONS INTO DEEPER DEPRIVATION

The study *Siromaštvo u senci brige i nege* shows that **out-of-pocket (OOP) payments for medicines, assistive devices, transport and care** routinely push households into poverty or prevent them from escaping it. Many older persons ration medicines, delay treatment or forego assistive devices due to inability to pay, leading to preventable deterioration of health and higher future healthcare costs.

This cycle illustrates how *policy underinvestment today becomes a fiscal burden tomorrow*.

3.3 SPILLOVER COSTS: HOW POVERTY AMONG OLDER PERSONS AFFECTS ENTIRE HOUSEHOLDS

3.3.1 FAMILIES ABSORB THE FINANCIAL CONSEQUENCES OF MISSING SERVICES

Because LTC and community support services are scarce, families must cover:

- private home care,

- medicines and medical supplies,
- household adaptations,
- transport to health services,
- or the costs of private institutional care

For low-income families, these expenses are unsustainable. Research shows that households caring for older persons with dependency frequently **reduce consumption of essential goods**, **accumulate debt**, or **sell assets** to cover basic LTC needs. The economic burden thus extends well beyond older persons themselves, creating a **multi-generational poverty risk**.

3.3.2 HIDDEN COSTS: EMOTIONAL STRAIN, LABOUR LOSS AND FINANCIAL INSTABILITY

Spillover poverty also manifests in non-monetary ways:

- psychological stress from caregiving,
- reduced economic activity,
- inability to plan long-term household finances,
- withdrawal from social life.

These effects reinforce broader patterns of social exclusion documented among older persons and their families.

3.4 LABOUR-MARKET COSTS: GENDERED EXITS DRIVEN BY MISSING OR UNAFFORDABLE SERVICES

3.4.1 WOMEN'S LABOUR-MARKET EXITS AS A CONSEQUENCE OF POLICY AGEISM

Most unpaid caregivers in Serbia are **women aged 45–64**, often during their most productive working years. Because formal LTC services are limited, insufficient or unaffordable, women frequently must:

- reduce their working hours,
- decline promotions,
- shift to part-time or informal work,
- or exit the labour market entirely (8,10).

This creates a cascade of economic losses:

- reduced lifetime earnings,
- lower pension accumulation,
- future old-age poverty for today's middle-aged women,

- reduced tax contributions and labour-force participation.

The mental-health study on caregivers highlights high levels of emotional burden, anxiety and burnout among informal carers, confirming the **human and economic cost** of relying on unpaid care.

3.4.2 NATIONAL PRODUCTIVITY LOSSES

The absence of a functional LTC system converts a demographic reality into an economic challenge. Women leaving work due to caregiving contribute to:

- a shrinking labour supply,
- stagnation in rural and semi-rural economies,
- reduced competitiveness,
- slower GDP growth.

International literature shows that countries with developed LTC systems maintain higher labour-market participation among women and experience lower long-term social expenditures. Serbia's current model therefore undermines its long-term economic resilience.

3.5 INCREASED HEALTH AND SOCIAL-CARE EXPENDITURES FROM UNMET NEEDS

When community support systems are weak, older adults experience preventable health deterioration:

- untreated chronic diseases,
- increased risk of falls,
- mental-health decline,
- delayed rehabilitation,
- acute crises requiring emergency care.

Because institutional care is often the only accessible form of support, older persons enter residential facilities earlier and stay longer, even though **institutional care is significantly more expensive per capita** than home-based services. The LTC study notes that inefficient allocation of resources — reactive rather than preventive — is a major systemic weakness.

These patterns represent classic **cost-shifting mechanisms** produced by ageist policy design: savings in community services translate into higher institutional and hospital costs.

3.6 INTERGENERATIONAL AND SOCIETAL SPILLOVERS

Ageist policies create broader societal consequences:

3.6.1 EROSION OF INTERGENERATIONAL SOLIDARITY

Families under financial and emotional pressure may internalise negative stereotypes about older adults, strengthening societal ageism.

3.6.2 DEMOGRAPHIC CONSEQUENCES

The strain on mid-life women contributes to:

- lower fertility rates (due to combined eldercare and childcare demands),
- higher emigration of younger adults seeking more supportive welfare systems,
- faster demographic ageing.

3.6.3 REDUCED TRUST IN INSTITUTIONS

Older persons facing administrative discrimination, inaccessible services or high OOP costs often lose trust in public institutions, which further reduces help-seeking and increases long-term costs.

3.7 A SYSTEMIC LOSS: AGEISM UNDERMINES SERBIA'S SOCIAL AND ECONOMIC DEVELOPMENT

The cumulative effect of poverty, unpaid caregiving, limited services and weak protection mechanisms shows that **ageism is both a human rights problem and a macroeconomic problem**. By neglecting older persons' rights, Serbia incurs long-term costs that affect all generations.

Addressing policy ageism — through universal LTC development, stronger social protection, gender-responsive caregiver support and age-inclusive public services — is therefore essential not only for dignity and equality but also for **economic sustainability**.

SECTION 4 — COMMUNITY SUPPORT, CONTINUUM OF CARE AND FAMILY CAREGIVERS IN SERBIA

4.1 PREVENTION, EARLY SUPPORT AND THE FOUNDATIONS OF AGEING IN PLACE

A rights-based LTC system relies on accessible, preventive and community-based supports that maintain autonomy and delay or avoid dependency. In Serbia, however, prevention is **the weakest element** of the care continuum. Research shows that many older persons experience functional decline, chronic illness or sensory impairment without early intervention, assessment or community outreach.

Primary health care institutions rarely provide structured screening for early functional decline, frailty or social isolation, despite these indicators being strong predictors of later dependency. Community health nurses ("patronažne sestre") provide valuable outreach but their mandate is limited, staffing insufficient, and linkage with social services inconsistent.

Social participation opportunities—day clubs, volunteering programmes, intergenerational activities—exist in only part of the country. Older women living alone, persons in rural areas and

low-income households have significantly lower access. These services are often donor-funded rather than structurally embedded, which reinforces territorial inequality.

This underinvestment reflects implicit **policy ageism**: autonomy-supporting preventive services are not prioritised because older persons' rights to participation, community life and early support are undervalued.

4.2 HOME- AND COMMUNITY-BASED SERVICES: LIMITED, UNEQUAL AND UNDERFUNDED

4.2.1 HOME ASSISTANCE: WIDESPREAD NEED, LIMITED AVAILABILITY

The most common community service—home assistance—exists in only about half of municipalities and is often limited to *one or two visits per week* (8). These visits typically include household tasks rather than personal care, rehabilitation support or assistance with complex needs. For persons with moderate or high dependency, these services are insufficient to enable ageing in place.

4.2.2 DAY CENTRES AND RESPITE CARE: PRESENT IN POLICY, ABSENT IN REALITY

Although strategic documents mention day centres for older people, respite care and mobile support teams, actual implementation is sparse. The LTC study shows that **respite is almost non-existent**, despite being one of the most urgently needed services for family caregivers. Day centres operate in a limited number of municipalities and often serve primarily as socialisation hubs rather than support for persons with functional limitations.

This mismatch between policy and practice reflects an implementation gap rooted in ageism: rights are recognised in formal wording, but not operationalised where older persons actually live.

4.2.3 AFFORDABILITY BARRIERS

Even when services exist, cost is a major obstacle. Many older adults rely on low pensions that do not cover minimal consumption needs. Co-payments for home care, transport or private providers are often prohibitive. Households frequently purchase services informally, with no regulation or safety standards.

Unequal municipal capacity further amplifies disparities: wealthier cities offer more services, while rural municipalities offer none. Such postcode-based inequality constitutes **systemic discrimination**, where access to rights depends on geography.

4.3 EMERGENCY PREPAREDNESS AND ENVIRONMENTAL RISKS: OLDER PERSONS AS AN OVERLOOKED GROUP

Serbia increasingly faces heatwaves, floods and extreme weather events. Older persons—especially those living alone, with chronic illness or mobility limitations—are disproportionately affected. Yet most local emergency plans do not include age-specific measures such as proactive check-ins, targeted alerts, or transport to cooling centres.

Evidence from social inclusion studies shows that older adults often lack access to early warning systems, digital alerts or social networks that facilitate evacuation or assistance. Age-blind

emergency planning reflects a broader structural oversight: **older persons are not systematically recognised as a group requiring tailored protection**, despite clear risk factors.

4.4 FAMILY CAREGIVERS: THE INVISIBLE FOUNDATION OF THE CARE SYSTEM

4.4.1 CARE IS GENDERED AND STRUCTURALLY UNSUPPORTED

Serbia's LTC system relies heavily on **unpaid family caregiving**, with over 80% of care provided by relatives—predominantly women aged 45–64. These caregivers often juggle employment, childcare and intensive care responsibilities with little formal support.

The mental-health study of informal caregivers documents high levels of **stress, exhaustion and compassion fatigue**, especially among women who provide round-the-clock care without respite or financial support. Despite their central role, caregivers remain *unrecognised* in legislation and absent from major policy documents on social protection and health.

4.4.2 ABSENCE OF ENTITLEMENTS: A DEEP EXPRESSION OF POLICY AGEISM

Unlike many European countries, Serbia does not provide:

- caregiver allowances;
- pension credits for caregiving periods;
- legal status and rights for caregivers;
- systematic training;
- counselling or mental-health support;
- respite services.

This absence is not simply a resource constraint—it reflects **ageist and gendered assumptions** that care is a private family matter and that the labour of women has no fiscal or social value.

4.4.3 INTERSECTION WITH POVERTY AND EMPLOYMENT INEQUALITY

Unpaid care responsibilities directly reduce women's labour-market participation. Many reduce working hours, decline promotions, or leave employment. This accelerates lifetime earning gaps and increases women's poverty risk in older age, reproducing cycles of inequality across generations.

Without formal recognition or support, caregiving becomes both a **personal burden** and a **structural barrier** to gender equality and economic development.

4.5 INSTITUTIONAL CARE: NECESSARY BUT OVERUSED DUE TO WEAK COMMUNITY SERVICES

Institutional care remains the de facto option for many older adults with high dependency, not because it is preferred but because community-based services are inadequate. Public

institutions have waiting lists, while private homes require monthly payments far exceeding most pensions.

Premature institutionalisation occurs when early rehabilitation, home nursing or daily support could have prevented decline (8). This pattern is both more expensive for the state and less aligned with human rights principles emphasising autonomy, participation and ageing in place.

4.6 GOVERNANCE AND CONTINUUM OF CARE: FRAGMENTATION AS A STRUCTURAL BARRIER

A functional continuum of care requires coordination across sectors, levels of government and providers. In Serbia, the LTC study identifies fragmentation as one of the system's defining features:

- weak coordination between health and social care;
- inconsistent responsibilities between national and local levels;
- variable municipal capacity;
- lack of integrated assessment and case management;
- absence of common standards and monitoring.

Older persons and families often navigate complex, inconsistent pathways, moving between primary health care, centres for social work, and municipal services with no single point of coordination. This institutional fragmentation disproportionately harms those with low education, low income or limited mobility—groups already at higher risk of exclusion.

4.7 WHY STRENGTHENING COMMUNITY SUPPORT MATTERS: ECONOMIC, SOCIAL AND HUMAN RIGHTS IMPERATIVES

A strong community-based system delivers benefits across multiple domains:

- improved quality of life and autonomy for older persons;
- reduced risk of poverty and catastrophic expenditures;
- prevention of early institutionalisation;
- higher labour-market participation for women;
- improved social cohesion and intergenerational solidarity;
- lower long-term health and social costs.

International and Serbian evidence shows that **every dinar invested in community-based LTC yields multiple returns**—economic, social and rights-based. By contrast, underinvestment in preventive and community supports reinforces ageism and undermines system sustainability.

Strengthening community support is therefore not an optional reform—it is **central to fulfilling Serbia's human rights obligations and ensuring equitable development**.

SECTION 5 — POLICY IMPLICATIONS AND ADVOCACY RECOMMENDATIONS

Ageism embedded in Serbia's public policies—through underinvestment, fragmentation, weak implementation, gendered reliance on unpaid care and territorial inequality—creates preventable hardship for older persons and their families. Evidence presented in this report shows that disadvantages in older age are rarely the result of individual choice; rather, they reflect cumulative inequalities across the life course, particularly in relation to caregiving, informal employment, health trajectories and access to services.

The recommendations below translate these findings into **realistic, actionable policy priorities** that strengthen existing systems, mitigate predictable risks and improve protection in later life, without reopening core pension parameters or creating parallel institutional frameworks.

RECOMMENDATIONS

Work on the play opened space for recognizing, through the lived experiences of older persons, patterns of systemic inequality and ageism that are deeply embedded in public policies in Serbia. The challenges older persons face do not arise from individual choices, but from cumulative inequalities across the life course, particularly in relation to unpaid caregiving, unstable employment status, health risks, gender roles, unequal access to services, and negative perceptions of ageing and old age.

These recommendations represent realistic and applicable measures that strengthen existing systems of protection and support, in line with the principles of non-discrimination, gender equality, and dignity in older age.

A. RECOMMENDATIONS RELATED TO ACCESS TO SERVICES, PROTECTION, AND SUPPORT

STRENGTHENING THE ROLE OF THE HEALTH SYSTEM AS AN ENTRY POINT TO LONG-TERM CARE

The experiences presented in the play show that the health system is too often activated only in crisis situations, and even then older persons remain on the margins. Health services, including emergency care, should be linked with the long-term care system so that repeated interventions and hospitalizations automatically trigger a needs assessment and referral to appropriate support. Emergency medical services must be equal for all, regardless of age. The Law on Emergency Care should ensure that patient triage is based on medical doctrine rather than simple waiting order.

Equal and continuous access to healthcare must be ensured without discrimination on the basis of age.

CONTINUOUS AND AGE-RESPONSIVE INSTITUTIONAL SUPPORT IN CASES OF VIOLENCE

The play clearly demonstrated how complex, discouraging, and often retraumatizing the reporting procedures for violence against older persons can be. Support must not stop at the moment of reporting, but should encompass the entire process — from reporting to monitoring the outcome.

Particular attention should be given to older women, recognizing fear, dependency, and health limitations. Violence against older persons must be treated as a public issue of rights protection, not as a "family matter." The tolerance of violence in the private sphere must be clearly rejected.

Research in Serbia shows that older persons often withdraw from reporting violence due to complex procedures, fear of losing support, and lack of trust in institutions. The play further illuminated how violence is often relativized, especially when it occurs within the family.

Preventive measures:
- Simplify and interconnect procedures between healthcare, social protection, and police
- Develop services for older women victims of violence, including safe houses and SOS helplines
- Organize training and information sessions enabling older women to recognize violence and understand reporting mechanisms
- Introduce age-responsive support throughout the entire process
- Recognize violence against older persons as an issue of public safety and human rights, not private relations

COMBATING AGEISM IN HEALTH AND SOCIAL CARE PRACTICE THROUGH TRAINING AND ACCOUNTABILITY

Numerous studies confirm that ageism in healthcare leads to delayed diagnoses, denial of treatment, and poorer communication with older patients. The play showed how older persons often feel "invisible" within the system.

Health and social care professionals should undergo continuous, practice-oriented training that includes recognizing ageism and gender bias in everyday practice. This implies better communication with older persons, understanding their needs, and ensuring appropriate referrals within existing systems.

Preventive measures:
- Mandatory training on ageism and multiple discrimination
- Integration of non-discrimination standards into institutional performance evaluation
- Strengthening communication skills and participation of older persons in decision-making

SUPPORTING FAMILY CAREGIVERS AS A MEASURE FOR PREVENTING VIOLENCE

Research shows that caregiver overload increases the risk of unintentional neglect and violence. The play clearly highlighted the gender dimension of this invisible role.

Preventive measures:
- Respite services and psychosocial support

• Education on health and communication
• Reliable emergency support mechanisms

IMPROVED LOCAL COORDINATION OF PREVENTIVE, EMERGENCY, AND LONG-TERM SERVICES

Local coordination mechanisms should be strengthened — through joint protocols, regular meetings, and information exchange — in order to ensure that risks in older age are identified in a timely manner.

B. RECOMMENDATIONS RELATED TO FINANCIAL SECURITY IN OLDER AGE

MITIGATING THE RISK OF POVERTY THROUGH LIFE-COURSE SENSITIVE MEASURES

Poverty in older age is not an exception, but a predictable outcome of long-term inequalities, particularly affecting women. Instead of altering core pension rules, targeted supplements and relief measures should be introduced to mitigate living and healthcare costs. Research confirms a strong link between poverty, poor health, and exposure to violence in older age, especially among women.

Preventive measures:
• Targeted supplements and subsidies for health and long-term care services
• Reduction of co-payments and hidden costs
• Comprehensive assessment of poverty risks when drafting the new Pension and Disability Insurance Law

These measures should be aligned with the principle of substantive equality.

INTRODUCTION OF A NON-CONTRIBUTORY OLD-AGE BENEFIT FOR PERSONS WITHOUT PENSIONS

A significant number of older persons, particularly women from rural areas and former informal workers, are not entitled to a pension. The introduction of a non-contributory old-age benefit would provide minimum security and reduce extreme poverty. Exclusion from the pension system is not an individual failure, but the result of structural inequalities.

Preventive measure:
The introduction of a minimum income in old age reduces dependency, health risks, and exposure to violence.

REDUCING GENDER GAPS IN INCOME IN OLDER AGE

Gender inequalities in older age require compensatory and preventive measures that recognize the consequences of unpaid work and career interruptions. Special support is needed for older women who live alone or without family networks. Older women are disproportionately affected by poverty, poorer health, and violence.

Preventive measures:
• Targeted support for women living alone
• Integration of economic, health, and protection policies
• Strengthening autonomy and access to information

CAMPAIGNS AND CHANGING THE NARRATIVE AND IMAGE OF OLDER PERSONS

Preventive measures:
• Advocacy for including content on ageing and healthy ageing within civic education curricula
• Media campaigns portraying older persons as active contributors to family, community, and society
• Creating opportunities for older men and women to remain active in community and social life
• Promoting intergenerational encounters

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PART V – AUDIENCE SURVEY FINDINGS

5. PERCEPTIONS OF AGEISM: FINDINGS FROM THE WHO AGEISM QUESTIONNAIRE

5.1 SURVEY METHODOLOGY

As part of the *Age Against the Machine* project, a survey based on the World Health Organization (WHO) framework on ageism was conducted among audiences attending theatre performances. The purpose of the survey was to explore how exposure to socially engaged theatre addressing issues of ageing and age discrimination may influence perceptions of older persons.

The survey combined two complementary instruments:

- a **short questionnaire administered before and immediately after performances**, designed to capture short-term shifts in attitudes among audience members;
- a **longer questionnaire administered once**, aimed at exploring deeper perceptions and beliefs related to ageing, intergenerational relations, and age-based stereotypes.

The questionnaire design followed the conceptual framework presented in the **WHO Global Report on Ageism**, which conceptualizes ageism as consisting of three interconnected components:

- **stereotypes** (cognitive beliefs about people based on age),
- **prejudice** (emotional responses toward people based on age),
- **discrimination** (actions or institutional practices that disadvantage individuals because of their age).

This framework guided both the selection of questions and the interpretation of findings.

Participation in the survey was **voluntary and anonymous**, and respondents completed questionnaires during theatre events organized within the project.

Because questionnaires were completed anonymously, it was not possible to match individual responses before and after the performance. Consequently, the results should be interpreted as **patterns observed at the audience level**, rather than precise measurements of individual attitude change.

5.2 PROFILE OF RESPONDENTS (THEATRE AUDIENCES)

The respondents consisted of audience members attending theatre performances organised within the *Age Against the Machine* project.

As the survey was conducted in a public cultural setting, the sample represents a **heterogeneous audience group** including individuals of different ages, professional backgrounds, and levels of prior engagement with issues related to ageing.

Participation varied across performances and locations, reflecting the natural composition of theatre audiences rather than a controlled research sample.

For this reason, the survey results should be interpreted as **exploratory insights into audience perceptions**, rather than representative estimates of the wider population.

5.3 KEY FINDINGS

PERCEPTIONS OF OLDER PERSONS

Results from the pre- and post-performance questionnaires indicate that exposure to the performances was associated with **a decrease in explicit negative perceptions of older persons**.

For example, agreement with the statement that **older people represent a burden to society** declined from **38% before the performances to 22% afterwards**. Similarly, agreement with the statement that **older people are unable to adapt to social change** declined from **55% to 39%**.

These findings suggest that theatre performances addressing themes of ageing and discrimination may encourage audiences to question some of the most explicit age-based stereotypes.

STEREOTYPES ABOUT AGEING

While explicit negative stereotypes declined in the short questionnaire, results from the extended questionnaire indicate that **broader cultural stereotypes about ageing remain relatively persistent**.

For example, a significant proportion of respondents agreed with statements suggesting that older persons are **stubborn** or that they **have difficulty understanding contemporary society**, with agreement levels of approximately **55% and 51% respectively**.

These perceptions appear to reflect **widely shared cultural narratives about ageing**, which tend to be more resistant to short-term change.

PERCEIVED DISCRIMINATION

The survey also explored perceptions of discrimination and autonomy of older persons.

Results suggest the presence of **paternalistic attitudes**, where older persons are perceived as needing protection or guidance in decision-making. For instance, **44% of respondents agreed that older people should be told what is best for them**, while **52% agreed that older persons should be spared difficult decisions**.

Although often expressed as concern or care, such attitudes may also limit perceptions of older persons as autonomous actors capable of making their own decisions.

INTERGENERATIONAL ATTITUDES

The survey findings also indicate changes in attitudes related to **intergenerational relations and emotional distance between age groups**.

For example, respondents reporting **discomfort in contact with older persons** decreased from **29% before the performances to 17% afterwards**. Similarly, the share of respondents expressing **fear of their own ageing** declined from **61% to 45%**.

These findings suggest that theatre performances addressing ageing may help reduce emotional distance between generations and encourage reflection on personal perceptions of ageing.

At the same time, attitudes related to **public roles and authority of older persons** appeared to change less significantly. For example, agreement with the statement that **older people should withdraw from public life** declined from **47% to 31%**, while agreement with the statement that **politics is not for older people** declined from **18% to 10%**.

These results indicate that while emotional perceptions may shift relatively quickly, attitudes related to social roles and power structures may be more resistant to short-term change.

5.4 DIFFERENCES ACROSS COUNTRIES

As the survey was conducted in several countries participating in the *Age Against the Machine* project, some variation in responses was observed across locations.

However, due to differences in audience sizes and response rates, the survey was not designed to provide statistically comparable national samples. For this reason, country-level findings should be interpreted cautiously.

Despite these limitations, a broadly consistent pattern emerged across locations:

- exposure to theatre performances was associated with **reduced endorsement of explicit age-based stereotypes**,
- respondents reported **greater openness toward intergenerational interaction**, and
- **paternalistic attitudes toward older persons remained relatively common**.

These similarities suggest that the themes explored in the performances resonate with audiences across different cultural contexts and may contribute to broader reflection on ageing and ageism.

5.5 INTERPRETATION AND IMPLICATIONS FOR ADVOCACY

The findings from the audience survey provide insight into how socially engaged theatre can contribute to reflection on ageing and ageism. While the survey was exploratory in nature and conducted in a natural audience setting, the results suggest that theatre performances addressing themes of ageing and discrimination can influence how audiences perceive older persons and intergenerational relations.

The results of the short questionnaire indicate that exposure to the performances was associated with a reduction in explicit negative stereotypes about older persons and a decrease in social distance between age groups. Audience members reported lower levels of agreement with statements portraying older persons as a burden to society or incapable of adapting to social change. In addition, respondents reported lower levels of discomfort when imagining interaction with older people. These patterns suggest that theatre can serve as a meaningful space for audiences to reflect on commonly held assumptions about ageing.

At the same time, the extended questionnaire highlights the persistence of broader cultural perceptions about ageing. Attitudes related to the social roles and authority of older persons showed smaller changes, and paternalistic views about older persons remained relatively common. This distinction between shifts in emotional perceptions and the persistence of structural attitudes is consistent with the conceptual framework presented in the *WHO Global Report on Ageism*, which emphasises that ageism operates simultaneously through stereotypes, prejudice, and discrimination embedded within broader social and institutional contexts.

From an advocacy perspective, these findings suggest that socially engaged theatre can function as an important catalyst for dialogue about ageing and age discrimination. By presenting personal narratives, lived experiences, and alternative representations of later life, theatre performances can challenge stereotypes and create opportunities for audiences to reconsider their perceptions of older persons. Research on theatre-based interventions has shown that participatory arts and drama activities can foster empathy, strengthen intergenerational understanding, and contribute to social inclusion of older people. In this sense, theatre can help open public conversations about ageing and encourage more nuanced understandings of later life.

At the same time, the findings also underline the importance of linking cultural and artistic initiatives with broader structural efforts to address ageism. While theatre may stimulate reflection and challenge stereotypes, sustainable change in perceptions of ageing also depends on supportive public policies that promote the participation, autonomy, and rights of older persons in social, economic, and civic life. Cultural initiatives such as socially engaged theatre can therefore play a complementary role within wider strategies aimed at combating ageism and promoting inclusive societies for all ages.

Taken together, the results of the survey suggest that theatre can be an effective tool for awareness-raising and public engagement on issues related to ageing. By creating spaces for dialogue and reflection, theatre can contribute to challenging stereotypes and encouraging more inclusive perspectives on ageing, while broader societal and policy frameworks remain essential for achieving long-term change.

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6. RECOMMENDATIONS BASED ON THE SURVEY

6.1 USING THEATRE TO CHALLENGE AGEISM

The findings of the audience survey conducted within the *Age Against the Machine* project provide insight into how artistic and cultural interventions can contribute to challenging ageism and encouraging reflection on ageing. While the survey results should be interpreted cautiously due to the exploratory nature of the study, they suggest that theatre can play a meaningful role in shaping how audiences perceive older persons and intergenerational relations.

Rather than replacing policy or structural interventions, theatre can complement them by opening spaces for dialogue, empathy, and critical reflection. The following sections outline key insights from the project regarding the role of theatre in addressing ageism and suggest directions for future initiatives.

6.2 HOW THEATRE INFLUENCES PERCEPTIONS OF AGEING

The audience survey suggests that theatre performances addressing themes of ageing and discrimination can encourage audiences to reconsider commonly held assumptions about older persons.

In particular, the comparison of responses before and after the performances indicates that exposure to theatre narratives may reduce agreement with explicit age-based stereotypes and decrease emotional distance toward older persons. These findings suggest that theatre can create opportunities for audiences to reflect on their perceptions of ageing and question simplified or negative portrayals of later life.

Unlike traditional awareness campaigns based primarily on information and statistics, theatre engages audiences through storytelling, personal narratives, and emotional experience. By presenting ageing through lived experiences rather than abstract descriptions, theatre can help audiences connect with the realities of ageing in a more immediate and personal way.

This experiential dimension appears to be particularly relevant for challenging stereotypes and encouraging reflection about intergenerational relations.

6.3 CULTURAL APPROACHES TO COMBATING AGEISM

Ageism is not only expressed through individual attitudes but is also embedded in cultural representations of ageing. Cultural narratives about ageing often portray older persons primarily

through lenses of decline, dependency, or vulnerability. These narratives can influence how societies perceive older people and shape expectations about their social roles.

Cultural initiatives, including theatre, film, literature, and other artistic practices, can play an important role in expanding these representations. By presenting diverse stories about ageing, cultural initiatives can highlight the complexity of later life and challenge one-dimensional portrayals of older persons.

Theatre is particularly well suited for this role because it creates a shared public space in which audiences collectively engage with social issues. As a collaborative art form that combines storytelling, dialogue, and performance, theatre can contribute to public conversations about ageing, intergenerational relations, and social inclusion.

The survey findings from this project suggest that such cultural engagement may help audiences reconsider stereotypes and develop greater empathy toward older persons.

6.4 USING PARTICIPATORY THEATRE IN ADVOCACY AND EDUCATION

Participatory theatre approaches offer particular potential for addressing ageism. Unlike traditional performances where audiences remain passive observers, participatory theatre encourages active engagement from participants and audiences alike.

In participatory theatre processes, older persons themselves can contribute to the creation of narratives and performances. This approach allows their experiences, perspectives, and voices to become visible in public discourse. In doing so, participatory theatre can challenge stereotypes not only through representation but also through the active involvement of older persons as co-creators of cultural content.

Participatory theatre can also be used in educational and community contexts. Schools, universities, community centres, and cultural institutions can use theatre-based methods to facilitate discussions about ageing, stereotypes, and intergenerational relationships.

By combining storytelling, reflection, and dialogue, theatre-based methods can help participants explore complex social issues in ways that traditional educational approaches may not easily achieve.

6.5 RECOMMENDATIONS FOR POLICYMAKERS, CULTURAL INSTITUTIONS AND CIVIL SOCIETY

Based on the findings of the audience survey and the experiences of the *Age Against the Machine* project, several recommendations can be identified for strengthening the role of theatre and cultural initiatives in addressing ageism.

FOR POLICYMAKERS

Public policies addressing ageing should recognise the role of cultural participation in promoting inclusive and age-friendly societies. Supporting cultural initiatives that explore themes of ageing can contribute to public awareness and help challenge stereotypes about older persons.

FOR CULTURAL INSTITUTIONS

Theatres, cultural centres, and festivals can play an important role by incorporating themes related to ageing and intergenerational relations into their programming. Partnerships with organisations working with older persons can also help ensure that cultural narratives about ageing reflect diverse experiences.

FOR CIVIL SOCIETY ORGANISATIONS

Civil society organisations working in the fields of ageing, human rights, and social inclusion can collaborate with artists and cultural practitioners to develop theatre-based initiatives that address ageism. Such collaborations can help connect cultural expression with advocacy efforts and community engagement.

FOR EDUCATION AND COMMUNITY PROGRAMMES

Theatre-based approaches can also be used in educational settings to encourage reflection on ageing and intergenerational relations. Schools, universities, and community organisations may benefit from incorporating creative and participatory methods into discussions about ageing and social inclusion.

7. CONCLUSION

The *Age Against the Machine* project explored how theatre can contribute to raising awareness about ageism and encouraging reflection on ageing in contemporary societies.

The audience survey suggests that exposure to theatre performances addressing ageing can influence how audiences perceive older persons. In particular, the findings indicate that theatre can help challenge explicit stereotypes and reduce emotional distance between generations, while deeper cultural perceptions about ageing remain more resistant to short-term change.

Beyond the survey results, the project highlights the broader value of cultural participation in addressing social issues. Theatre creates spaces where personal experiences, emotions, and social realities intersect. Through storytelling and performance, it allows audiences to encounter ageing not as an abstract demographic trend but as a lived human experience.

In this sense, theatre reveals dimensions of ageing that statistics alone cannot capture. While demographic data and policy analyses provide essential insights into ageing societies, artistic and cultural expressions help illuminate the everyday realities, relationships, and identities that shape how ageing is experienced and understood.

By encouraging dialogue, empathy, and reflection, theatre can contribute to more inclusive conversations about ageing and intergenerational relations. Cultural participation therefore represents an important component of democratic societies, where diverse voices and experiences can be shared, recognised, and valued.

ANNEX 1

WHO AGEISM SCALE – SHORT VERSION (5-ITEM)

INTRODUCTORY STATEMENT

The following statements are designed to measure your experiences with different age groups. Use the response options below to indicate how much you agree with each statement. When answering, think about whether the statement applies in relation to the **past 12 months**.

RESPONSE OPTIONS

Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
Don't know / Not applicable

STATEMENTS

1. Due to my age, I limit my participation in discussions even when they are about things that affect me.
2. Others think that I have nothing valuable to contribute to society because of my age.
3. Others feel frustrated with me due to my age.
4. Others make decisions for me because of my age.
5. Policies made by the government (e.g., on housing, social security, healthcare) do not meet the needs of people my age.

ANNEX 2

WHO AGEISM SCALE – FULL VERSION (15-ITEM)

INTRODUCTORY STATEMENT

The following statements are designed to measure your experiences with different age groups. Use the response options below to indicate how much you agree with each statement. When answering, think about whether the statement applies in relation to the **past 12 months**.

RESPONSE OPTIONS

Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
Don't know / Not applicable

STATEMENTS

1. At my age, my life has plenty of purpose.
2. I am a burden because of my age.
3. I am embarrassed of my age.
4. Due to my age, I limit my participation in discussions even when they are about things that affect me.
5. There are things I would like to do if I did not consider them inappropriate for my age group.
6. Others think that I have nothing valuable to contribute to society because of my age.
7. Others think that at my age I am able to make decisions for myself.
8. Others feel frustrated with me due to my age.
9. Other people feel uncomfortable around me because of my age.
10. Due to my age, other people talk to me as if I need things simplified.
11. Others make decisions for me because of my age.
12. Due to my age, others make me feel excluded.
13. Policies made by the government (e.g., on housing, social security, healthcare) do not meet the needs of people my age.
14. People my age are portrayed positively in the media.
15. I have been turned down for an opportunity (e.g., a job or volunteering opportunity) that I was qualified for because of my age.

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