Australian Human Rights Commission

# The age barrier: Older adults' experiences of ageism in health care

November 2025

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**Acknowledgements**

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**Note on terminology**

The Commission recognises that labels or terminology can be both empowering and limiting for individuals and communities.

The terms First Nations, Indigenous, and Aboriginal and Torres Strait Islander peoples are used interchangeably in this report. The Commission acknowledges that definitions of these terms vary and that community members may not identify with these terms.

The acronym LGBT+ is used in the report to refer to individuals who identify as lesbian, gay, bisexual, transgender, and other sexuality (including asexual), gender, and bodily diverse people. The Commission acknowledges that identities are deeply personal, and people express their sexual orientation and gender identity in many different ways. The Commission recognises that terminology is constantly evolving and supports the right of people to identify their sexual orientation and gender identity as they choose.



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- Fairer laws, policies and practices: We review existing and proposed laws, policies and practices and provide expert advice on how they can better protect people's human rights. We help organisations to protect human rights in their work. We publish reports on human rights problems and how to fix them.
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# Contents

# Commissioner's foreword

**Australia is a nation that prides itself on fairness, dignity, and respect for all. Yet, for many older people, these values are not always reflected in their everyday experiences.**

This report, *The age barrier: Older adults' experiences of ageism in health care*, is not just a research project – it is a mirror held up to Australian society, reflecting the voices of older people who have too often felt unseen, unheard, or undervalued. It is also a call to action: to listen more closely, to challenge assumptions, and to work towards systems that treat every person as an individual, not a stereotype.

As Australia's Age Discrimination Commissioner, I have heard countless stories from older adults about the subtle and not-so-subtle ways ageism affects their interactions – whether in workplaces, when accessing services, or participating in community life. These are not isolated incidents. They reflect a broader pattern of age-based assumptions embedded in our systems, institutions, and even in our own thinking.

Addressing ageism in Australian society is a key priority for me as Age Discrimination Commissioner, focusing on areas where its impacts are especially harmful and far-reaching, such as in employment, the media and health care. The *Changing Perceptions: How Australian Media Reports on Ageing* report, released in 2024, found that media representations of ageing and older people often reinforce negative stereotypes, with structural factors within the media industry contributing to these portrayals.

The present report turns attention to health care – an area where older adults are among the most frequent users of services. It draws on qualitative insights from focus groups and interviews with older adults, their families, and advocates, supported by a desk review of Australian and international research. It does not seek to assign blame, but to illuminate the voices and lived experiences of older adults. It invites us to listen and reflect on how our systems can better uphold the principles of equity and respect. While recognising the pressures faced by health professionals and the complexity of delivering care in a system under strain, it reminds us that respect, empathy, and inclusion are not aspirations – they are essential to good, equitable care.

The insights in this report reveal that older adults perceive ageism across multiple levels of the healthcare system – through interactions shaped by assumptions about age, dismissal of their health concerns, exclusion from discussions about their own care, and policies and practices that create barriers to accessing services. These experiences can undermine older adults' wellbeing, autonomy, and in some cases, their willingness to engage with health services. Yet, they also offer practical insights into how health services can become more inclusive, respectful, and equitable.

**Ageism is a real and often overlooked barrier to ageing with dignity, respect, and fairness. It is something that will affect all of us eventually, if we live long enough. I hope this report prompts reflection, conversation, and most importantly, action – towards a health system where age is never a barrier to being heard, respected, and receiving quality care.**

**Robert Fitzgerald AM**
Age Discrimination Commissioner

# Executive summary

Australia's population is getting older, with more than one in 6 people now aged 65 years and over.[1] This trend is projected to continue, and by 2064–65, nearly one in 4 people will be aged 65 and over.[2]

Despite this demographic shift, ageism remains widespread and largely unchallenged in society. Ageism is prevalent in Australian society. It is common in our workplaces, care systems, housing markets, and financial services.

Older adults continue to face negative stereotypes, such as assumptions of cognitive decline, frailty, ill health, and dependency. Exposure to ageist attitudes can also lead to individuals internalising these beliefs, affecting how older adults perceive themselves and influencing their behaviour.[3] Ageism has serious implications for older adults' health and wellbeing. Research consistently links it to poorer physical and mental health, reduced quality of life, and even shorter lifespans.[4]

Put simply, ageism is the enemy of positive and healthy ageing.

Older adults are among the highest users of the healthcare system and are therefore particularly affected by ageism in these settings. Existing research indicates that ageism in health services can shape clinical interactions – for example, through inappropriate language or the delegitimisation of older people's needs by health professionals – and may lead to inadequate diagnostic investigation, restricted access to treatments, and reduced overall quality of care.[5]

This report draws on qualitative insights from older adults, their families, and advocates to highlight lived experiences of perceived ageism in healthcare settings, supported by a desk review of existing research. It also presents strategies identified by older adults and advocates to address ageism and promote more inclusive care – offering practical insights to complement empirical research in shaping age-inclusive policies and interventions.

Research into ageism in Australian health care remains limited, with insufficient evidence on its prevalence, extent, and manifestations. Additionally, few studies have directly explored older adults' experiences and perceptions of ageism within the health system. This research contributes to the current evidence base by capturing older adults' lived experiences of perceived ageism in healthcare settings, and by providing insights grounded in real-world experience to inform more inclusive and respectful health policy and practice.

### Data sources

The findings presented in this report are based on data collected through:

- Desktop research
  - Australian and international research
- Qualitative research
  - 7 x focus groups with older adults
  - 8 x individual interviews with older adults
  - 2 x focus groups with adult children who support their parents in accessing healthcare services.
  - For the purposes of this research, 'older adults' were defined as individuals aged 65 years and over. For Aboriginal and Torres Strait Islander peoples, individuals aged 60 years and over were included.
  - In total, 45 older adults and 9 adult children participated in the research.

Additionally, interviews were conducted with representatives from 8 stakeholder organisations.

## KEY FINDINGS

Older adults perceive ageism across multiple levels of the healthcare system, from interpersonal interactions with health professionals to broader health system and policy contexts.

### 1. Age-based assumptions in healthcare interactions.

Older adults described interactions with health professionals influenced by age-based assumptions about their physical and cognitive abilities. These often led to communication that felt disrespectful or disempowering, including being spoken to in simplified or condescending language, encountering insensitive remarks about their age, having their concerns dismissed, and being excluded from discussions and decisions about their own care.

### 2. Perceived invisibility of older adults in healthcare settings.

Older adults reported feeling overlooked or treated as though they were absent, including being referred to in the third person or reduced to a chronological age rather than recognised as individuals. While invisibility was acknowledged as a broader societal issue for older adults, it was seen as particularly pronounced in busy healthcare environments.

### 3. Dismissal or attribution of health concerns to age.

A common theme among older participants was that their symptoms and health concerns were often attributed to older age, without adequate explanation. These experiences raised concerns about missed diagnoses and delayed treatment and reduced older adults' confidence in the care they received.

### 4. Limited participation in decisions regarding their own care.

Older adults described being left out of discussions about their own care, with health professionals often directing communication to accompanying family members. Exclusion also occurred via inadequate provision of information, undermining older people's autonomy and the ability to provide informed consent.

### 5. Perceptions of age influencing clinical decisions.

Older adults shared experiences in which their age was explicitly cited as a reason for being denied access to care, as well as instances where they felt age implicitly shaped clinical decisions. While treatment decisions may be influenced by factors such as treatment intent, expected outcomes, comorbidities, clinical risks, and provider or contextual considerations, inadequate communication of these reasons may reinforce perceptions of differential treatment based on age. There is growing concern that age-based responses could be used to ration or manage workload pressures in clinical and acute settings.[6]

## 6. Structural barriers reinforcing perceptions of ageism.

System- and policy-level factors, such as age-based eligibility criteria for services, contributed to feelings of being devalued. Operational pressures, such as time constraints and workforce shortages, were also seen as unintentionally reinforcing age-based categorisation by health professionals.

## 7. Perceptions of ageism compounded by intersectional disadvantage.

Intersectional experiences of ageism revealed that participants were often unable to disentangle age-related bias from other forms of discrimination linked to their identity. These overlapping factors influenced clinical interactions and intensified feelings of exclusion.

## 8. Impact on wellbeing and care engagement.

Perceived ageism in healthcare settings contributed to emotional distress, a sense of disempowerment, and internalisation of negative beliefs. For some, it impacted on their willingness to engage with health services, increasing risks of discontinuity of care and potential gaps in treatment.

## 9. Importance of person-centred care in shaping positive experiences.

Older adults emphasised the importance of being treated with respect, having their c oncerns taken seriously, and being recognised as individuals rather than defined by age. Participants also called for workforce training to raise awareness of ageism and promote age-inclusive practice.

## What we heard:

They treat you as a number and as an old person. They would be talking to me in monosyllabic or, you know, two-syllable words, as though that's the level of your comprehension.

—Older adults

You are, to some degree, you are sort of invisible because you're aged.

I need to be acknowledged as a person, not as an older thing that is not worth anything [that you] put in the corner and let it die.

—Older adults

[The GP] says, 'Oh you're old, put up with it.'

—Older adult

I was right there in the room, but the doctor spoke directly to my daughter about me like I wasn't even present.

—Older adult

Assumptions are being made ... [because] you're female and you're older.

—Older woman

We do have a very big problem with our health system. I think it's more the system than the people.

I understand ... they're in a rush, they're not paid enough. But it doesn't make the patient feel good. It doesn't make the patient feel as though they've been heard.

—Older adults

Just because I'm that age, why should I put up with the pain? I've been told, 'You're just going to live with that.' [But] I still have life to live. I just had the feeling that I was too old to be bothered with.

—Older adults

Because you're not only old but also, you're a migrant ... It becomes extremely complicated.

—CALD older adult

It makes you feel you're a lesser person. I feel that everything is a battle. And when you're unwell, you can't fight those battles. It becomes so difficult.

I am actually fearful that one of these days I will choose not to call an ambulance because of my dread of that whole experience.

—Older adults

It's about valuing the older person. It's seeing them as a person, and not an age – it's just a stage of their life.

—Older adult

If it was done with empathy, I think that would improve things for us right away.

—Older adult

The number one thing is education. Don't look at the person as a number. Look at them as a person who can have a viable and very productive end of life.

—Adult child caregiver

## NEXT STEPS

### Collaborative approaches to address ageism:

Future initiatives should prioritise collaboration with health professionals, educators, researchers and sector leaders to critically examine the systemic, cultural and operational drivers that sustain ageist attitudes and practices in health care.

This includes:

- reviewing and strengthening clinical guidelines, standards, and codes of conduct to reduce age bias in practice
- improving the representation of older adults in clinical trials
- collaborating with academic institutions and professional bodies to enhance the integration of geriatric and gerontological content within health curricula and ensuring that education and training programs adequately prepare the workforce to deliver age-inclusive care.

Additionally, co-design approaches that bring together older adults and health professionals could help identify priority areas for action and support the development of age-inclusive models of care that are grounded in lived experience.

### Age-awareness training to prompt change:

Evidence suggests that brief, interactive age-awareness workshops can positively influence attitudes and promote respectful, inclusive care. Scaling such interventions across the health workforce could help challenge subtle biases and improve care quality for older adults.

### Strengthening the evidence base:

The findings of this research provide a foundation for further investigation into ageism in Australian health care. Despite growing recognition of its impacts, evidence remains limited regarding the prevalence and extent of ageism in healthcare settings, including its interactions with other intersectional forms of discrimination. Future research should also explore how ageism in health care affects younger people and its cumulative effects across the life course. Expanding the evidence base in these areas will support the development of more inclusive and equitable healthcare systems for all ages.

# 1. Introduction

## 1.1 About this research

The proportion of Australia's population aged 65 and over has grown steadily – from approximately 12% in 2000 to 16% in 2020 – and is projected to reach between 21% and 23% by 2066.[7] While life expectancy continues to rise, healthy life expectancy has not kept pace.[8] The majority of older adults in Australia have at least one chronic health condition and are among the highest users of healthcare services.[9]

Despite their frequent engagement with the health system, older adults perceive ageism by health professionals and within the health system. Ageism in health care can significantly impede older people's access to quality care, affecting the appropriateness of treatments and diagnoses they receive.[10] Age-based assumptions and stereotypes held by health professionals may result in dismissive or disrespectful interactions, minimisation of health concerns, and differential treatment.[11] Such experiences can also contribute to internalised ageism,[12] in which older adults adopt discriminatory attitudes towards themselves, potentially affecting their confidence in seeking care and expectations of treatment.

This research aimed to examine older adults' experiences and perceptions of ageism in the Australian healthcare system, drawing on insights from a desktop review and qualitative research involving older individuals, their families, and advocates.

The objectives of the research were to:

- examine contemporary research on the extent, nature, and impacts of ageist attitudes and practices in healthcare settings
- explore older adults' perceptions and experiences of ageism in Australian healthcare settings, and identify common themes and patterns in the expressions of ageism in practice
- contribute to broadening the knowledge base and provide evidence-based insights to inform future priorities and actions.

## 1.2 Research approach

This project involved a combination of desk-based literature review and qualitative research. The initial desk review informed and complemented the qualitative component by providing contextual background and identifying key areas for exploration, including existing gaps in knowledge.

### Desktop research

A narrative review was undertaken, focusing on contemporary Australian and international research on ageism towards older adults in healthcare settings. The review examined manifestations of ageism within healthcare contexts, its underlying drivers and impacts on older adults, as well as gaps in the existing evidence base. These insights provided essential context to guide the design and focus of the qualitative research.

### Qualitative research

The qualitative component explored older adults' experiences and perceptions of ageism within Australian healthcare settings. For the purposes of this research, 'older adults' were defined as individuals aged 65 years and over. For Aboriginal and Torres Strait Islander peoples, individuals aged 60 years and over were included.

Data collection occurred through focus groups and in-depth interviews with older adults, their families, and stakeholders from organisations representing the interests of older people, as well as those with expertise in ageing and health-related fields. These qualitative insights expanded on and contextualised the findings of the desktop review, providing a more detailed understanding of the ways in which ageism is experienced and perceived in practice.

In total, 54 individuals participated in the qualitative research, comprising 45 older adults and 9 adult children who support their parents in accessing healthcare services. In addition, interviews were conducted with representatives from 8 stakeholder organisations.

Further detail on the research methodology is provided in the Context section of this report.

# 2. Understanding Ageism in Health Care


## Summary

- Ageism refers to stereotypes, prejudice, and discrimination based on age, and can occur with or without conscious awareness.
- Ageism is widespread in society. It may be self-directed, expressed in interactions with others, or embedded within institutions.
- In healthcare settings, implicit biases among health professionals – such as perceiving older patients as cognitively impaired or their care as overly complex and time-consuming – may be reinforced by structural factors such as time pressures, workforce shortages, and limited geriatric training.


### What is ageism and how common is it?

Ageism is defined by the World Health Organization (WHO) as involving 'stereotypes (how we think), prejudice (how we feel), and discrimination (how we act)' towards people on the basis of their perceived chronological age.[13] It can be explicit or implicit – i.e. expressed with or without conscious awareness and intention – and operate on multiple, interconnected levels that are mutually reinforcing.[14] It can be directed towards oneself via internalised ageist stereotypes and norms,[15] or occur interpersonally among individuals and within social groups, such as workplaces.[16] At the institutional level, ageism can manifest through established laws, regulations, policies, norms, and practices that restrict opportunities and disadvantage individuals based on their age.[17]

Ageism is widespread both in Australia and across the globe. A 2021 national survey by the Australian Human Rights Commission (the Commission) found that 90% of adults agreed ageism exists in Australian society, 63% had personally experienced it, and 60% admitted to stereotyping or making assumptions about others based on age.[18] Globally, a survey of over 83,000 people in 57 countries found that at least one in two people held moderately or highly ageist attitudes.[19]

Ageism is also one of the most socially accepted forms of prejudice.[20] It is deeply ingrained and normalised in society – evident in everyday expressions such as 'having a senior moment', which equates ageing with cognitive decline, and media portrayals that reduce older adults to ageist stereotypes or frame ageing as something to be resisted or reversed.[21]

## 2.1 Ageism in the healthcare sector

### Health status and service use among older adults

As Australia's population ages, increasing numbers of older adults will come into contact with the healthcare system. This growing demand places added strain on services and raises concerns that ageism may also intensify,[22] making the health sector a critical setting for examining ageism.

While 3 in 4 adults aged 65 years and over in Australia report being in good health,[23] this age group also has the highest rates of chronic conditions and multimorbidity.[24] Approximately 67% of those aged 65–84 and 79% of those aged 85 and over live with two or more long-term health conditions, compared to 33% and 48% for those aged 25–44 and 45–64, respectively.[25] Chronic conditions commonly experienced by older adults include arthritis, cardiovascular disease, kidney disease, asthma, diabetes, and dementia.[26]

Older adults account for a significant proportion of healthcare system users in Australia and access healthcare services more frequently than younger people. In 2023–24, people aged 65 years and over made up about 17% of the population but accounted for 23% of emergency department presentations, with 52% of those subsequently admitted to hospital compared to 30% for all patients.[27] Medication use also increases steadily with age. In 2022, almost all (97.6%) individuals

aged 75 years and over were dispensed at least one Pharmaceutical Benefits Scheme (PBS) medication, compared to 72% of people aged 45–54 and about half of children aged 0–17 years (50.4%).[28]

Recent data from the Australian Bureau of Statistics (ABS) further highlights this trend. In 2023–2024, around 97% of adults aged 85 years and over visited a general practitioner (GP) at least once, compared to about 71% of those aged 15–24.[29] Older adults in this age group were also more likely than young people aged 15–24 to:

- consult a specialist (60.5% vs 27.4%)
- visit a hospital emergency department (29.2% vs 14.1%)
- be admitted to hospital (26.7% vs 7.2%).

### Prevalence of perceived ageism in health care

International research has documented perceived ageism towards older people in healthcare settings. For example, more than one-third (34%) of Canadian adults aged 66 years and over reported experiencing age-based discrimination by health professionals,[30] while 28% of adults aged 50 years and over in Israel perceived discrimination based on their age in the healthcare system.[31] Evidence from Poland indicates that 30% of adults aged 65 years and over felt discriminated against in a healthcare setting because of their age, while 47% of medical and nursing students reported witnessing age-based discrimination against older patients while undertaking clinical placements.[32]

In Australia, evidence on the prevalence of ageism in healthcare settings is limited, with existing studies providing mixed findings. A 2017 quantitative study analysing nationally representative data found that the majority of the Australian public (63%) did not perceive differences in treatment by health professionals based on age, though adults aged 50–64 were more likely to perceive negative attitudes towards older patients.[33]

More recently, a 2021 survey of 140 adults – most of whom were aged 55 years and over – conducted by Health Consumers NSW and the Older Women's Network found that almost half (49%) of the respondents felt they had been treated differently in a healthcare setting because of their age.[34]

While not designed to examine age-based differences in care, the latest ABS Patient Experiences Survey found that in 2023–24, people aged 85 years and over reported more positive interactions with health professionals than those aged 25–34 years.[35] This included being listened to carefully, treated with respect, and afforded sufficient time during consultations.

## 2.2 Drivers of ageism in health care

### Theoretical perspectives

Researchers have proposed a number of theories to explain the origin of ageism. Terror management theory asserts that older people serve as direct reminders of our inevitable mortality.[36] As a way of managing these death-related anxieties, individuals may distance themselves from older people and, through this process, come to perceive them in a diminished and unfavourable light.[37] In healthcare contexts, prolonged exposure to older patients – particularly those with complex health issues – may heighten health professionals' awareness of mortality and exacerbate their death anxiety, leading to biased perspectives and a desire to disassociate themselves from this population.[38]

Another theory that may be relevant to understanding ageism towards older adults in healthcare settings is the functional approach theory. This theory posits that stereotypes serve important cognitive functions (e.g. increasing efficiency through quick categorisation) and social functions (e.g. helping individuals to identify with a social in-group).[39] In clinical settings, categorisation can aid decision-making processes.[40] However, under time constraints and demanding circumstances, these categorisations can lead to subjective judgements about treatment futility – particularly for interventions perceived to have low success rates or limited impact on quality of life.[41]

## Health professionals' perceptions of ageing and older adults

According to the WHO, ageism is pervasive, deeply entrenched in society, and more socially accepted than other forms of bias.[42] While perceptions of ageing can be positive, neutral, or negative, the literature indicates that older people are more likely to be negatively stereotyped.[43] Common stereotypes about older people include that they are warm and likeable, but also frail, dependent on others, and have declining cognitive abilities.[44]

Health professionals, like the general population, hold both implicit and explicit biases about ageing and older age, underpinned by pervasive, negative stereotypes that are deeply ingrained in society. Regardless of intent, these biases can affect the quality and equity of care provided to older adults.

Within the health system, the lack of positive role models in geriatric care may also reinforce ageist attitudes among health professionals.[45] Clinical skills and approaches to patient care are often shaped by observing senior clinicians.[46] When those in leadership or teaching roles convey negative attitudes towards older patients, such views may be implicitly passed on to students, and become normalised within healthcare settings.[47]

## Systemic and structural factors

### Resource constraints

Systemic pressures within the healthcare system, such as constraints related to time, staffing levels, and access to appropriate equipment, can influence health professionals' perceptions of the care of older adults.[48]

Research indicates that medical students and junior doctors often view healthcare systems as being ill-equipped to meet the needs of older patients, particularly those with limited social and economic support.[49] In this context, older patients may be perceived as more difficult or less desirable to treat, especially when their care requires additional time, coordination, or resources.[50]

Workforce shortages, contributing to high patient-to-provider ratios, increase the risk of burnout and compassion fatigue among health professionals.[51] Under these pressures, health professionals may be more susceptible to implicit biases and stereotypes, which can influence clinical judgements about patients and their conditions.[52] Older patients, in particular, may be perceived as time- and resource-intensive, and having limited prospects for recovery.[53] Such perceptions may reinforce therapeutic nihilism – the belief that treatment is futile – and contribute to negative attitudes towards their care.[54]

## Gaps in geriatric training

Another structural factor that may be reinforcing age bias against older patients within the healthcare system is the limited nature and extent of geriatric training received by health professionals.[55] Across countries and health disciplines, geriatric content remains limited and inconsistently integrated into health curricula, despite older adults representing a significant and growing proportion of healthcare users.[56]

In Australia, while all undergraduate medical programs include general clinical rotations from at least second year, not all include mandatory, dedicated rotations in geriatric medicine, and the nature of this training varies significantly across institutions.[57] Similarly, while gerontological content is widely recognised as essential in nursing education,[58] studies have found that it often receives limited attention, with overcrowded curricula and a shortage of nursing academics with specialist gerontological expertise identified as key barriers.[59]

These limitations may contribute to negative perceptions and avoidance of geriatric care and older patients.[60] Experts have also observed that existing education pathways often fail to challenge ageist assumptions or promote geriatrics as a viable career.[61] The literature demonstrates a significant relationship between health professionals' knowledge of ageing and their attitudes towards older adults, suggesting that enhancing geriatric content in health education may play a key role in addressing ageist attitudes and improving the quality of care provided to older patients.[62]

## Emphasis on curative models of care

Contemporary medical training tends to emphasise intervention and curative treatment over managing chronic conditions.[63] This emphasis may influence health professionals to prefer working with patients whose conditions can be resolved effectively,[64] and bias them against older adults, who are more likely to experience multiple chronic illnesses requiring long-term management.[65]

Research indicates medical students and junior doctors often find it more rewarding to 'cure' than to 'care', and express frustration about working with older patients who typically present with multiple chronic conditions.[66] Some perceive working with older patients as primarily involving low-level medical maintenance, which is devalued and dismissed as 'social work' or 'nurse's work'.[67]

Nursing education reflects similar patterns. Research indicates that undergraduate nursing curricula remain focused on acute care, with limited emphasis on chronic disease management or ageing, contributing to career preferences among nursing students for highly technical, acute care environments such as emergency departments or intensive care units.[68]

# 3. Older Adults' Experiences in Health Care

## Key findings

- Older adults report experiencing ageism in various forms within the health system, including age-based assumptions by health professionals, attribution of their concerns to age, disrespectful communication, limited opportunities to meaningfully participate in decisions about their care, and clinical decisions that appear to be driven more by age than individual need.
- Intersectional experiences of ageism reveal compounded disadvantage, with participants often unable to disentangle age-related bias from other forms of discrimination linked to their identity.
- Ageism is also perceived by older adults and advocates to operate at the structural and policy level, including through upper age limits on government-funded services, the routine exclusion of older adults from medical research, and systemic barriers that restrict access to appropriate care.
- The findings indicate that older adults perceive ageism as occurring across multiple levels of the healthcare system, encompassing interpersonal interactions, institutional practices, and broader systemic and policy contexts.

This section draws on insights from qualitative research with older adults, highlighting their firsthand experiences of ageism in Australian healthcare settings. Perspectives from families of older people, stakeholder interviews, and desk research provide additional context and support for these insights.

Direct quotes from participants, obtained through focus groups and in-depth interviews, are included to illustrate the experiences of individuals in their own words. Quotes from older adult participants are attributed as 'Older adult'. Where relevant, additional group descriptors (eg, 'Older women') are used. Quotes from adult children who support their older parents in accessing healthcare services are attributed as either 'Adult child of CALD parent' or 'Adult child caregiver', depending on whether the parent is from a culturally and linguistically diverse (CALD) background. Quotes from representatives of organisations that support older people are attributed as 'Stakeholder'.

Pseudonyms are used for the case studies, except where individuals specifically requested that their real name be retained.

## 3.1 Age-based attitudes and stereotypes

Existing research on ageism among health professionals reveals complex and mixed attitudes towards older adults, ranging from clearly negative perceptions to more neutral and positive attitudes.[69] While some describe older adults as wise and interesting,[70] they are frequently perceived as difficult, time-consuming, cognitively impaired, and dependent.[71] Older adults are often regarded as presenting more complex and challenging cases, stemming from the assumption that they typically have multiple chronic conditions, with the involvement of families adding further complexity.[72]

Participants in the Commission's qualitative research shared experiences where they felt health professionals made generalised, age-based assumptions about older people's physical and cognitive capabilities. An older participant recalled recently encountering a seemingly well-intentioned remark that, while framed as a compliment, was underpinned by ageist assumptions.

> **The technician called my name when I went to have an X-ray. She looked along a line of people and I stood up … and she said, 'Oh, I was looking for a frail old lady, not someone who looks like they're in their 60s.' And I'm thinking, you shouldn't be saying that. Even though she probably meant it as a kind of compliment … You shouldn't be assuming that because people are a certain**

> **age, they're going to look a certain way and they're going to walk a certain way or behave [in] a certain way.**
>
> —Older adult

Another participant, who cares for her 96-year-old mother, reported that health professionals often seem unable to see beyond her mother's age, interacting with her primarily through the lens of age-based assumptions.

> **The clinician basically doesn't see anything else but [her] age. I feel that when you have a certain age group … the person is dismissed. I say to [health professionals], 'Yes, she's 96 years old but she's got a good quality of life – she crochets, we visit, she's capable of discussing with people …' And yet … it's like it's drummed into [some people] that once you reach [a certain] age … they're just waiting to die basically … They [health professionals] don't look at the person, but look at the age. The number is more important than the person.**
>
> —Adult child of CALD parent

Stakeholders emphasised that ageism among health professionals reflects and stems from broader societal ageism. Even narratives of successful ageing – developed to counter ageism and the dominant framing of ageing as a period of decline – can unintentionally increase pressure on older people by emphasising individual responsibility and lifestyle choices, potentially placing blame on those perceived to be ageing 'unsuccessfully'.[73]

> **We have a bit of a narrative in society about successful ageing, ageing healthy, ageing well, staying fit and young … [That narrative is] about remaining young rather than acceptance that older people still have inherent value, even if they're declining in various aspects of their physical and cognitive health.**
>
> —Stakeholder

## 3.2 Perceived invisibility

Experiences of ageism among older adults in the Commission's research often centred around a sense of invisibility, arising from interactions where they felt overlooked, passed over, or not afforded the same level of attentiveness or engagement as younger people around them. While this sense of invisibility was acknowledged as part of a broader societal issue, it was seen as particularly pronounced in busy healthcare settings. They were often unsure whether this was due to structural issues, such as insufficient resources and overcrowding, or due to their age. Some felt the need to speak up in order to be noticed and receive medical attention, though this carried the risk of being perceived as difficult and demanding.

> **You are, to some degree, you are sort of invisible because you're aged … Invisible in all sorts of situations, not just in the medical system. When you go to a shop, you seem to be invisible – all the sweet young things get served first.**
>
> **You're very uncertain, too. You don't know if you've got to do anything more, like if you're waiting to be called and everyone else gets called, [and] you're sitting there thinking, 'Have they forgotten me or is this just [something] that happens … with old people.'**
>
> **I think now I've sort of come around to thinking [that] I've got to try and speak out, because if I don't, I'll be left, you know, I'll miss out.**
>
> —Older adults

Older adults' experiences also included feeling overlooked in favour of younger patients – both in terms of clinical attention and interpersonal engagement. Participants noted that health professionals often seemed to prioritise younger individuals, engaging more readily with them in discussions and showing greater responsiveness to their needs. In contrast, older adults frequently felt sidelined, as though their presence and perspectives were less valued.

> **[A] podiatrist I go to … I don't know why, but I don't get engaged in friendly conversation like I know I've heard from other people who [go to] this podiatrist … They probably don't think that I'm of the age that they would be entertained or amused by what I've got to say … I know from other people who go to her … they talk a lot about football. And I happen to be a football lover … but we don't [engage] … I think it's because of my age … She probably thinks I probably don't go to the football … because I'm old and [a] fragile little man.**
>
> **I had my knee done, and I was in a private hospital … and the first weekend, they were so understaffed, and I was complaining of pain, and the nurse – to be fair, she was run off her feet – but she came along and said, 'Look, I'll just leave you some Panadol and a glass of water. Here, I've got more important patients to look after.' … A few days later, when I was up and walking down the corridor on crutches, [I saw that] there was one other person in sort of my age bracket, and most of the others were in their 30s and 40s. I try and think positively all the time, but I did take it that [the younger patients] were more important … It gives you a bit of a kick in the guts.**
>
> —Older adults

## Case study

### 'I don't know why it is, but I have noticed that I've become invisible' – Helen's experience of being overlooked in healthcare settings

Helen is 82 years old. She is on long-term oxygen therapy and uses a walker, but maintains an active lifestyle with support from a carer who assists with daily activities.

Helen stated that she often feels invisible in everyday life, including in healthcare settings.

> **I think it's because I'm on oxygen and I walk with a walker, or perhaps because it's to do with my age, but suddenly I've become invisible. I go out anywhere with my daughter or a carer, they ask that person all the questions. 'What's her name?' That's how they refer to me – 'What's her name?' … I'm quite capable of answering these questions but they just seem to ignore me.**

She recalled a visit to the optometrist to get new glasses. Arriving on a motorised scooter with her carer, Helen noticed that staff addressed all questions to the carer – for example, asking the carer, 'Where does she live?' 'Does she live alone?' Eventually, Helen interjected, saying, 'I'm here, you don't have to ask my carer these questions.' They replied, 'Oh.' Later, when it came time to choose frames, they again turned to the carer and asked, 'Which ones do you think she would like?'

Helen feels that because of her age and physical limitations, people often assume that she is not able to speak for herself or make decisions independently. Helen's experience reflects a broader issue of ageism, where assumptions about age and competence may lead to older adults being overlooked and rendered invisible.

## 3.3 Negative interactions

### Disrespectful and unsympathetic communication

Within the broader theme of interactions shaped by negative perceptions of ageing and older age, participants described recurring patterns of disrespectful and unsympathetic communication from health professionals.

Experiences of disrespectful interactions included health professionals who were abrupt, blunt, and dismissive. While acknowledging many patients feel rushed during consultations, participants felt that some health professionals appeared to be influenced by the stereotypes of older people as time-consuming and in need of social engagement.

> **Sometimes they're just short with you. You try to ask something, and they brush you off like you're taking up too much of their time.**
>
> **I had a skin cancer check … It was a 15-minute appointment, and I'd need to hurry up … I did some stuff standing up … and then [the doctor] wanted me on the bed and … it's like, 'We'll just roll over on your side and do this.' And I've got hip and knee issues … I couldn't roll from one side to the other quick enough for him … I was going to fall off the bed trying to roll over. But the impatience was just … He didn't even try to mask it.**
>
> —Older adults

Disrespectful interactions also included health professionals making insensitive remarks about the person's age and supposed proximity to death.

> **I tried a new GP clinic and said, 'My GP is likely to be retiring within the next year or two. I'm looking for a new GP to see me into my old age.' At that point, I was 70, and [the] response to me – which I found arrogant and, of course, I never went back – was, 'Well, you *are* 70.'**
>
> **I was just trying to find out what the timeframe for what I have was, when things were going to happen. And [the doctor] said, 'Don't worry, don't worry, you'll have a heart attack.' And I've had heart tests, there's nothing the matter with my heart … Basically, because I'm that age now, [he's saying] not to worry about it, because [I'll] have a heart attack [before anything else]. They're not going to say that to some 20- or 30-year-old, are they?**
>
> —Older adults

A number of participants reported encountering hostility when they were perceived to be questioning or challenging the health professional. These interactions led some to feel compelled to take a more passive stance to avoid conflict.

> **[My chiropractor] said, 'How are you doing?' and I said, 'Well, I'm still no better than when I came here the first time.' And she arced up and said, 'Oh well, at your age, what do you want for nothing?'**
>
> **I wanted to know if it was possible there was a different reason or outcome. And they're like, 'What would [you] know?' … I said, 'Is it possible it could be this, that or the other?' [The response was], 'No, I've made my decision. That's what it is.'**
>
> —Older adults

### Disempowering communication

Patronising and infantilising communication by health professionals was consistently raised as an issue in interviews and focus groups with older adults. Participants described interactions in which health professionals used simplified language, slowed down their speech, or spoke loudly without reason. They also shared experiences of being spoken down to and treated as though they were incompetent. These behaviours were perceived to be based on assumptions about their age, rather than an assessment of their individual communication needs.

> **Some of the doctors and some of the nurses … they would be talking to me in monosyllabic or, you know, two-syllable words, as though that's the level of your comprehension. And that's not just straight after surgery, where you may be a little**

> **bit less cogent because of the effects of the anaesthesia … I felt [it was] ageism. You know, 'We have to talk down to you, because that's the way you'll understand.' And that's happened on a number of occasions.**
>
> **They treat you … as if you are stupid, that you don't comprehend what they say in any way, shape, or form.**
>
> —Older adults

One participant shared his experience of a patronising interaction he had with a triage nurse when he attended a local hospital with severe stomach pain. He stated that the nurse publicly shamed him, remarking that 'by his age, he should know what not to eat.'

> **When I ended up last year at a local hospital and on the trolley, and there were 6 or 8 other people in the corridor as well, and the triage nurse came along to each one and said, 'What's wrong with you?' And I had all this pain in the gut … And she said, 'You've probably eaten something you're not [supposed to]. You should know by your age what not to eat.' I looked at her, and I was in so much pain I couldn't think of a retort … [After some testing] they said, 'Well, there's nothing really we can do for you. We'll give you some strong painkillers and [you can] go home.' … As it turned out, what I had was the cancer that I'm going to be treated for … It was pretty horrendous lying there on this trolley being spoken down to like that.**
>
> —Older adult

The literature demonstrates evidence of ageism in the language and communication styles used by health professionals.[74] A prominent example is 'elderspeak' – a form of speech characterised by the use of simplified language, exaggerated intonation, and a slower pace.[75] It often includes terms of endearment (eg, calling someone 'Love' or 'Dear'), tag questions that suggest a preferred response (eg, 'That wasn't too bad, was it?'), and the use of collective pronouns instead of a singular pronoun (eg, 'We're going to sit up now.').[76] While often intended to be friendly or supportive, elderspeak reflects implicit ageist assumptions and conveys messages of incompetence and dependence.

Ageist communication can make older adults feel controlled, infantilised, and less competent.[77] It depersonalises interactions by relying on stereotypes, directly contradicting the principles of person-centred care, which emphasise respecting and recognising each patient as an individual.[78] Repeated exposure to such interactions can lead older adults to internalise negative age-based stereotypes – for example, viewing themselves as weak or incapable – and behave in ways that align with these assumptions.[79]

## 3.4 Dismissal and age-based attribution of health concerns

Previous studies examining older people's experiences of ageism in healthcare settings have identified a recurring theme of having their health concerns overlooked, dismissed, or attributed to their age by health professionals.[80]

Age-based assumptions held by health professionals can lead to inadequate diagnostic investigation and under-recognition of conditions that are neither inevitable nor untreatable.[81] For example, the literature indicates depression in older adults is often unrecognised or misattributed in primary care, with symptoms attributed to normal ageing, grief, or other medical conditions – by both physicians and older adults themselves.[82] Using hypothetical patient scenarios, one study in the United States found that primary care physicians were more likely to view suicidal ideation in older patients as normal, and consequently less inclined to treat these patients than younger patients with suicidal ideation.[83]

Consistent with the findings from earlier studies, dismissal and attribution of health concerns to ageing by health professionals also emerged as a key theme in the Commission's research. Older participants reported encountering a dismissive approach from health professionals, with their symptoms attributed to age – often without adequate communication or follow-up.

> **The previous GP would say, 'These things happen. You're getting old.'**
>
> **Two years ago, we had a big accident, and afterwards, my knee started to hurt, and I thought maybe I banged my knee somewhere without knowing it. [I] went to the doctor, and he had a look and said, 'It's old age.' I said, 'What? I'm just 64. I'm not old.'**
>
> **My previous GP, when I complained about things … it just didn't go through to him. He's just, 'This is the way it is.'**
>
> **Every time I went [to see my GP] I said, 'I've got this tingling in my hand.' And he would just ignore it. And one day I said, 'Look, I think I've got carpal tunnel. I've been mentioning it all the time.' And he went back [to the records] and told me what I'd come to see him for, and carpal tunnel [or] tingling was not mentioned one time.**
>
> —Older adults

Older adults felt that such dismissive behaviours were influenced by age-based assumptions, with some perceiving that health professionals viewed certain symptoms as inevitable or unworthy of intervention due to their age. While acknowledging that ageing does involve certain physical changes, participants expressed the importance of being taken seriously and offered appropriate care.

> **It's dismissiveness. It's this idea of, 'Oh well, we can't do much about that.'**
>
> **It's good if they can say, 'It's age-related, but we can still do this or we can do that.'**
>
> **It is feeling you are worthwhile. It's almost like, because you're more mature, [you should] put up with the pain. Just because I'm that age why should I put up with that pain? I've been told, 'You're just going to live with that.' [But] I still have life to live. I still have life in me.**
>
> —Older adults

One female participant described consulting a specialist about pigmentation on her face, only to have it dismissed as age-related, without further explanation or discussion of treatment options. She felt this response reflected the specialist's assumption that older people are not concerned about their physical appearance.

> **[I asked the specialist] 'What is an age spot? What causes them?' [The specialist said] 'They're what you get when you get old and you have to put up with it.' But you shouldn't have to put up with it … That wasn't answering my question … There's many different types of spots and if you have lots of money and all that, you can have them removed or covered … But you're never told that or given that information … Old people shouldn't [have to] want to look bad … [But] we expect old people to not look good.**
>
> —Older adult

For some, these experiences undermined their confidence in the care they received and left them questioning whether their concerns had been understood or taken seriously. Others expressed frustration that their knowledge of their own bodies had been disregarded or devalued.

> **I've been living in this body for 80-odd years, so I should know how my body functions. And they [health professionals] don't want to, they tend to not want to listen … And what would a silly old guy like me know anyway?**
>
> —Older adult

## 3.5 Exclusion from decision making

Existing research on ageism in health care has identified the exclusion of older adults as a key theme, with health professionals often treating older patients as 'absent-present': directing questions to accompanying family members and failing to involve the older person in discussions about their own medical history or future care.[84] These behaviours may be underpinned by pervasive stereotypes that characterise older people as experiencing cognitive decline and reduced functional capacity.[85]

Older adults in the Commission's research also described experiences of being excluded from discussions about their own health. They reported that health professionals often directed conversations to accompanying family members or carers, even when they were fully capable of participating. This exclusion was observed in both hospital settings and during GP consultations, and was particularly pronounced when the older person was accompanied by a support person. Participants described instances in which doctors referred to them in the third person as if they were not present, and made treatment decisions after consulting with family members, without their direct involvement or consent.

> **I was right there in the room, but the doctor spoke directly to my daughter about me like I wasn't even present. I had to interrupt to ask what was going on.**
>
> **They made a decision not to operate before I even knew it was an option. I found out after the fact that they'd discussed it with my son and decided it wasn't worth it because of my age.**
>
> **Things are basically decided for you because they just assume you don't have the knowledge … They just prescribe things, and you just take them.**
>
> —Older adults

Exclusion of older adults was also evident in the inadequate provision of information about their health conditions, treatment options, and expected outcomes. Being told 'you don't need to know' or having critical information withheld – such as recovery timelines or treatment implications – may reflect implicit attitudes that older people are either incapable of understanding or undeserving of full transparency.

> **I said [to the specialist], 'But I'd like to know what's going on, what will you do and what will be the effects?' [He said,] 'Don't worry about that. I know what I'm doing. You don't need to know.' I just had the feeling that I was too old to be bothered with.**
>
> **I went to a hand specialist, and he said, 'Definitely treat the finger. [It's] quite bad.' He said, 'Surgery'. So, I had the surgery. But after the surgery … the finger wouldn't flatten … He said, 'You need some hand therapy.' So, I went to the hand therapist, and I said to her, 'I wasn't expecting this. How long will this take to clear up?' And she said, 'It could take up to 12 months.' And I said, 'What? 12 months! He didn't tell me that!' And she said, 'The more mature people, they don't tell them because they're concerned that you might, a) panic and get worried, and b) not do it [the surgery].'**
>
> —Older adults

Such experiences left participants feeling as though they were not given the opportunity to make informed decisions about their own care. Some participants questioned whether their age had influenced the level of information and engagement they received, which further contributed to feelings of frustration and exclusion.

> **They actually cut quite a bit of my skin off my leg, and didn't really give me good warning as to what was going to happen … The communication with me was not efficient.**
>
> **[The] GP said, 'Oh, we wouldn't want to go down a knee replacement sort of thing.' And he didn't really give any reasons. And I thought, why? Is it because I'm getting on a bit? And I don't think that's the reason, but that's the way I interpret it … [The GP should be] communicating more [about] the reasons, rather than just leave it to me to draw conclusions.**
>
> —Older adults

## 3.6 Age as a factor in clinical decision making

Globally, age has been found to frequently determine access to medical procedures and treatments. A 2020 systematic review found that, among 149 studies examining denied access to health services and treatments, age determined access to procedures and treatments in 85% of cases.[86] Examples include a study in Ireland, which found that older patients with ischaemic heart disease were less likely than younger patients to be prescribed important preventive medications.[87] Another study in the United States found that older patients with depression were less likely than younger patients to have their suicide risk assessed, symptoms explored, or be referred to mental health services by their primary care physicians.[88]

### Case study

**'I am just the woman sitting in the corner' – Jane's experience of being excluded from discharge planning**

Jane is 74 years old and lives independently. A few years ago, she was placed on a permanent oxygen concentrator following a hospital stay. Although she had previously used oxygen intermittently, becoming fully dependent on it marked a significant shift in her daily life. She described feeling unprepared and excluded during her hospital discharge.

> **When I was being discharged from the hospital, I was put on this [oxygen concentrator] for the first time with no information as to what to do. I'd used oxygen before, but I'd never been on it full time … It's a whole different thing. I mean, 24/7 dependent on oxygen and straddled to a machine is a whole different ball game. [But] I had absolutely no information given to me.**

Jane also recalled that the respiratory specialist spoke directly to her adult children, without addressing her.

> **The specialist calls in my children and sits them down. And it's like I'm not even in the room. [The specialist said to my children], 'Well, things have really changed for your mother. She is now totally dependent, and you need to be able to deal with this.' And so, they immediately said, 'Oh, okay, well, how do we get [her] into a nursing home?'**
>
> **I'm sitting in the bed. It's a four-bed ward and the other three, I've been in hospital for about two months at this point, and we are all really good friends. My fellow patients, they're all listening to this, and I just glanced at my friend across in the corner and he [mouthed], 'Oh my God.' I mean, it was bizarre … You know, being in the hospital, being treated like an idiot.**

Jane's experience illustrates how assumptions based on age and physical limitations can lead to exclusion from decision making and a disregard for an older person's autonomy.

Older adults in the Commission's research reported instances where age was explicitly cited as a reason for denying access to treatment or for deprioritising service provision. Examples included being told by a specialist that a heart procedure would not be undertaken due to their age and being turned away by a private clinic that had imposed its own age-based cut-offs for certain procedures.

> **[The doctor] actually said, 'We don't fix them if you are over 65.' I was so astounded. I was speechless. I'm still deciding what to do … You know, if a cardiologist said to me … 'It's a very small hole and where the aneurysm is, we're not going to bother', I would take some reassurance from that … [But] I think because I was over 65, I've immediately fallen off their radar [for treatment].**
>
> **[The reception] said, 'Well, we don't see anybody if they're over 75.' And that was the [surgeon's] front desk, his practice manager. And I couldn't get through to [see the surgeon].**
>
> —Older adults

In other instances, the message was more implicit, with older participants speculating that a different approach might have been offered had they been younger.

> **I wasn't going to die wondering if an operation was going to work for me. So, I probably pushed [the specialist] more than he pushed me. He was very reluctant. He put off the surgery for a matter of years before he finally did it … He finally agreed with me that, you know, nothing else was working, so let's try surgery. But I think if I'd been a younger person, I'm sure he would have done it earlier … I would have much preferred to have the operation earlier.**
>
> **They're careful how they say it, but that's the bottom line – we're too old.**
>
> —Older adults

Some participants perceived that health professionals considered treating certain conditions in older patients to be potentially futile, which may have influenced the range of treatment offered.

> **The impression I've got is that basically all they're doing is try and just to give you pills or whatever. And whatever you've got wrong with you, it's not going to get fixed, I think … So, they'll just treat us as, 'Oh yeah, come and get some more tablets and get out.'**
>
> **I get the feeling that they don't care that much because I'm not going to be around for all that much longer … They don't really care about fixing you because it's just going to be too difficult and not worth it. When you're young, they try to keep you fit and healthy. But when you're old, they think, 'Oh well, we don't have to worry so much about it.' With the spots, [the attitude seemed to be] 'If it's not melanoma, it's not going to kill her.'**
>
> —Older adults

Previous research has found evidence of therapeutic nihilism (see page 14) and perceptions of treatment futility among health professionals in relation to the care of older adults. A global systematic review of qualitative studies examining health professionals' attitudes identified feelings of frustration, hopelessness, and demoralisation among doctors regarding the care of older patients.[89] In a time-pressured healthcare environment, older patients were often perceived as time-consuming and resource-intensive, contributing to perceptions of their care as futile, with recovery considered unlikely.

These perceptions may influence clinical decision making. A nationwide mortality follow-back study in the Netherlands found that physicians withheld or withdrew treatment in 42% of patients aged 80 years and above, compared with 36% for those aged 65–79 and 25% for those aged 17–64.[90] The most commonly cited reasons for forgoing treatment were 'no chance of improvement' (72%) and 'futility of prolonging treatment' (62%). However, the authors noted that rather than being driven by ageism, these decisions were more likely to reflect a clinical focus on providing comfort and avoiding burdensome treatment.

## The role and limits of age in clinical decision making

It is important to recognise that age may play a legitimate role in clinical decision making. Increasing chronological age is associated with the development of comorbidities and physiological decline, which may reduce treatment tolerance and increase the risk of significant side effects.[91]

However, chronological age alone is often a poor indicator of an individual's functional and physiological status.[92] The concept of biological age, which reflects the physiological condition of an individual, offers a more accurate assessment of an individual's age-related risk of adverse outcomes.[93] Frailty, a syndrome marked by a decline in physical and cognitive reserves and increased vulnerability to adverse health outcomes,[94] is increasingly recognised as a reliable indicator of biological age,[95] particularly when combined with biomarker assessment.[96]

While chronological age may be a relevant factor when considered alongside other indicators, it should not be used as a sole determinant in clinical decision making.

Finally, it should be acknowledged that not all health services or individual practitioners are equipped or authorised to deliver all types of care, as these are subject to licensing and regulatory frameworks designed to ensure safety and quality. For example, the level of emergency service provided by a hospital will vary depending on the availability of support services, staffing expertise, physical design, activity, and acuity.[97] The experience of being referred on to another service may reflect limitations in a service's capability to support individuals with complex needs. These assessments typically are – and should be – based on clinical presentation and individual needs, rather than age alone.

A range of factors can influence clinical decisions, including patient complexity and preferences, practitioner expertise and scope of practice, characteristics of the treatment, and the capability of the service to deliver appropriate care. In resource-constrained environments such as hospitals, clinical decisions may also involve the rationing of limited resources, with priority determined by factors such as clinical urgency and prognostic expectations.[98] However, insufficient communication about decision-making processes may contribute to perceptions of differential treatment based on age, potentially undermining trust and confidence in the care provided.

## 3.7 Ageism embedded within the health system

Participants in the Commission's research also discussed systemic and structural issues that contribute to older adults' perceptions of ageism in healthcare settings. Stakeholders identified a range of structural issues including challenges related to resource allocation, service design, and operational pressures. For older adults and their families, their focus was often on more immediate and visible issues – such as rushed medical appointments and age-based eligibility cut-offs in government-funded programs.

### Access to health services and health research

#### Upper age limit for government programs and services

Participants in the Commission's research identified age-based restrictions – such as restrictions in Medicare-funded knee imaging and upper age cut-offs in government-funded screening programs – as examples of policies that disadvantage older adults.[99] These policies reinforced older participants' perceptions of being devalued and deprioritised within the health system.

Additionally, funding models that disincentivise longer GP consultations were perceived to disadvantage older adults, who are more likely to present with multiple health concerns and require longer consultations.

> **I had to get an MRI on the knee and … I sort of found it interesting that if you had the symptom I had and you fell in the age group of 16 to 49, you're eligible for a Medicare rebate. But if you're over 50, you got … zilch. They give a rebate for younger people because … that's a better investment. [Because] they're probably in the workforce and paying taxes.**
>
> **Women have mammograms up to a certain age, then they stop. Pap smears [to] a certain age, then they stop. Bowel testing for both men and women – at a certain age, it stops. Not because [older] people don't get any of these problems. It's just … 'Oh, we're not**

> **funding it beyond a certain age.' You can still have this, but then you've got to pay for it when, probably, your earning capacity is a lot less. It's quite weird because incidents of various cancers actually go up as people age, and yet the regular free testing is not available anymore.**
>
> **I find it interesting that I've had the bowel screening test ... I did a number of those and then ... you get to [a certain age], they don't do it anymore. I think bowel cancer is more common as you get old. [But] when you get to this magic age ... that's it. No more tests. No more government's test. You can still go and get it privately. The reason they don't do that is because it's not cost effective, because the number of lives they're going to save is not worth the cost of it.**
>
> —Older adults

While age restrictions on access to certain government-funded services may be perceived as discriminatory, the development of public policy is a complex process involving a multitude of factors. These include the political context, scientific evidence, stakeholder and public influence, and economic considerations.[100] A detailed examination of these influences is beyond the scope of this report; however, it is important to acknowledge that such decisions are rarely made in isolation or based on a single rationale.

For example, the removal of the ability for GPs to request a knee MRI for patients aged 50 years and over from the Medicare Benefits Schedule (MBS) was informed by the MBS Review Taskforce, which found inappropriate use of knee MRIs in older patients.[101] The Taskforce noted limited evidence of clinical benefit in this group, who often have coexisting symptoms of osteoarthritis that can be difficult to distinguish from those of a meniscal tear, potentially leading to misattribution of symptoms and unnecessary interventions.[102]

### Age-based exclusion from health research

While it did not emerge as a major theme in the Commission's qualitative findings, older adults are frequently excluded from health research, despite having a greater risk of being diagnosed with serious medical conditions.[103] The literature demonstrates evidence of older adults' exclusion from clinical research across a broad range of specialties including cardiology, internal medicine, nephrology, oncology, preventive medicine, psychiatry, rheumatology, and urology.[104] The use of upper age limits in clinical trials is often unjustified, with a systematic review finding that 93% of the 1,258 studies that specified an upper age limit did not provide an explanation for it.[105] This exclusion is particularly problematic, because clinical trials provide critical information about the safety and efficacy of new medical interventions,[106] resulting in limited scientific evidence to guide treatment decisions for older people.

In Australia, one study found that more than half of older adults with advanced lung cancer would typically be excluded from clinical trials, meaning the findings from the research might not apply to them.[107] Even for conditions such as dementia, which predominantly affect older people, participants included in clinical research are systematically younger than the actual distribution of patients in the general population.[108] A review of clinical trials of pharmacological treatments for Alzheimer's disease found that 78% of trial participants were younger than 80 years, despite the fact that those aged 80 and over form the large majority of patients with Alzheimer's disease, and only 8% were aged 85 years and older.[109]

## Operational pressures

Participants in the Commission's research perceived day-to-day operational pressures within healthcare settings as unintentionally contributing to ageist interactions. Time and resource constraints were cited as significant factors influencing the attitudes and behaviours of health professionals towards older patients.

Standard consultation times were widely viewed as insufficient to address the needs of older adults with multiple health concerns. As a result, interactions were frequently rushed, contributing to poor communication and, at times, perceptions of dismissiveness by health professionals.

> **You've got a constrained system where you've got busy people who feel it's easier to have a quick conversation with a young person than a longer conversation with an older person and having to deal with the related issues [of age]. It's a carry-over of general ageist assumptions in society.**
>
> **I think people in acute settings tend to be under a lot of time pressure ... They don't provide ... the older person with the level of input or information that would allow them to make the best decision about their health care.**
>
> —Stakeholders

Participants acknowledged the broader systemic challenges – particularly in public hospital settings – including overcrowding and understaffing. These pressures were seen to necessitate difficult decisions regarding the prioritisation and rationing of limited resources. However, while participants expressed empathy for health professionals operating under such conditions, this understanding did not always mitigate the perception of being unfairly treated due to age – for example, during hospital triage.

> **I've been taken to hospital in an ambulance and … there's 6 or 8 ambulances and trolleys all there. And [the triage nurse] has to pick who's the next person he's going to take in … It must be very difficult for them.**
>
> **I understand – they've done a lot of training, they're in a rush, they're not paid enough. But it doesn't make the patient feel good. It doesn't make the patient feel as though they've been heard.**
>
> —Older adults

## 3.8 Diverse experiences of ageism

In the global context, inequities in health care have been shown to disproportionately affect older adults – particularly those facing compounded forms of disadvantage, such as older women, individuals from culturally and racially marginalised communities, and people with diverse gender identities and sexual orientations. A combination of social, financial, and health-related challenges may also exacerbate these impacts.[110] There is a critical need to increase the evidence base on the effects of ageism in healthcare settings on older adults, with attention to intersecting identities.[111] The limited research examining the interaction between ageism and other forms of discrimination within the Australian population is indicative of a significant gap in understanding the overlapping experiences of discrimination experienced in healthcare settings.

The insights presented below are drawn from a series of focus groups and interviews conducted with older adults to explore intersectional experiences of ageism and are supplemented by

desk research. Participants included older women; older adults of diverse gender identities and sexual orientations; Aboriginal and Torres Strait Islander (First Nations) older adults; and older adults from culturally and linguistically diverse (CALD) backgrounds. Quotes are attributed using group descriptors (e.g. 'Older women').

While the focus of this section is on ageism and its intersections with other forms of discrimination in healthcare settings, some participant insights extend beyond these themes to highlight broader structural, social, and economic barriers to accessing health care. These include limited availability of in-language or culturally appropriate care, service shortages, financial hardship, and geographic challenges. Although not directly related to ageism, these barriers nonetheless affect older adults' ability to access and engage with healthcare services and are important to consider – particularly in the context of an ageing population.

## Older women

The intersection of ageism and sex-based discrimination can influence the quality of care received by older women, contributing to experiences of compounded disadvantage. The combined impact of ageism and sexism in older age is described as a 'double jeopardy', referring to discrimination arising from both patriarchal norms and a cultural preoccupation with youth.[112] This gendered ageism frequently renders older women invisible and is deeply embedded in contemporary society, including in healthcare settings.[113]

Reflecting the effects of gendered ageism, older women in the Commission's research described a sense of diminished value and worth in society as they aged.

> **I would say that in general, once a female is judged to have had menopause, she becomes less valuable.**
>
> **You do, across the board, whether it's medicine or shopping or anything, once you reach a certain age, it's over. We don't seem to be needed or wanted in society because of our age.**
>
> —Older women

While having their health concerns dismissed or attributed to age-related factors by health professionals was a key finding among older adults in the Commission's research, a recurring sentiment among older women was that this experience was intensified by gender bias – leading them to feel their symptoms were overlooked not only due to their age, but also their gender. This is consistent with existing research, which has shown that health professionals often dismiss the health-related concerns of older women.[114]

> **[My GP said], 'If I pulled 20 women your age off the street today, they'd all have the same complaint.' That doesn't help me! He wasn't being condescending. He was just trying to say it was just age.**
>
> **You will occasionally come across a practitioner who's arrogant, dismissive, doesn't listen … Firstly because you're a woman, secondly, because you're an older woman.**
>
> **I said [to my GP], 'Look, my menopause was 25 years ago, why am I still having hot flushes? And he said, 'No, can't possibly.' And I thought, well, I'm having them, aren't I? … I feel like I am being fobbed off because I'm old and female … I've had a few cases like that, and the only way out is [to] change GPs or insisting on [being referred to] a specialist.**
>
> —Older women

Participants also described experiences where health professionals withheld information or directed communication to a male companion, leaving them feeling sidelined in their own healthcare experience.

> **Assumptions are being made … [because] you're female and you're older. That's a double whammy and we can't be [fully informed] in case we keel over with fright or faint or whatever it is … It's an assumption. I can take bad news.**
>
> **When I go in with my brother, I have noticed that, interestingly, they all talk to my brother as if I'm not there … Simply because he's male, the [interaction] goes directly to him.**
>
> —Older women

## Older adults of diverse sexual orientations and gender identities

Historically, members of sexual and gender minority groups have been pathologised, with some even subjected to so-called 'reorientation' interventions, ranging from surgical, hormonal, and pharmacological treatment to behavioural and psychoanalytic therapies.[115] These experiences can have lasting impacts on the healthcare-seeking behaviours of people who identify as lesbian, gay, bisexual, transgender, and other sexuality, gender, and bodily diverse people (LGBT+).[116]

While research on LGBT+ older adults who face dual stigmatisation – experiencing both ageism and discrimination related to sexual orientation and/or gender identity – remains limited,[117] existing studies suggest that older adults from sexual minority groups often report heightened concerns about ageing.[118] These concerns also extend to the healthcare system, where research indicates LGBT+ older adults may experience anxiety about potential discrimination and a lack of understanding among health professionals regarding LGBT+-specific issues.[119] Furthermore, existing evidence suggests that older bisexual and lesbian women may delay or avoid seeking medical care, including preventive health screenings, due to expectations of biased or inappropriate health care.[120]

Older adults in the Commission's research, who identified as belonging to LGBT+ communities,[121] shared that it was often difficult for them to disentangle differential treatment based on age from prejudices related to their gender identity or sexual orientation.

> **When I started thinking about this subject of ageism … I sensed ageism in a number of areas but it's a little bit hard for someone like me to differentiate because … there's a whole lot of people [who are] more than happy to judge you for being a transgender. And I think that is so, with minority groups. Although there's ageism visible – in short answers or standing back from [you] … There's an inevitable mix … of being a minority person … It's hard sometimes to perceive where the semi-aggressive parts come from in people. I find it really difficult to separate those because people go to some lengths to mask their [prejudice] … You can see people masking the answers they give or the treatment they want to deal out.**
>
> —LGBT+ older adult

Participants also discussed the challenges faced by LGBT+ older adults with a history of trauma, particularly how such experiences can make it difficult for these individuals to advocate for themselves. They noted that ageism – even seemingly minor incidents – can have a heightened impact on individuals carrying the burdens of trauma and intersecting forms of marginalisation.

> **Aged people who have a history of trauma, who have intersectional disadvantages and stress … Quite commonly, they are not skilled at self-advocacy or they're too shy to be self-advocates, which means that a tiny thimble full of ageism can actually be a bucket full of ageism … The way we keep agency is to keep advocating for ourselves, and those of us who are carrying trauma burdens and intersectional load will find it difficult to do that. All of the grief is multiplied by those numerous factors.**
>
> **It is far too complex, in terms of all these privileges and the intersections of power and past experience, and of course, overlaid in the case of most of us with pretty hideous trauma as well.**
>
> —LGBT+ older adults

## Case study

**Alexis's experience of age and gender identity shaping healthcare interactions**

Alexis is a 67-year-old transgender woman who was recently admitted to a coronary care unit. During her stay, she reported interactions with health professionals that reflected assumptions about her cognitive capacity, which she attributed to both her age and gender identity.

She recalled an encounter with a senior registrar who initially communicated with her in an overly simplified manner – speaking very slowly, using short sentences, and repeating phrases.

> **I firmly believe he was talking to an old person in the bed, and he was talking to me as if my IQ was 60. And I gently let him know that I had an education. My IQ went up to 70 … He would be speaking very, very, very, very slowly. Very short sentences, very small words, lots of repetition. But once he decided I had an education, and I wasn't quite as old as he thought … My IQ went from 60 to 70.**

Alexis noted that the interaction changed again once the registrar became aware that she was a transgender woman.

> **Once [he] worked out that I was a trans woman, not a 'real' woman, my IQ went up to 90 because he was treating me like a man now … There's … a lot of misogyny that intersects with ageism.**

She also described experiencing the opposite – being treated as less intelligent or less credible because of her gender identity.

> **I've also had the opposite happen. I've had my IQ downgraded because [for some] people, their belief structure seems to include that if you are trans, you're either an idiot or you are lying to yourself, because [they believe] there's only two genders. Because they have a binary view of the world, the only way I could behave the way I behave is if I'm deceptive, a liar, or very severely mentally ill.**

Alexis's experience demonstrates the ways in which age-related bias may interact with discrimination based on gender identity and expression. These intersecting factors can shape how patients are perceived and treated, potentially contributing to disparities in care quality, reduced patient satisfaction, and diminished trust in health professionals.

## Aboriginal and Torres Strait Islander older adults

The Commission recently released a report detailing the findings of a scoping review on the impact of racism on health outcomes and healthcare access.[122] The report identified systemic discrimination in healthcare settings as an ongoing barrier for Aboriginal and Torres Strait Islander (First Nations) peoples, with cultural stereotyping and dismissive treatment by health professionals undermining care and reducing engagement with services.

Contemporary Australian literature on age discrimination has largely overlooked First Nations peoples, resulting in limited insight into the intersections of racial and age discrimination experienced by older First Nations individuals and their associated impacts.[123] Older First Nations adults generally exhibit poorer health outcomes and higher disability rates compared to their non-Indigenous peers.[124] These disparities are further compounded by structural barriers to accessing appropriate health care, including limited availability of culturally competent health workforces.[125] Despite these challenges, the compounding effects of ageism and racism in this context remain critically under-researched, leaving a substantial gap in the evidence base needed to inform inclusive and culturally responsive policy and practice.

First Nations participants in the Commission's research described experiences that are similar to other older adults in the Commission's research, such as having their health concerns dismissed and attributed to older age, and feeling rushed, deprioritised, and depersonalised during consultations.

> **Being dismissed, not being heard. They think that you're having a sook.**
>
> **They said, 'You know, it's your age.' And after that I struggled for years. It mucked up my head. It made me give up on myself.**
>
> —First Nations older adults

For First Nations older adults, these experiences tended to be perceived and experienced through the additional – and often primary – lens of racial discrimination. There was a strong awareness that negative treatment could stem from racial bias, age bias, or a combination of both, making it difficult to disentangle the two. This created a heightened sense of exclusion among First Nations participants, as they navigated the dual burden of racial and age-related stereotypes.

> **How do you know if they're being prejudiced or discriminating against you because of your age or because you're black? Because that's really hard to separate out.**
>
> **Racism is the first thing that we identify. Ageism is just another layer, but we still measure from racism – it might be ageism, but it could be racism, and I think there's a little bit of crossover there.**
>
> —First Nations older adults

The issue of cultural safety also emerged as a key theme. First Nations participants reported experiencing discomfort in mainstream healthcare settings, which was sometimes attributed to past trauma or negative encounters within the general healthcare system. Some described passively agreeing with health professionals in order to leave the situation as quickly as possible, while others reported avoiding medical care altogether. Participants also identified individuals who are less able to advocate for themselves, such as those in remote communities who may not speak English as a first language, as especially vulnerable.

Existing research indicates that perceptions of unfair treatment within healthcare settings can lead older First Nations adults to avoid accessing health services. A study using data from the National Aboriginal and Torres Strait Islander Social Survey found that older First Nations peoples – defined as those aged 45 years and over – were more likely than younger age groups to avoid health care due to prior experiences of unfair treatment.[126] Specifically, 21% of individuals aged 45 and over reported avoiding health care, compared to 9% of those aged 15–29 and 11% of those aged 30–44.

> **I've been scared of hospitals all my life because they did tests on me as a kid.**
>
> **People come in from out in the communities and they don't understand, you know, English is probably [their] second or third language. They're the ones that make us [feel] sorry because people talk down to them when they don't have interpreters or someone with them … It happens all the time because those people can't speak for themselves. They can say stuff, but they don't fully understand it. They can't express themselves properly and [health professionals] take advantage of that.**
>
> —First Nations older adults

Participants also discussed the cultural significance of showing respect for Elders, noting this was often lacking in mainstream healthcare interactions. They shared examples of health professionals using overly familiar or diminutive language, which was perceived as deeply inappropriate. In contrast, Aboriginal Medical Services or Aboriginal Community Controlled Health Organisations were generally viewed positively, with older First Nations adults reporting they were more likely to be treated with respect and cultural understanding in these settings.

> **There's a duty of care to Elders. In our culture, children and Elders always come first. It's sad that as Elders we don't get the treatment we deserve.**
>
> **I go to a Murrie doctor, so, they will treat you as an Elder – they treat you well. I don't think ageism comes into it [in Aboriginal Medical Services] … They all, even the doctors, call you Uncle or Aunty … It's just respect, I think, for your age.**
>
> —First Nations older adults

## Culturally and linguistically diverse older adults

Research indicates that systemic discrimination in healthcare settings can lead to delayed treatment, lower quality of care, and unmet health needs for individuals from culturally and linguistically diverse (CALD) backgrounds.[127] Language barriers, inadequate access to interpreter services, and perceived biases among health professionals may deter individuals from seeking care and reduce trust in health professionals, contributing to unaddressed health needs and poorer long-term health outcomes.[128]

Among older CALD adults, these challenges may be compounded by the overlapping effects of ageism and racism. Evidence suggests that the intersection or cumulative effects of racism and ageism can lead to health disparities among older adults from CALD backgrounds, including delays in accessing care and unmet healthcare needs.[129]

In the Commission's research, insights into ageism among CALD communities were gathered from both older CALD adults and adult children of CALD parents, offering a broader perspective on these experiences.

Among participants from CALD backgrounds, communication emerged as a key issue in healthcare interactions, consistent with broader findings. However, for older CALD adults, these challenges were compounded by assumptions related to their cultural identity, which shaped how they were perceived and treated within the healthcare system.

> **They [see you] and they think, 'Oh you are a typical male, Indian macho male, whatever, whatever …', which I'm not. [But] that's the whole perception. Then they look at your date of birth and they relate that to your memory … I mean they don't say it, but they operationalise it.**
>
> **It's lack of communication … And I'm thinking, hey, I'm alive, I'm still here and I still need [help].**
>
> —CALD older adults

Participants also reported questioning whether their experiences were influenced by their cultural background, accent, or migrant status.

> **You start to think, is it me [being] of a different colour, of a different nationality, I can't speak proper [English]? I can, but not that it matters, because … the reality is [it's about] what accent you have.**
>
> **Because you're not only old but also, you're a migrant. Because what happens is [there is] racism bias and also ageism bias – it becomes extremely complicated.**
>
> —CALD older adults

A stakeholder from an organisation representing CALD individuals echoed these sentiments.

> **Once you have an accent and you look different, you're always treated differently. And it adds up when you are older – it gets harder and harder.**
>
> —CALD stakeholder

Some participants described adopting behavioural strategies to navigate these challenges, such as adjusting their communication style or using humour to elicit empathetic treatment from health professionals – as illustrated in Elena's experience below. One participant labelled these not merely as strategies, but as 'skills for survival' developed over time.

> **I do not call that a strategy. I actually call it the skill of being a multicultural aged person because as a multicultural aged person, you need to develop those skills for survival in complex surroundings, and we all have developed those skills in us.**
>
> —CALD older adult

## Case study

**Elena's experience of navigating the health system as an older CALD adult**

Elena is from a culturally and linguistically diverse background and has been a long-term carer for her husband. She is deeply engaged with issues that impact older adults from CALD communities.

To improve her interactions with health professionals, Elena described softening her tone and using humour – even 'making comedy out of her pain' – to elicit more empathetic care.

> **I was speaking very … sweetly to the nurses. I said, 'Come on, darling, I'm like your mama. That really hurts.' Despite my age and my accent … to make comedy out of my pain because it was the only way to relate … I learned how to be assertive, but 'sweet-assertive', you know. Almost dumb myself down in a way … so they will [help me].**

Elena also recalled being locked down in a hospital ward due to a COVID-19 case, where she observed another older patient with limited English skills struggling to communicate. No interpreter was provided, so Elena stepped in to help, despite only having a basic understanding of the patient's language.

> **They [the hospital] didn't bring an interpreter, they didn't bring anyone to help her. So, I was translating. I was thinking, this is bad. I was translating to the nurses about what she needed. And, you know, for [them] to help her. I think that was very, very below standards.**

Elena's story highlights the personal strategies that older individuals may develop – often out of necessity – to navigate healthcare environments and improve the quality of their interactions with health professionals. It also underscores the systemic gaps in culturally and linguistically appropriate care, particularly for those with limited English proficiency.

It is important to note that all older CALD adults who participated in the Commission's research were proficient in English. While insights into the experiences of older CALD adults with limited English skills were obtained indirectly from their adult children who support them, this research did not directly capture the experiences of these individuals who likely encounter additional and more complex barriers when accessing healthcare services. This presents a limitation of the current study and highlights the need for future research to directly engage older CALD adults with limited English skills, in order to better understand and address the specific challenges they face.

Participants themselves acknowledged this gap, discussing the significant challenges faced by others in their communities who struggle with language and communication. One participant reflected on her late mother's experience, highlighting the difficulty those unable to communicate effectively in English face.

> **Of course, we're able to speak English, but I remember my late mum – [she] was very limited in English. She was stuck in hospital for days on end, weeks on end. And [how she was treated] depended on who the nurses were, who were on shift … If [the patients] don't have the language, then they can't engage. So, they can be seen as just difficult patients because they're in pain … With us, we had four siblings, and we were always at the hospital because my mother was being left in her own urine, waiting for hours on end and that was just really unacceptable.**
>
> —CALD older adult

Adult children of CALD parents also shared how language barriers intersected with ageism, particularly as their parents' confidence in using English declined with age. In the absence of interpreting services, this intersection was perceived to increase the parents' vulnerability in healthcare interactions, intensifying the risk of being overlooked, dismissed, or misunderstood by health professionals.

> **Language is power and although my mother has some English, some people will take advantage of those with broken English. Coupled with [the perception of] being**

**elderly and weak, I think there are some really inappropriate attitudes. So, it's not just [about] being elderly, it's the language as well … You know she's not stupid, she should be treated like any other patient.**

**It's the language. If I wasn't there, my mother wouldn't have received any information whatsoever … They can't speak up and say, 'Look, can you tell me …' So, [health professionals] tell me, because I've got the language, [and] I'm asking all the questions. But you shouldn't have to. The doctor should be informing the patient about all the risks and what [the treatment] involves.**

—Adult children of CALD parents

Adult children reported they often acted as intermediaries, with health professionals bypassing their parents to speak directly to them, even when the parent had sufficient English to participate in the conversation.

**The clinician will read the name, date of birth, and suddenly … they look at me and they will speak to me. They will not look at mum. Although I do explain for her and I do sort of intervene on her behalf … the person that needs the care seems to be overlooked … simply because the other person [the accompanying adult child] is more vocal and can answer their questions more quickly without them having to spend time with [the older person].**

**You should be communicating with her, then telling me. And then we can work it out together. I can fill in the gaps, but she's the patient. The doctor should be primarily talking to the patient, in my view … I find sometimes they take shortcuts. Like, 'I've told you, now you go [and] tell her.' [I'm thinking], hang on, you're the doctor, why don't you speak to her as well?**

**Sometimes I'm being told things first, and then my mother is informed. I'm like, hang on, what does my mother think about this? … English isn't her first language, so I do find the attitude is, 'Let's not bother informing her.' That's wrong.**

—Adult children of CALD parents

Cultural norms that position doctors as figures of authority were also perceived to complicate interactions, leading to some older CALD adults taking a passive role in their own health care. Adult children of CALD parents noted that their parents often agreed with doctors, even when they did not fully understand the information being communicated. This dynamic placed additional pressure on adult children, who were frequently required to assume the role of advocates and interpreters to ensure their parents received appropriate care.

**Doctors are regarded as a very, very high authority … They're regarded very, very highly in our culture … The doctor's word is almost like the Bible.**

**These cultural differences, sometimes there can be a level of respect for the doctors where [the parent is] saying, 'Yes, yes, yes.' But they don't really understand, they're just trusting that everything is okay. But I think it's important to be critical, like, you know your body best, so you need to have agency, not just [say to the doctor], 'Yes, yes, yes.'**

—Adult children of CALD parents

Older CALD parents were reported to prefer health professionals who shared their language and cultural background, which helped to build trust and facilitated communication. However, when these trusted professionals retired or became unavailable, it was often difficult to find suitable replacements, causing distress and leading to reduced engagement with health care.

> **My mum had a very trusted GP, [who] spoke the same language – he was a family friend … He passed away about five years ago. She was almost lost, she [said], 'Who am I going to talk to now?' … My cousin graduated as a GP about four years ago, so she automatically became her GP.**
>
> **I used to take my mum to a GP who was Greek speaking … He was more of a psychologist and a friend, so she was very happy because she could explain her situation … I could see that [the] doctor was very caring and empathetic towards her. After he retired, we went looking for a new Greek speaking doctor and initially he was great … but I've found that every time we've seen him lately, he's become more corporate and very dismissive … If mum says, 'I've got a complaint with my knees', he's very dismissive. He'll just go to the next thing and won't even look at her.**
>
> —Adult children of CALD parents

## Older adults facing geographic and socioeconomic barriers

Approximately one in three adults aged 65 years and over in Australia live in rural and remote areas,[130] where structural barriers significantly impede access to health care. Existing research has identified a range of challenges faced by older adults in these regions, including limited availability of services, inadequate transport options, and affordability concerns – particularly for those managing complex health needs.[131] Where long distance travel is required, it further adds to the financial burden and undermines timely and consistent access to care.[132]

These barriers are compounded by persistent workforce shortages in rural areas, which further reduce healthcare accessibility and disrupt service delivery.[133] This shortage is evident across specialisations, but is particularly pronounced in mental health and oral health services.[134] For example, small rural towns have almost 4.6 times fewer dentists than metropolitan areas.[135] Similarly, the availability of GPs declines with increasing remoteness – from 115.2 full-time equivalent GPs per 100,000 people in metropolitan areas to 78.2 in small rural towns, and 68.1 in remote communities.[136]

Older adults in the Commission's research who reside in regional areas echoed these concerns, citing long wait times and limited service availability as significant challenges. One participant described the difficulty in securing a local GP appointment, leading them to travel two hours by train to the nearest major city for care.

> **Most of [the practices here] … there's a two- or three-week waiting list to get an appointment, whereas my GP in Sydney, I can ring up … and book for the following day and catch the train down and see him. So that's a massive problem for a lot of people in our area.**
>
> —Older adult

Another participant described delays in accessing specialist care due to the infrequent presence of specialists in their area.

> **So now I'm in a situation where the [specialist's office] phoned me and said, 'Yes, we have your results and we would like you to come in for an appointment, but we don't know when.' … Because the specialist isn't here. They have to wait for the specialist to arrive in the town, and then they look at her appointments.**
>
> —Older adult

In Australia, 22.6% of individuals aged over 65 live in relative income poverty, with older women facing a higher risk of poverty than older men.[137] Previous Australian research has revealed significant affordability barriers that hinder older adults' access to healthcare services.[138] For example, a 2023 survey of more than 5,800 adults aged 50 years and over found that cost prevented around a quarter of respondents from accessing mental health services (26%) and dental treatment (24%).[139] Additionally, 20% reported going without dental checkups, while 19% missed out on other healthcare services such as hearing aids, glasses, and vaccinations and pathology tests that are not covered by Medicare.

Older adults in the Commission's research also expressed concerns about healthcare affordability, especially highlighting the significant challenges faced by those who live on limited income and have multiple health conditions.

> **My husband and I live on the pension, and I needed my shoulder examined and the X-ray and ultrasound [were] bulk billed. But then my doctor wanted an MRI … and I had to pay $330 … [That] is a lot of money and [when] you're on a small pension … that's not right.**
>
> **I think [the cost] affects older people much more so, because the needs increase while your income reduces.**
>
> **When people are older and they've got multiple health problems or they're on the pension … they have restricted income … Trying to find a doctor who will bulk bill is … incredibly difficult. Doctors are not given sufficient money from Medicare to cover their costs, not only in terms of the time taken to see the patient, but all of the other things [involved in] running a practice.**
>
> —Older adults

Existing data indicates that substantial proportions of older adults reside in rural and remote areas or experience financial disadvantage, placing them at increased risk of persistent barriers to accessing health care – including challenges related to affordability, accessibility, and availability. While these issues are not unique to older populations, their cumulative impact – particularly for individuals with multimorbidity – raises important questions about the extent to which current health systems and policies adequately reflect and respond to the diverse realities of ageing, especially for those facing geographic and socioeconomic disadvantage.

## 3.9 Impact of ageism on older adults

Research has consistently demonstrated that ageism has serious consequences for older people's health and wellbeing. Being exposed to, or having, negative perceptions about ageing have been linked to adverse health outcomes, such as poor physical and psychological health, delayed recovery from disability, decreased memory performance, reduced quality of life and wellbeing, and even earlier death.[140]

The Commission's research found that ageism in health care affected older adults in multiple ways, including reduced emotional and psychological wellbeing, loss of control and autonomy, and mismanagement of care. It also contributed to the internalisation of ageist stereotypes and attitudes by older individuals themselves.

### Emotional and psychological effects

Previous research has consistently demonstrated a significant relationship between experiences of ageism and reduced psychological wellbeing among older adults. The WHO estimates that globally, 6.3 million cases of depression are attributable to ageism.[141] Perceived ageism is also associated with increased levels of anxiety and stress, as well as reduced life satisfaction, lower self-esteem, and poorer overall wellbeing.[142]

Participants in the Commission's research described a range of emotional responses following interactions in which they felt depersonalised or devalued due to their age. These included feeling frustrated, angry, and emotionally depleted.

> **I get resentful, angry, frustrated.**
>
> **It was like a factory. You are just a number … and when I got spat out at the end … It was a very unpleasant experience.**
>
> —Older adults

These experiences often had lasting emotional consequences beyond the immediate encounter. Participants described feelings of self-doubt, diminished self-worth, and internalised blame resulting from being ignored, spoken down to, or treated as incapable.

> **It makes you feel you're a lesser person, so to speak … You think people think you're not really in the same league as other people.**
>
> **We often blame ourselves. And I think, my God, how could I possibly … there must be something wrong with me. How could I possibly have got into this situation? … It just destroys your heart … It's so brutal.**
>
> —Older adults

Some participants described a growing sense of resignation and emotional exhaustion from having to continually advocate for themselves, particularly when unwell. Others reported an increasing reluctance to seek care, shaped by expectations of being dismissed and mistreated again. In some cases, this led individuals to disengage from their usual healthcare provider and seek care elsewhere, increasing the risk of discontinuity in care and potential gaps in treatment.

> **I feel that everything is a battle. And when you're unwell, you can't fight those battles. It becomes so difficult to advocate and battle for yourself.**
>
> **Older women are often invisible, and not all women are comfortable with being in that adversarial role. I don't always want to be in that adversarial role because it takes a lot out of me, particularly when I'm not well … I shouldn't have to be in that adversarial role.**
>
> **I am actually fearful that one of these days I will choose not to call an ambulance because of my dread of that whole experience.**
>
> **I get annoyed and eventually – and I've done this a few times – I change providers.**
>
> —Older adults

These accounts demonstrate that ageism in health care is a deeply personal experience, often carrying significant emotional and psychological consequences for older individuals. The erosion of dignity, trust, and self-confidence can not only impact older adults' attitudes towards health professionals and themselves, but also their engagement with health services. This may exacerbate disparities in access to care and health outcomes, particularly for marginalised groups who are already vulnerable to discrimination within healthcare settings.[143]

## Loss of autonomy and disempowerment of older adults

Autonomy, one of the fundamental principles of medical ethics, typically refers to a person's ability to make informed decisions about their care, free from pressure or influence.[144] The literature suggests that older people's autonomy is often undermined in healthcare settings.[145] For example, a population-based study in Belgium found that older age was associated with a higher likelihood of exclusion from end-of-life decision making.[146] Drawing on data collected from physicians, the study found that 70% of patients under 65 were included in discussions about pain and other symptom management during their final stages of care, compared to just 19% of those aged 80 and over. Older patients were also more frequently deemed to be lacking decision-making capacity.

Findings from the Commission's research similarly revealed that older adults experienced exclusion from discussions about their own health care. This often resulted from interactions that did not provide sufficient information or the opportunity for older adults to fully understand their diagnosis, treatment options, and prognosis. Such interactions may reflect implicit ageist assumptions that associate older age with declining cognitive abilities and mental capacity, potentially leading to the exclusion of older patients from decision-making processes.[147]

> **In the hospital they took over and talked over the top of me when I was talking about pain. I didn't want any medication, but they kept sticking needles in me. They wouldn't listen.**
>
> —Older adult

For older adults from CALD backgrounds, autonomy may be further compromised by the limited availability of culturally appropriate care and in-language information.[148] In the Commission's research, adult children of CALD parents reported that their parents, particularly those with limited English proficiency, often agreed with health professionals without fully understanding the information provided.

Unequal power dynamics were also identified in the Commission's research as a key barrier to older adults' participation in healthcare interactions. This imbalance was perceived to exacerbate experiences of ageism, with some participants feeling unable or unwilling to question health professionals or advocate for themselves due to fear of jeopardising their care.

> **I still haven't found out what's going on … When you do question … the response you get is, as if you've insulted them. So, what you do is you don't request too much, because you're going to have to go and find another GP because that one, you've insulted.**
>
> —Older adult

This finding aligns with existing research. A 2022 systematic review identified perceived or actual power imbalances in patient-practitioner relationships as a significant barrier to older patients' participation in clinical communication.[149] The review found that such asymmetries often left older individuals feeling disempowered, leading them to adopt a passive role in interactions with health professionals – even when they wished to be actively involved in decisions regarding their care.

Patients from historically marginalised groups, such as women, individuals from minority communities, and those of lower socioeconomic status, are particularly vulnerable within these clinical hierarchies.[150] The Commission also found that power imbalances were intensified for older adults from CALD backgrounds and older First Nations peoples, who more frequently faced heightened barriers arising from language difficulties, fear of discrimination, and past negative experiences within the health system.

> **She gets angry but she doesn't speak up … and I'll say to her, 'Why didn't you speak up?' and she goes, 'Well, I'm worried what [the doctor] might say to me.'**
>
> —Adult child of a CALD parent

The effects of this power asymmetry were evident in accounts from older First Nations participants, who described passively nodding in agreement with health professionals as a way to disengage from uncomfortable situations. Similarly, adult children of CALD parents reported that cultural norms and language barriers often prevented their parents from questioning medical authority. These dynamics were perceived to contribute to reduced patient agency among older adults, reinforcing hierarchical relationships that limit their active participation in healthcare decision making.

## Compromised care

Ageism in healthcare settings can undermine the quality of care provided to older adults. The impact on care may manifest across various dimensions, including diagnostic accuracy, access to appropriate treatments, and prescribing practices.[151]

Research has consistently demonstrated that increasing age is associated with lower diagnostic accuracy. A systematic review of diagnostic errors in older adults found that both underdiagnosis and overdiagnosis were common for several prevalent and high-burden conditions, including dementia, heart failure, Parkinson's disease, and acute myocardial infarction.[152]

Age-based assumptions held by health professionals can also hinder older adults' access to timely and appropriate medical interventions. For example, the perception that older people are less sexually active and are uncomfortable discussing sexual health can result in reduced screening for sexually transmitted infections, increasing the risk of delayed diagnoses and treatment.[153]

Older adults also tend to receive less aggressive treatment than younger counterparts. The German Trauma Registry found that older polytrauma patients were more often treated with a 'wait and see' approach, compared to younger patients.[154] This included lower rates of prehospital care interventions, limited diagnostic investigations in the emergency department, and fewer surgical procedures. Similar patterns are also evident in cancer treatment. A meta-analysis of studies reporting surgery rates of younger and older

patients with breast, lung, or colorectal cancer found consistently lower surgery rates in older patients across all three types of cancer, even after accounting for factors such as comorbidity.[155] A national audit in England and Wales also found rates of surgery, radiotherapy and chemotherapy decreased with age, regardless of comorbidities or tumour characteristics.[156]

Older adults who participated in the Commission's research described experiences in which they felt the care they received was influenced by their age. These included instances where their health concerns were dismissed or minimised, raising concerns about delayed or missed diagnoses. For example, one participant reported that her GP dismissed her concerns about sudden bouts of diarrhoea, citing that she was not scheduled for a bowel screening for several months.

> **People don't listen, particularly when they think, 'Oh well, you know, this person is old. They may even have signs of dementia.' There's a lot of judgement, I think, made by medicos, where they know better … They need to listen to their patients more.**
>
> —Older adult

Ageism also contributes to inappropriate prescribing, with older adults more likely to be under- or over-medicated, particularly in relation to pain management.[157] In Australia, a review of literature on problems with medicine use revealed that older adults are frequently exposed to potentially inappropriate prescribing, including both over-prescribing and under-prescribing.[158] Polypharmacy – the regular use of multiple medications at the same time – is widespread among older people, with almost 40% of adults aged 75 years and over taking five or more medicines in Australia.[159] Polypharmacy is generally advised against, as it increases the risk of inappropriate and unsafe prescribing.[160] It is associated with increased risks of adverse medication reactions, harmful interactions, hospitalisation, reduced physical capacity, and incidents such as falls.[161]

Older adults in the Commission's research also shared experiences of being prescribed medications, sometimes without what they considered to be a thorough investigation of underlying causes or a review of existing prescriptions.

> **They just give you prescriptions for painkillers instead of finding out what's causing the pain.**
>
> **It's like [they're thinking], 'You're 78 and you're not going to be here for long anyway … Here's the script, now bugger off.'**
>
> **They don't review your case at all. They just add to it, add to it. A friend of mine was taking something like 25 different [tablets] a day and her doctor went on holidays and had a locum there. She'd run out of prescriptions and went in … and the locum said, 'Hang on, what do you want this for? … Tell me about all the medicines you're taking.' … She was taking medications that didn't agree with each other … And [the locum doctor] cut her medications down to about five a day … [Doctors had] just kept prescribing her [more] stuff without checking the whole list of medications.**
>
> —Older adults

These findings suggest that age-related biases – whether implicit or systemic – may influence clinical decision making in ways that potentially compromise care for older adults. From diagnostic oversight to restricted access to treatment and prescribing practices, the cumulative effect may result in care that does not consistently align with best practice or individual needs.

## Internalised ageism

One of the most harmful aspects of ageism is that negative stereotypes about ageing affect not only people's perceptions of older adults and behaviours towards them, but also how older individuals view themselves and their behaviour. Even ageism that may be well-intentioned, such as overprotective and overaccommodative behaviours based on assumptions of vulnerability, can undermine older adults' sense of self-efficacy and competence.[162]

Internalised ageism occurs when negative beliefs about older age become self-directed over time and operate unconsciously.[163] Research indicates that internalised ageism can become a self-fulfilling prophecy, in which older adults view themselves in stereotypical ways and act accordingly.[164] Previous studies have demonstrated that the association between ageism and health outcomes is the strongest for self-directed ageism.[165] Older adults with

internalised negative expectations of the ageing process may not seek treatment for health issues or engage in preventive health behaviours, due to their belief that ageing naturally results in deteriorations in health. This could lead to a more rapid decline in their health than older adults who do engage in healthcare-seeking and health-promoting behaviours.

In line with existing evidence, the Commission's research found that internalised beliefs about ageing may influence older adults' health behaviours and decisions. Among some older participants, 'old age' was accepted as a sufficient explanation for their health issues, with physical decline viewed as a natural and unavoidable part of ageing. While many participants expressed frustration when health professionals dismissed their health concerns as age-related, others considered such explanations reasonable, given the inevitability of physical deterioration in older age. Some older adults were reluctant to seek medical attention for conditions they perceived as age-related. One participant, for example, preferred to live with conditions such as arthritis than undergo what they described as 'torturous tests'.

The Commission's research also found that some older adults believed limited healthcare resources should be prioritised for younger people, who are more likely to benefit over the long term.

While this view was often framed as pragmatic, it reflects internalised assumptions about the relative value of care across age groups.

> **I feel that my body's breaking down bits and pieces … It doesn't work as well as it used to … And to say, 'Okay, now the government system has to not only keep me alive, but fix things that I've broken, or that time has broken …' I just think it'd be nice, but it's not realistic. And I realise that the government, if they spend $100 on something that gives me three more months of life, compared to the same money could be spent on somebody else and give them 30 years more life, they've gotta do that sort of sum.**
>
> —Older adult

These accounts highlight a tension between accepting certain health issues as an inevitable part of ageing and questioning whether treatment is warranted – particularly when weighed against the physical, emotional, or financial costs. While some decisions to forgo treatment may be rational and appropriate to one's life stage, age itself can become a filter through which care-seeking decisions are made, suggesting the presence of internalised ageist beliefs.

# 4. Addressing Ageism: Insights from Older Adults and Advocates


## Summary

- The following recommendations reflect the priorities and needs expressed by older adults and those who support them.
- While older adults tended to focus on interpersonal improvements – such as being informed and having their views and experiences respected – these reflections also point to a broader need for cultural and structural change within the healthcare system.
- Stakeholder insights bridge the gap between lived experience and systems-level knowledge, offering practical and policy-relevant recommendations that address both individual needs and structural challenges.
- Taken together, these perspectives offer valuable, community-identified approaches that can supplement empirical research to inform the development of targeted interventions and policies to promote more inclusive healthcare services and practices.


## 4.1 Person-centred care and respectful healthcare interactions

Older adults in the Commission's research consistently emphasised the importance of empathetic and respectful interactions with health professionals, viewing these as central to their overall healthcare experiences and outcomes.

> **It starts with empathy, and it starts right from the top. If it was done with empathy, I think that would improve things for us right away.**
>
> **[To] be acknowledged as a person, not as an older thing that is not worth anything [that you] put in the corner and let it die.**
>
> **It's about valuing the older person. It's seeing them as a person, and not an age – it's just a stage of their life. Listening to [the older person], actually looking at them when you are talking to them and they are talking to you, so that they feel heard and that how they are explaining themselves is actually being understood.**
>
> —Older adults

Participants described feeling respected when health professionals clearly explained treatment plans, processes, and likely outcomes. Their sense of agency was reinforced when they were invited to ask questions and contribute to decisions about their care. Personalised interactions – such as proper introductions, addressing patients and their companions by name, and acknowledging the individual beyond their age or medical condition – were seen as especially meaningful. Older adults valued health professionals who were attentive to their concerns and took them seriously, and demonstrated genuine care for them as individuals.

> **When I had breast cancer and saw the doctor … my partner came with me … and the specialist talked to both of us and told us what was going to happen, [about] the surgery and the hospital. Everyone was extremely respectful and very, very kind, and I just really felt nurtured.**
>
> **Sometimes you're just a bundle of symptoms and don't sort of fit their little checker box. [But] she [the nurse] organised a biopsy, organised immediate treatment. She rang me. This is a public hospital. She rang me at home, and her team rang me at home regularly for a couple of months to check in on how I was going, how I was responding to the treatment.**
>
> —Older adults

These reflections point to a set of guiding principles that older people would like to see underpin their experiences within healthcare settings and systems. These principles are summarised in Table 1 below.

**Table 1. Key elements of positive healthcare experiences**

| Principle | Description |
|---|---|
| **Person before age** | Recognising the individual beyond their age. Care should be person-centred, not based on age-related assumptions or stereotypes. |
| **Active listening** | Engaging older people in meaningful, two-way conversations about their health. |
| **Respectful and dignified treatment** | Demonstrating basic courtesies, such as greeting patients, acknowledging the individual's lived experience and expertise in their own health, and avoiding dismissive or patronising treatment. |
| **Taking patients' concerns seriously** | Avoiding dismissal of health concerns based on age. Older adults want their symptoms taken seriously and given appropriate attention. |
| **Right to information** | Ensuring availability of comprehensive, accessible information. Avoid withholding or oversimplifying unless requested by, or appropriate for, the patient. |
| **Shared decision making** | Involving older adults in decisions about their care. Offering and explaining options conveys respect and supports autonomy. |
| **Adequate time** | Allowing sufficient time for older adults to have their needs addressed. Rushed appointments can undermine older adults' confidence in the care received and reinforce perceptions of age-based bias. |
| **Equitable care** | Age should not be a basis for deprioritising care or making assumptions that disadvantage older patients. A duty of care applies at all ages. |

## 4.2 Equipping health professionals for age-inclusive practice

To support age-inclusive health care, stakeholders advocated for the inclusion of geriatrics and gerontology as core elements of health education, ensuring a strong foundation in ageing and the care of older adults. In addition to foundational content, specific training modules were identified as a way to raise awareness of ageism and develop practical skills. Ideally, these modules should be co-designed with older adults to incorporate lived experience and ensure relevance to real-world practice.

Older participants and their families also emphasised the importance of targeted training to increase health professionals' awareness of ageism and support age-inclusive practice.

> **Not just medical training. Dealing with people and other things on the side.**
>
> **Why should we be denied the twilight of our lives because of this … ageism that's within the consciousness of many medical people?**
>
> —Older adults

> **The number one thing is education. Don't look at the person as a number. Look at them as a person who can have a viable and very productive end of life. Remind clinicians that everyone's going to get old and … that because of the limitation of the body, it doesn't necessarily mean that they are not still productive members of the society.**
>
> —Adult child caregiver

Stakeholders also called for a stronger focus on applied research to address ageism in health care – for example, for researchers to partner with health professionals and older adults to co-design, pilot, evaluate, and scale interventions aimed at promoting positive change. This applied, collaborative approach would support the generation of practical insights and evidence to inform age-inclusive practice.

## 4.3 Promoting public awareness and empowering older adults

Addressing ageism in health care was widely seen as requiring greater public awareness of the issue and the empowerment of older adults.

Stakeholders proposed long-term, multi-pronged public health-style campaigns aimed at shifting societal attitudes on ageing. It was suggested that these campaigns should adopt a strengths-based approach, highlighting the contributions, diversity, and value of older people. Such positive framing was considered necessary to challenge ageist stereotypes and promote more inclusive narratives around ageing.

Peer-to-peer education was identified as a particularly effective strategy for raising awareness among older adults. By encouraging older individuals to share knowledge and experiences with their peers, this approach could foster a sense of solidarity and reinforce the message that all people, regardless of age, are entitled to respectful and high-quality health care.

Empowerment was a recurring theme across stakeholder and participant feedback. Importantly, older adults emphasised that empowerment should not mean placing the responsibility of addressing ageism on individuals. Rather, it should involve providing appropriate support to enable self-advocacy, or access to assistance when healthcare experiences are compromised by ageist attitudes or practices. While some participants felt confident calling out ageism, others expressed hesitation or uncertainty, underscoring the need for safe and supportive environments where concerns can be raised without fear of reprisal or dismissal.

The availability of clear and accessible mechanisms for raising concerns or lodging complaints – whether within healthcare systems or through community-based channels – was thought to convey the message that ageism should not be accepted or tolerated.

Additionally, stakeholders highlighted the importance of providing accessible information, practical tools, and platforms that enable older adults to speak up about their healthcare experiences and assert their rights to high-quality and equitable care.

## 4.4 Driving structural and cultural change for equitable care

> **There are systemic problems. Especially with an ageing population and there's going to be more and more of us oldies in the next generation that are coming up. Medicare and the whole health system is not coping. The health system should be more accountable.**
>
> **We do have a very big problem with our health system. I think it's more the system than the people. Some of [the negative experiences are] to do with age, but I think it's a bigger thing.**
>
> —Older adults

While some older participants discussed structural challenges, such as time and resource constraints, contributing to negative healthcare experiences, most recommendations in this area came from stakeholders. These focused on system-level improvements aimed at supporting more equitable care across the healthcare system.

Table 2 below provides a summary of stakeholder recommendations aimed at driving structural and cultural change in health care.

**Table 2. Summary of recommendations**

| Recommendation area | Description |
|---|---|
| **Funding models** | Review and adapt funding models to better reflect older patients' needs, including adequate time for consultations, especially when interpreters or additional supports are needed. |
| **Medical research inclusion** | Remove upper age cut-offs in medical research, where appropriate, to strengthen the evidence base for older populations. |
| **Person-centred care** | Develop implementation strategies that adopt a life course approach and explicitly address ageism. |
| **Safeguards against bias** | Establish safeguards and accountability mechanisms to prevent age-related bias in care. |
| **Co-design and older people's participation** | Involve older people in the design, delivery, and evaluation of health services to ensure their perspectives are reflected. |
| **Patient advocacy** | Expand the roles of independent patient advocates or community health navigators to support older patients in navigating systemic barriers within the health system. |
| **Leadership commitment** | Promote visible leadership support for age-inclusive values and person-centred care across all levels of the health system. |
| **Opportunities for older health professionals** | Create opportunities for older health professionals to remain engaged in the workforce. |

Stakeholders proposed reassessing existing funding models to better reflect the complex needs of older patients. This included ensuring sufficient time for consultations, particularly where interpreters or additional supports are required. There was also a call to review age-based rules in access to services and funding – such as those found within Medicare and the interface between the National Disability Insurance Scheme and aged care systems.

Concerns were raised about arbitrary age cut-offs in medical research, which can exclude older people from clinical trials and limit the evidence base on the safety and efficacy of interventions for this population. Stakeholders suggested that removing these cut-offs, where appropriate and feasible, would help ensure that research more accurately reflects the age profile of those living with various health conditions.

Stakeholders emphasised the need to develop and resource clear implementation strategies for existing policies related to person-centred care. This approach – widely recognised as the gold standard in healthcare delivery – places the individual at the centre of care delivery, respecting their rights, fostering mutual respect, and building relationships.[166] Evidence indicates person-centred care is associated with improved wellbeing, patient satisfaction, and health outcomes among older adults.[167] It was considered essential that implementation strategies explicitly address ageism and adopt a life course approach, recognising the continuum between health care and aged care services.

Further recommendations included embedding safeguards in healthcare policies and procedures to prevent bias in decision making and ensure equitable and respectful care across all healthcare settings. Stakeholders advocated for accountability mechanisms to address ageist attitudes and practices among health professionals, ensuring that age-inclusive care is not only encouraged but expected.

> **How can you open someone's eyes and say, 'Hey, you are being discriminated against because you're older', but not have the resources and pathways to address it?**
>
> **You need [a system] that is actively challenging ageist behaviour and actively encouraging and rewarding respectful behaviour. Training on its own won't bring about change.**
>
> —Stakeholders

Stakeholders also called for greater inclusion of older people in the design, delivery, and evaluation of health services. The 'nothing about us without us' principle was referenced to ensure older people have a meaningful voice in shaping the systems and services that affect them.

Expanding the role of independent patient advocates or community health navigators was proposed as a practical strategy to assist older patients in overcoming barriers within the health system. These roles could help bridge communication gaps, reduce power imbalances in patient-practitioner relationships, and provide feedback to services to support continuous improvement efforts.

It was widely acknowledged that addressing ageism in health care requires not only structural improvements but also a cultural shift within the sector. Leadership commitment was regarded critical to driving this change – particularly in promoting person-centred care and actively challenging ageist attitudes and practices across healthcare settings. Visible support from senior leadership would help set expectations, model inclusive behaviours, and embed age-inclusive values into organisational culture.

Finally, stakeholders highlighted the importance of creating greater opportunities for older health professionals. Supporting their continued participation in the workforce would not only affirm the value of their experience and expertise, but could also serve to challenge ageist assumptions about capability and contribution.

# 5. Conclusion

## Summary

- Ageism is perceived by older adults as widespread within the Australian healthcare system, occurring across interpersonal, institutional, and systemic levels.
- These experiences negatively affected older adults' emotional wellbeing, limited meaningful participation in their own health care, and impacted the quality of care they received.
- Participants called for person-centred, inclusive care, targeted training of health professionals, and broader structural changes to improve healthcare experiences and outcomes for older adults.
- Future work could focus on sector collaboration and co-design to develop practical, age-inclusive models of care, supported by initiatives to raise awareness of ageism and improve the quality of care for all ages.
- While this research offers detailed insights into older people's firsthand experiences of perceived ageism in healthcare settings, the findings do not represent conclusive evidence. Further research is needed to address key evidence gaps, including the prevalence and extent of ageism in Australian health care and its intersection with other forms of discrimination.

## 5.1 What we learned

This research provides detailed, firsthand insights into older adults' experiences and perceptions of ageism in Australian healthcare settings. Drawing on qualitative insights from older individuals, their families, and stakeholders, and informed by contemporary literature, the findings contribute to the growing evidence base needed to inform policies and practices that promote more inclusive and equitable care.

The Commission found that older adults perceive ageism as occurring at interpersonal, institutional, and structural levels of the healthcare system. Older adults reported experiences in which their interactions with health professionals and the care they received appeared to be influenced by age-based assumptions. Structural factors, such as operational pressures, were perceived as unintentionally contributing to ageist interactions, while age-based eligibility criteria for services were regarded as creating barriers to accessing appropriate care.

These experiences had detrimental effects on older adults' emotional wellbeing, and limited their ability to participate meaningfully in their own care. The impact was heightened for older adults facing intersecting forms of discrimination, such as those from culturally and linguistically diverse backgrounds, First Nations communities, and LGBT+ populations.

Existing research further suggests that ageism directed towards older adults in health care may increase the risk of missed diagnoses, delayed or inadequate medical interventions, and contribute to internalised ageism[168] – all of which have serious implications for health outcomes.

Participants emphasised the need for person-centred, empathetic, inclusive care that recognises older adults as individuals, supported by targeted training to enhance health professionals' awareness of ageism and capability in delivering age-inclusive care. Broader structural and systemic improvements, alongside sustained cultural change within the health system, were seen as essential for improving healthcare experiences and outcomes for older people.

## 5.2 Ways forward

### Health sector engagement

The current research centred on the perspectives of older people, drawing attention to their experiences and perceptions of ageism within the health system. Building on the findings of this research, future initiatives could involve collaboration with the health sector to examine the systemic, cultural, and operational drivers that sustain or could help mitigate ageism in healthcare settings.

Engaging health professionals, educators, researchers, and sector leaders will be essential to understanding the practical context in which care is delivered, including the challenges faced by those working within it. These stakeholders can provide critical insights into gaps in training and practice, challenge prevailing assumptions, and identify areas where the findings of this research may diverge from on-the-ground realities.

As part of this effort, collaboration with the health sector could support the review and improvement of clinical practice guidelines, standards, and codes of conduct to reduce age bias in decision making and address the under-representation of older adults in clinical trials, thereby strengthening the evidence base on the safety and efficacy of interventions for older populations. Collaboration with academic institutions and professional bodies is also needed to enhance the integration of geriatric and gerontological content within health curricula and ensure that education and training programs adequately prepare the workforce to deliver age-inclusive care.

Future work may also involve co-design methodologies, bringing together older adults and health professionals to collaboratively identify priority areas for action and develop practical, sector-specific strategies to support more inclusive, person-centred models of care. Such approaches have the potential to inform both cultural and structural improvement efforts, grounded in the lived experience of patients and practitioners.

### Educational interventions

The Commission's previous research demonstrated the potential of brief educational interventions to catalyse positive attitudes, leading to changes in the way people interact with older adults.[169] Targeting these interactive age awareness workshops to healthcare workers may help to challenge subtle biases and socially accepted forms of ageism, and promote respectful work practices. Ultimately, a reduction in ageism should improve the quality of health care provided and contribute to improved health outcomes.

### Areas for further research

While this research provides important insights into older adults' experiences and perceptions of ageism in healthcare settings, the findings do not constitute conclusive evidence. Rather, they provide a foundation for further research in this area.

There is a clear need to strengthen the evidence base on the prevalence, extent, and nature of ageism within Australian healthcare settings, including its various forms, the domains in which it occurs, associated factors, and the characteristics of older adults most commonly associated with these experiences.

Further research should also explore the intersection of ageism with other forms of discrimination and structural disadvantage. Age-based discrimination is multidimensional and often overlaps with factors such as gender, cultural background, sexuality, disability, education, and socioeconomic status.[170] An intersectional approach will provide a deeper understanding of how overlapping forms of discrimination contribute to compounded disadvantage and shape older people's experiences within the health system.

In addition, while this study focused on older adults, the effects of ageism towards younger people in healthcare settings remain underexplored.[171] Further research is needed to examine the ways in which age-based assumptions and stereotypes may affect younger people, both in the short term and through cumulative impacts over the life course. A more comprehensive understanding of age-related bias will be essential for designing inclusive and equitable healthcare systems that meet the needs of all people, regardless of age.

# Context

## Overview

- This section provides additional background information on the concept and definition of ageism.
- It presents a detailed overview of the methodology used in the desktop review and qualitative research, including the scope, data sources, and research design.
- It also outlines the limitations of the study, such as potential selection and reporting bias, and the limited generalisability of the findings.

## Background

Ageism involves stereotypes, prejudice, and discrimination towards people based on their perceived chronological age.[172]

- Stereotypes are generalised beliefs about the characteristics of members of social groups. Stereotypes about age may be descriptive (what individuals belonging to an age group are like) or prescriptive (how individuals belonging to an age group should behave).[173]
- Prejudice involves emotional reactions (positive or negative) towards individuals based on their perceived social group membership. For example, stereotypes of older adults as warm but less competent may lead to feelings of pity and sympathy, while younger workers may face prejudice through dismissive attitudes towards their contributions.
- Discrimination includes actions or policies that advantage or disadvantage people based on their age. In Australia, the *Age Discrimination Act 2004* (Cth) prohibits discrimination on the basis of age in areas such as employment, education, and services.

## Method

### Scope

The scope of this research encompassed acute, primary, secondary, and allied healthcare settings – such as hospitals, general practice, outpatient clinics, and diagnostic services. Mental health services were not a specific focus, and aged care settings were excluded.

### Desktop research

The Commission worked with an external research partner (Urbis Pty Limited) to undertake a targeted desktop review of contemporary research. This review aimed to provide a broad contextual understanding and an overview of the current state of knowledge relating to ageism in health care in Australia.

Priority was given to documents published in Australia, New Zealand, and the United Kingdom in the past 10 years; however, where recent evidence was limited, sources published more than 10 years ago and from other jurisdictions were also included.

The following sources were used to locate relevant academic literature, grey literature, and internet resources:

- Informit, PubMed, and Scopus
- Google, Google Scholar, and relevant websites in Australia and overseas, including but not limited to, international, national, and state government health department websites, and not-for-profit organisation websites.

The desktop review was guided by a set of research questions and sub-questions developed by the Commission and Urbis, with key search terms derived from these questions. The main research questions included:

- How is ageism defined and conceptualised?
- How prevalent is ageism in primary and secondary healthcare settings?
- What are the causes of ageism in healthcare settings?
- What are the impacts of ageism in healthcare settings on patients?

- How do intersecting factors influence experiences of ageism in health care?
- What theoretical frameworks and models have been developed or can be applied to combat ageism in healthcare settings?
- Are there successful interventions or lessons from anti-ageism efforts in other high-contact settings that can be applied to healthcare settings?

The initial desk research was supplemented by additional desk research undertaken by the Commission, focusing on sources published in English and drawing on a range of academic and grey literature to further strengthen the evidence base for this report.

## Qualitative research

The Commission worked with an external research partner (WhereTo Research Consulting Pty Limited) to explore older adults' perceptions and experiences of ageism in Australian healthcare settings and its impacts. This qualitative research sought to identify common themes or patterns in the manifestations of ageism in these settings, and to contextualise and substantiate the findings from the desktop review.

Fieldwork was conducted between March and April 2025, and comprised interviews and discussion groups with older adults, their families, and representatives from stakeholder organisations. In addition, the Commission conducted supplementary consultations in June 2025 with participant groups that were not adequately represented in the initial fieldwork.

All participants were provided with a privacy collection notice outlining the purpose of the research, the type of information to be collected and how it would be used, potential risks of participation, and their right to withdraw participation at any point. Participants acknowledged their understanding and provided informed consent by returning a signed consent form. An incentive, in the form of an electronic gift card, was offered to all participants in recognition of their time and contribution.

### Stakeholder interviews

Stakeholders representing diverse cohorts of older adults and experts in ageing and health were included to capture a broad range of experiences and perspectives.

It should be noted that not all individuals who participated in the research were subject-matter experts in ageism or healthcare systems. Additionally, for most of the participating organisations, addressing ageism in health care was not a core area of focus in their current work.

In total, interviews were conducted with 9 representatives from 8 stakeholder organisations.[174]

### Consumer research

Participants who indicated that they had experienced ageism in a healthcare setting were identified through a research panel (or through community networks for First Nations participants) and invited to take part in either an in-depth interview or a group discussion. For the supplementary consultations conducted by the Commission, participants were recruited with assistance from organisations representing these groups, who shared information about the research with their members and networks.

All fieldwork was conducted by researchers with experience in conducting discussions on sensitive topics. Discussions involving First Nations participants were co-moderated by a First Nations facilitator to ensure cultural safety, sensitivity, and respectful engagement.

In total, 54 individuals participated in the qualitative research, comprising 45 older adults and 9 adult children who support their parents in accessing healthcare services.

The following groups and interviews were conducted.

**Table 3. Participant profiles and modes of engagement**

| Group | Segment profile | Method | Location |
|---|---|---|---|
| Group 1 | Women, 65–75 | Online | Mixed locations |
| Group 2 | Men, 65–75 | In person | Outer metro Melbourne |
| Group 3 | Women, 75–80 | In person | Metro Melbourne |
| Group 4 | Men, 75–80 | Online | Mixed locations |
| Group 5 | First nations women, 60+ | In person | Melbourne |
| Group 6 | LGBT+ older adults, 65+ | Online | Mixed locations |
| Group 7 | Older adults (65+) from culturally and linguistically diverse (CALD) backgrounds | Online | Mixed locations |
| Group 8 | Adult children of parents aged 65+ from CALD backgrounds | Online | Mixed locations |
| Group 9 | Adult caregivers of parents aged 65+ | Online | Mixed locations |
| Interviews 1–3 | Women, 80+ | Telephone, online or in person | Mixed locations |
| Interviews 4–6 | Men, 80+ | | |
| Interviews 7–8 | First Nations men, 60+ | | |

# Limitations

## Desk research limitations

The desk-based research conducted was a narrative review rather than a systematic review. This approach was selected to provide a clear and practical synthesis of the available contemporary literature.

There are notable gaps in contemporary Australian literature. Importantly, the review identified a lack of comprehensive data to estimate the prevalence and extent of ageism in healthcare settings in Australia. Additional gaps exist in areas such as older adults' personal accounts of perceived ageism in healthcare settings and the intersectional experiences of ageism.

While priority was initially given to contemporary research from Australia, New Zealand, and the United Kingdom, older publications and other international sources were included to address gaps in the evidence. These documents offer valuable insights but should be interpreted with appropriate caution due to contextual and systemic differences across jurisdictions.

## Selection and reporting bias

Participants in the qualitative component were recruited based on self-identification of having experienced ageism in healthcare settings. This purposive sampling approach is useful for exploring complex, lived experiences in-depth. However, it may introduce selection bias by excluding individuals who have not recognised or reported such experiences. Additionally, the findings are based on self-reported data, which may be influenced by recall bias, subjective interpretation, or emotional framing. Collectively, these factors may affect the objectivity and breadth of perspectives captured, potentially skewing the findings towards more salient or negative experiences.

## Lack of generalisability

The generalisability of the findings is limited due to the small, non-representative nature of the participant sample. The research involved a relatively small group of participants with a demographically narrow profile, which may limit the applicability of the insights to the broader population of older adults across diverse regions, cultural backgrounds, and healthcare contexts in Australia. While the study provides rich, context-specific insights, its findings should not be assumed to reflect universal experiences.

# Appendix

**Appendix A: Definitions**

| Term | Definition |
|---|---|
| Health care / healthcare | In line with the terminology used by the Australian Commission on Safety and Quality in Health Care,[175] throughout this document, the Commission uses 'health care' as a noun (eg, 'prevalence of ageism in health care') and 'healthcare' as an adjective (eg, 'healthcare services' or 'healthcare settings'). |
| Health professionals | Refers to individuals who provide healthcare services, including doctors, nurses, and allied health professionals. Where participants identified the specific role of a practitioner, that designation is used (eg, General Practitioner). |
| Healthcare settings | Describes specific healthcare environments in which health care is delivered, such as clinics, consultation rooms, and hospitals. The scope of this research included acute, primary, and secondary healthcare settings. Mental health services were not a specific focus, and aged care systems were excluded. |

**Endnotes**


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