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International Journal for Equity in Health

REVIEW

Open Access

# Mapping gendered ageism in health care: concepts, contexts, and gaps

Hanna Köttl[1*], Nadia Primc[2,4] and Elisabeth Langmann[3*]

## Abstract

**Background** While ageism and sexism are increasingly acknowledged as critical determinants of health and health care, the concept of "gendered ageism" remains under-theorised and empirically underdeveloped, with notable gaps in conceptual clarity and engagement with how age and gender co-construct discrimination in health contexts.

**Objective** This scoping review maps how gendered ageism is conceptualized and studied in health-related contexts, with particular attention to definitional patterns, analytical levels, intersectional framing, and empirical gaps.

**Method** A scoping review was conducted to identify and categorize literature on gendered ageism in health-related contexts, focusing on its manifestations, consequences, lived experiences and analytical treatment across micro-, meso-, and macro-levels. A structured extraction framework was used to analyse study characteristics, conceptualisations of gendered ageism, levels of analysis, and patterns of exclusion.

**Results** Fifteen studies were included. The evidence base is small, heterogeneous, and largely descriptive. "Gendered ageism" is frequently named but rarely defined. Three framings recur: (1) sexism-structured ageism, in which gender norms shape the content of age-based devaluation (e.g., credibility and appearance norms), (2) an age-gender disparity label that documents who is disadvantaged without specifying mechanisms, and (3) a smaller, intersectional strand linking age-gender disadvantage to racism, classism, ableism, heterosexism, and labour precarity. Across different domains, studies indicate diagnostic delays, dismissal, and poorer service at age-gender intersections, especially for midlife women, LGBTQIA+ older adults and ethnic minority women. Intersectionality is more often invoked than operationalized; and existing measures rarely capture gendered mechanisms across micro, meso, and macro levels. Evidence is skewed toward cisgender women, later life, and the Global North.

**Conclusions** Conceptual ambiguity and measurement gaps limit comparability and intervention design. Progress requires clearer construct specification, gender-sensitive and intersectional measures, multilevel mixed-methods linking macro discourse to clinical practice, broader inclusion across gender identities and life stages and comparative work beyond the Global North. These steps can help move the field from naming to reducing gendered ageism in the context of health.

**Trial registration** Not applicable.

**Keywords** Gendered ageism, Intersectionality, Health equity, Scoping review, Ageism, Sexism, Epistemic injustice

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## Background

Age and gender are major social determinants that shape health, illness, and access to care across the life course, influencing symptom appraisal, diagnostic pathways, and treatment decisions from the clinical encounter to institutional structures (World Health Organization, [63], [64]). Sex refers to biological attributes (e.g., chromosomes, hormones, reproductive anatomy), while gender encompasses socially constructed roles, identities, and norms (World Health Organization, [65]); both dimensions interact with age to influence how health and illness are perceived, interpreted, and managed across the life course.

Within health systems, *ageism* - stereotypes, prejudice, and discrimination based on age - operates at individual, institutional, and structural levels [33] and is associated with measurable adverse outcomes including reduced quality of care, worse health, and substantial societal costs [11]. As a pervasive phenomenon, ageism is embedded in social interactions, institutional practices, legal frameworks, and policy structures on a global scale ([36]; World Health Organization, [63]). In parallel, a substantial evidence base documents that *sexism* in medicine contributes to diagnostic delays, suboptimal pain management, and structural inequities [1, 47], and that sex and gender act as modifiers of disease and therapeutic response [42].

Recognizing that ageism and sexism each independently structure health-related inequities, yet frequently intersect in ways that compound vulnerability, scholars have introduced the concept of *gendered ageism* to capture and theorize the joint operation of age- and gender-based disadvantage.

Gendered ageism can be understood as the co-constituted interplay of age- and gender-based stereotypes, prejudice, and discrimination as they manifest in beliefs, practices, and institutional structures, jointly shaping access to care, clinical processes, and health outcomes across the life course [35, 56]. The term is widely traced to the work of Itzin et al., [32], who examined age-related barriers in employment, and was subsequently expanded through theoretical contributions that emphasize its location within interlocking power structures (e.g., Krekula et al., [35]. Notably, neither ageism nor gendered ageism adheres to a single agreed-upon definition across the literature; the formulations presented here therefore represent widely used working definitions rather than consensus.

Beyond age and gender alone, scholarship increasingly documents how gendered ageism is patterned by race/ethnicity, sexuality, disability and class, with implications for health and care. Studies of racially minoritized older women point to compounded barriers in credibility, access, and safety in clinical and community settings (Merodio, 2024); work on older lesbians and LGBTQIA+ elders highlights heteronormative assumptions and stigma shaping symptom appraisal, disclosure, and service navigation; and disability and class further structure exposure to, and buffering from, age–gender disadvantage [40]. While this evidence remains emergent, especially in health contexts, it underscores why intersectionality is analytically necessary for specifying for whom, under what conditions, and through which institutions gendered ageism is produced.

In recent years, the concept of gendered ageism has been explicitly explored in the context of health care [20, 37, 46, 67], work [28, 45, 56], the media [2, 23, 58], justice and law enforcement [57], family relations, inheritance, and land and property ownership [57], violence, abuse and neglect [57] as well as in the context of societal norms around appearance-related ageing [10, 27]. Building on these cross-domain insights, health and health care are understood as key sites where gendered ageism is produced, enacted, and potentially mitigated. In positioning gendered ageism, we also briefly situate it relative to related constructs (e.g., ageism, sexism, intersectionality, minority stress, and 'doing' gender) to clarify what is analytically distinct about the age - gender nexus in health.

The operation of gendered ageism within health systems can be understood across interconnected levels [66]. Ageism operates at individual, institutional, and structural levels [33], and the same is true of sexism [13]. Examining gendered ageism across these interconnected micro-, meso-, and macro-levels is therefore essential to understanding how interpersonal encounters, organisational practices, and broader policy environments jointly shape health experiences and outcomes."

Although scholarship examining the intersection of age and gender has expanded considerably, the existing evidence base remains fragmented, limiting the development of a coherent understanding of gendered ageism in health and health care contexts. This conceptual fragmentation limits the field's capacity to build cumulative knowledge, identify mechanisms, and translate findings into policy or practice. In addition, work in this area is dispersed across disciplines and settings, and the field as a whole shows important gaps in scope, population coverage, and analytical focus.

In light of these gaps, a scoping review is well suited to systematically map how gendered ageism is conceptualized and studied within health and health care contexts. Such an approach enables examination of the full breadth of available evidence, synthesis insights across diverse domains, and clarification of conceptual and analytical boundaries that remain underdeveloped. To better comprehend the concept of gendered ageism and to build a

foundation for future work, this scoping review addresses four research questions:

1. How is *gendered ageism* defined and conceptualized in the context of health and health care contexts?
2. What are the scope and characteristics of existing studies on gendered ageism in health and health care contexts, including geographical distribution, methodological approaches, and disciplinary orientations?
3. At which analytical levels (micro, meso, macro) is gendered ageism examined, and how do studies conceptualise its operation across these interconnected levels within health and health care contexts?
4. Which populations, identities, and forms of disadvantage remain underrepresented or invisible in existing research, and what conceptual, methodological, or empirical gaps emerge from these patterns of exclusion?

Through these questions, we aim to advance conceptual clarity, synthesize how gendered ageism is framed and studied across health and health care contexts, and identify critical gaps that must be addressed to inform equitable policy and practice. Ultimately, this review seeks to support the development of more robust theoretical foundations and evidence-based strategies to understand and mitigate the intersecting inequalities shaping health and ageing.

## Methods

This scoping review follows the methodological framework proposed by Arksey and O'Malley [4], expanded by subsequent refinements in scoping review guidance [38, 53]. This approach was selected to systematically map the breadth of empirical evidence on gendered ageism in health and health care contexts, including its manifestations, consequences, and the lived experiences of those affected. The design allows for the inclusion of diverse study types and disciplinary perspectives, enabling a comprehensive exploration of how gendered ageism is conceptualized and investigated across settings and populations. In line with the study's goals, the review also examines conceptual, methodological, and empirical gaps within the existing literature to inform future research directions and policy development [4]. To ensure a transparent, comprehensive, and methodologically robust process aligned with the study's aim of mapping and synthesizing empirical evidence on gendered ageism in health and health care contexts, this review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews [39, 60]. Screening, eligibility assessment, data extraction, and synthesis were managed using a structured Microsoft Excel spreadsheet developed for this review. The spreadsheet was used to document screening decisions, track study eligibility, and organize extracted data throughout the review process.

### Search strategy

A comprehensive literature search was conducted across five electronic databases to identify empirical evidence explicitly referencing the concept of "gendered ageism" in health and health care contexts. The databases searched were PubMed, CINAHL, Cochrane Library, Scopus, and Web of Science. The initial search strategy was developed in June 2025 and iteratively refined over several meetings between June and August 2025 to ensure conceptual clarity and alignment with the review's aim of mapping how gendered ageism is defined, operationalized, and investigated in the literature. The final search was conducted on 28 August 2025. No publication date restrictions were applied, as the emerging and relatively limited nature of the evidence base warranted a comprehensive examination of the concept from its earliest appearances onward.

Because this scoping review focuses specifically on the concept *gendered ageism*, the search was limited to studies using this exact term in the title, abstract, or keywords. This approach was chosen to preserve conceptual specificity and to avoid conflating gendered ageism with related but distinct constructs such as ageism, sexism, double jeopardy, or intersectionality. To account for spelling differences, the search included two variants of the term, "gendered ageism" and "gendered agism", linked with the Boolean operator OR. In PubMed, the search was restricted to the Title/Abstract field because author-assigned keywords are not consistently indexed in this database. In contrast, searches in CINAHL, Scopus, Web of Science, and the Cochrane Library allowed the inclusion of database-specific keywords and subject headings, which were incorporated whenever available. For illustration, the PubMed search string was: ("gendered ageism"[Title/Abstract]) OR ("gendered agism"[Title/Abstract]). Equivalent versions of this search string were adapted for the respective syntactic requirements of each database. This decision was made to prioritize conceptual specificity over maximal sensitivity and may have led to the exclusion of adjacent work analyzing similar dynamics under different labels.

Although the review addresses gendered ageism in health and health care contexts, no health- or health care-related terms were added to the search string. Following methodological guidance for scoping reviews, the search was kept focused on the central concept, while contextual relevance was assessed during screening rather than at the database-search stage [52, 54]. In preliminary searches, we also found that studies explicitly mentioning

*gendered ageism* were typically linked to health or ageing contexts even if the term "health" did not appear in the title or abstract [46, 56]. For these reasons, we kept the search focused on the exact concept and assessed health relevance during screening. For screening, "health and health care contexts" were operationalized as studies with a clear link to (i) health conditions, symptoms, illness experiences, or well-being; (ii) health care encounters, services, or systems (including long-term care); or (iii) health-relevant work and organizational settings where health, illness, or care practices were substantively addressed. Studies limited to general social perceptions without an explicit link to health were excluded.

#### Study screening and eligibility assessment

During the screening process, we applied a set of predefined inclusion and exclusion criteria to ensure that only studies directly relevant to the review's focus were considered. To be included, a study had to explicitly mention the term *gendered ageism* in the title, abstract or keywords, as the review concentrated on work that engages directly with this specific concept. We included original research articles and review papers published in peer reviewed journals, written in English, and situated within a health and health care contexts. We excluded publications in languages other than English, as well as commentaries, opinion pieces, and study protocols, because the review was restricted to peer-reviewed original and review literature. Screening was conducted systematically, with each record evaluated against these criteria before progressing to full-text review.

#### Data extraction and analysis

Data extraction was conducted using a structured framework designed to capture the conceptual, methodological, and empirical characteristics of each included study in accordance with the aims of this review. Data were extracted independently by two of the three reviewers (HK, NP, EL) for each study, and extracted entries were compared to ensure completeness, accuracy, and consistency. Any differences were discussed and resolved through consensus, with a third researcher available to support adjudication when needed.

The coding grid used for extraction was developed deductively from the study objectives and refined inductively during a pilot phase using three sample studies assessed jointly by all researchers (HK, NP, EL). This allowed the team to test the clarity of categories, adjust the depth of conceptual dimensions, and ensure the grid reflected the multidimensional nature of gendered ageism in health and health care contexts. The final extraction framework included fields for bibliographic details, study characteristics, levels of analysis of gendered ageism (micro, meso, macro level), and conceptualization of gendered ageism. Because gendered ageism is often shaped by who is seen, heard, or counted in research and practice, the synthesis incorporated a dedicated analysis of patterns of exclusion. During this step, we examined how studies defined their populations, whose experiences were centred, and which groups remained invisible. This allowed us to trace cross cutting dynamics - for example, how individual experiences of dismissal or marginalisation may be shaped by institutional practices and further reinforced by structural trends in research and policy. This analytic strategy enabled us to produce a comprehensive, multi-level map of how gendered ageism is conceptualised, experienced, and embedded in health and health care contexts, alongside the structural silences and ethical implications that require attention in future research and policies.

## Results

A detailed overview of the screening and eligibility process is presented in the PRISMA flow diagram (Fig. 1). Two reviewers independently screened all 80 titles and abstracts. Initial agreement was reached for 72 of 80 records (90.0%), while 8 records (10.0%) were flagged for discussion due to discrepancies, most often relating to uncertainties about health relevance or publication type. These discrepancies were resolved through a consensus process that included consultation with a third assessor, who acted as an adjudicator when consensus could not be reached immediately. Following this process, 20 of 80 records (25.0%) proceeded to full-text screening.

During the full-text stage, all 20 articles were again assessed independently by two reviewers based on the predefined inclusion and exclusion criteria, with a third reviewer available to support consensus in cases of disagreement. Of the 20 articles assessed in full, five were excluded. Four were excluded because, although they engaged with perceptions of ageing or lookism, they did not sufficiently address health conditions, health settings, or concrete health-related experiences. One article was excluded because it was a study protocol rather than an eligible original research article or review paper.

#### Scope and characteristics of the reviewed studies

The studies included in Table 1 differ markedly in their geographical locations, methodological approaches, theoretical orientations, and institutional as well as socio-cultural settings, reflecting the multilayered and heterogeneous ways in Which gendered ageism is investigated within the field of health and health care.

A substantial line of research examines workplace health and organisational dynamics, highlighting how gendered age norms shape the treatment, visibility, and valuation of women - particularly but not exclusively during midlife transitions. Studies such as Targett and Beck

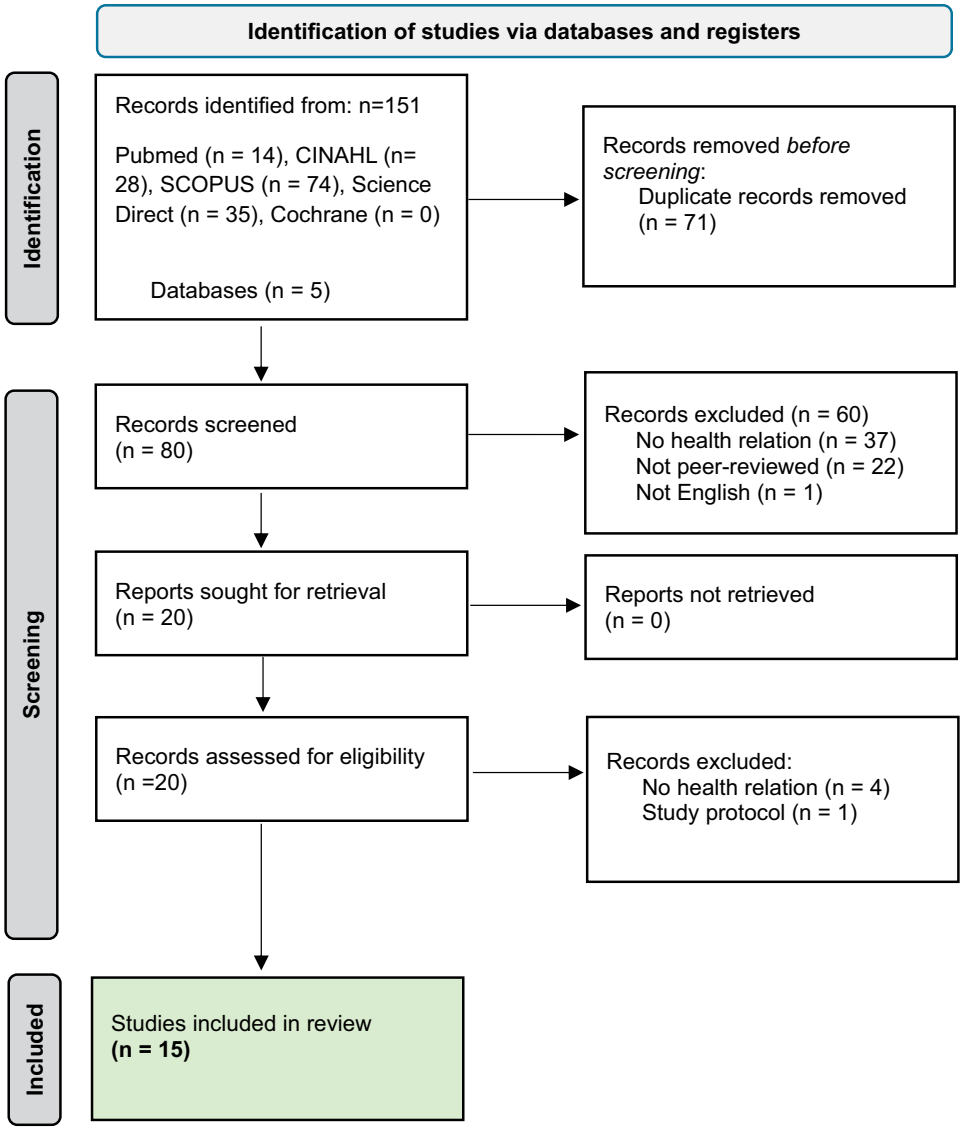


**Fig. 1** Source: Tricco, 2018. This work is licensed under CC BY 4.0. To view a copy of this license, visit https://creativecommons.org/licenses/by/4.0/

[59], Atkinson et al., [5], Earl and Taylor [22], and Beck et al., [6] show that gendered ageism manifests in performance expectations, disclosure norms, supervisory practices, and status hierarchies within feminised sectors like long-term care as well as male-dominated professions such as policing. These investigations illustrate how organisational logics, including neoliberal productivity frameworks and "ideal worker" cultures, reproduce age-gender biases that influence health, wellbeing, and career trajectories.

A second cluster centers on health care interactions, diagnostic processes, and clinical decision-making. Arber et al., [3] provide experimental evidence that patient gender and age jointly affect diagnostic thoroughness and treatment decisions for coronary heart disease, while Langmann et al., [37] discuss how ageist and gendered assumptions in medicine may lead to diagnostic errors and epistemic injustice in the care of individuals with (post)menopausal endometriosis. Merodio et al.,'s review [46] broadens this perspective, documenting widespread gendered ageism in health care systems globally and its intersectional amplification for women experiencing racism, disability, or socioeconomic disadvantage. These studies collectively underscore how gendered ageism is embedded within clinical reasoning, institutional norms, and broader structures of biomedical knowledge.

A third field of work focuses on media, public discourse, and cultural representations, revealing how gendered ageism circulates through communicative environments that shape public understandings of ageing and health. McCartan's analysis of UK magazine advertising [44] and Orgad and Rottenberg's longitudinal study of

**Table 1** Overview and characteristics of the included publications

| | **Study characteristics:** Study type; study design; type of analysis; sample / population | **Research Aim(s)** | **Key Results / Findings** | **Geographic Context Study context** |
|---|---|---|---|---|
| 01_Targett & Beck, 2022 | **Study type:** Empirical<br>**Study design:** Quantitative survey<br>**Type of analysis:** Quantitative analysis<br>**Sample / population:** N = 189 council workers; adults transitioning through menopause; age 25–64 (majority mid-40s to mid-50s); 89.4% white | Examines workers' experiences and reactions to an integrated health-and-well-being approach to menopause in a UK local council, while assessing its effectiveness and the contextual workplace factors that shape menopause transitions. | Menopause symptoms similar to prior studies; many respondents proactively seek support. Low awareness but high desire for workplace menopause resources. Menopause perceived as ageing and taboo. Reports of gendered ageism, sexism, vertical segregation, racism, and hostile workplace culture. Integrating menopause into broader wellbeing strategies seen as acceptable, though long-term effects remain unclear. | UK - one local council<br><br>Work context |
| 02_Yoeli et al., 2021 | **Study type:** Narrative Review<br>**Study design:** Narrative methodology using a systematic literature-retrieval approach<br>**Type of analysis**: Interpretive analysis of published studies to appraise arguments, generate critical discussion, and inform ongoing debates<br>**Sample / population**: Menopausal women in the Global North working in casual, informal, or precarious jobs | Reviews evidence on the health impact of casual work upon menopausal women, and specifically upon the menopausal symptoms they experience. | Casual work does not seem immediately harmful to menopausal women and may even support emotional coping; however, women in precarious jobs report more musculoskeletal pain than vasomotor symptoms, experience high anxiety linked to lifelong poverty, ill-health and caring burdens rather than work itself, and their menopause-related wellbeing is shaped more by early-life disadvantage than by current employment conditions. | Global North<br><br>Work and health (care) context |
| 03_Langmann et al., 2025 | **Study type**: Theoretical<br>**Study design**: n/a<br>**Type of analysis:** Intersectional analysis from the perspective of epistemic injustice<br>**Sample / population:** n/a | To examine the intersection of age and gender in the diagnosis and treatment of endometriosis through the lens of epistemic injustice: To explore the extent to which the diagnostic and treatment challenges faced by older women with endometriosis are related to the epistemic injustices they experience in medicine and health care. | The study uses an epistemic justice lens to show how age and gender intersect in shaping endometriosis experiences, highlighting that limited knowledge among clinicians and patients and insufficient recognition of lived experience contribute to injustice. Because endometriosis is framed as a condition of reproductive age, symptoms in (post)menopausal individuals are often misattributed due to ageist and sexist assumptions, leading to delayed diagnosis and mistreatment. | N/a<br><br>Health (care) context |
| 04_Arber et al., 2006 | **Study type**: Empirical<br>**Study design**: Randomized factorial video-vignette experiment (2×2×2×2 design), varying patients' gender, age (55/75), class, and race<br>**Type of analysis**: Quantitative statistical analysis (ANOVA; square-root transformation; pooled UK/US analyses; interaction tests)<br>**Sample / population:** 256 primary care doctors/GPs: UK (West Midlands, Surrey/SE London) and US (Massachusetts); response rates: 65% US, 60% UK | To examine how patient gender, age, class, and race influence doctors' decisions about CHD, assess whether these factors produce significant differences across UK and US practitioners, and determine whether clinical decisions align with known risk profiles. | Gender significantly shaped doctors' CHD decisions: women were asked fewer questions, received fewer diagnostic tests, and were prescribed less appropriate medication, with midlife women receiving the least appropriate care overall. Men were taken more seriously despite identical symptoms. Age effects were mixed: older patients received more diagnostic tests and earlier return visits, but no general age differences appeared for questioning, examinations, prescribing, or referrals. A UK-specific pattern emerged: older patients received more tests but fewer cardiology referrals, suggesting possible ageism; no such age effects appeared in the US. | UK and US<br><br>Health (care) context |
| 05_Loy-Ashe et al., 2024 | **Study type**: Empirical<br>**Study design**: Mixed-methods (quantitative survey + qualitative interviews)<br>**Type of analysis:** *Quantitative*: t-test, One-Way ANOVA, one-sample median test; Shapiro–Wilk test for normality; Levene's test for homogeneity. *Qualitative*: NVivo-supported open coding, axial coding, and thematic analysis.<br>**Sample / population:** Frontline long-term care workers: nurses (n=10), clinical coordinators (n=4), nursing assistants (n=3), social workers (n=2), recreational therapist (n=1), dietitian (n=1). Survey: n=56 LTC employees (all female). Interviews: n=21 employees. | To explore long-term care (LTC) employees' attitudes towards age and gender. | Employees' attitudes and interactions with residents reflected compassionate ageism, ableism, and identity-based perceptions. While most felt emotionally connected to residents, they simultaneously distanced themselves from ageing and feared their own future limitations. Staff preferred residents who were compliant, grateful, and aligned with their expectations of "good" ageing. Power dynamics were evident: employees valued their identity as carers, viewed residents as vulnerable, sought to protect them (especially during COVID-19), equated dependence with lower quality of life, and sought approval through positive interactions. Quantitatively, middle-aged employees (36–55) showed significantly higher ageism scores (FSA) than both younger (18–35) and older (56+) staff. | USA, more specifically LTC facility (2 campuses) located in a densely populated high-income state capitol in the northeastern region of the US.<br><br>Work and health (care) context |

**Table 1** (continued)

| | | | | |
|---|---|---|---|---|
| 06_McCartan, 2025 | **Study type**: Empirical<br>**Study design:** Longitudinal content analysis (4-year period) of UK women's magazines; additional literature review on historical menopause representation<br>**Type of analysis**: Quantitative & qualitative content analysis; deductive coding using an adapted postfeminist framework (Windels et al., 2020)<br>**Sample / population:** 195 digital editions of 4 UK women's lifestyle magazines; all ads referencing "menopause" or "menopausal" (May 2020–April 2024) | To examine how menopause is represented in magazine advertising by analysing the incidence of menopause-related ads, assessing the use of postfeminist discourses over time, and identifying dominant narratives that shape gendered ageism in media portrayals of female ageing. | Postfeminist discourses dominated the ads, promoting a "hold on to youth/hold on to self" message that made menopause visible without challenging gendered ageism. Representations emphasized continuity, control, and youthfulness rather than disruption. Over time, cosmetic menopause-related ads declined, with a relative increase in non-cosmetic product advertising. | UK<br><br>Health (care) and media context |
| 07_Beck et al., 2021 | **Study type:** Theoretical<br>**Study design:** Critical reflective case study of policy design and implementation (University of Leicester), integrating activist experience and illustrative survey testimony (Menopause Survey 2018)<br>**Type of analysis:** Reflexive conceptual and feminist organizational analysis supported by illustrative qualitative data<br>**Sample / population:** Organisation-level case (UK university); 5,399 survey respondents (working women in menopause transition or post-menopause) | To critically reflect on academic activism in implementing a workplace menopause policy and analyse how gendered ageism and performance-management frameworks shape menopausal women's experiences, using Meyerson & Kolb's (2000) change model to move beyond liberal individualism toward post-equity discourse change, and to identify what structural and cultural transformations are needed given that policies alone are necessary but insufficient. | Menopause policies were found to be necessary but insufficient, as gendered ageism and neoliberal performance-management systems continue to marginalize older women. Performance practices - such as capability procedures, short-absence penalties, and pressures to avoid disclosure - can disadvantage menopausal employees. Organizational activism can raise visibility but risks reinforcing individualistic, business-case framings when not paired with structural change. Overall, "maximize attendance" logics and productivity-focused agendas undermine equity and sustain inequalities. | UK<br><br>Work and health (care) context |
| 08_Girbés-Peco et al., 2025 | **Study type**: Empirical<br>**Study design:** Qualitative study exploring experiences of older women in three grant-of-use (GOU) cooperative housing projects (two senior, one intergenerational) in Madrid and Barcelona; data collected via two focus groups and two communicative daily-life stories, plus documentary review<br>**Type of analysis**: Communicative methodology; matrix with three deductive categories (community living, sovereignty in ageing, gendered ageism) and two dimensions (transformative vs. exclusionary); thematic analysis<br>**Sample / population:** 10 older women involved in three GOU (grant-of-use) cooperative housing initiatives; focus groups (N=2), communicative life stories (N=2), documentary materials (minutes, care guides, reports) | Examines how older women's participation in GOU cooperative housing projects in Spain impacts their subjective well-being, specifically focusing on three key areas: community living, autonomy in ageing, and experiences of gendered ageism. | Community living enhanced women's self-perceived well-being by fostering active participation, intellectual engagement, meaningful contribution, and a strong sense of belonging. In terms of sovereignty in ageing, participants described gaining control over their lives by rejecting traditional patriarchal caregiving expectations and embracing shared decision-making and self-care through the GOU model, which supported agency and autonomy. Regarding gendered ageism, involvement in the cooperatives encouraged reflection on ageing and helped participants recognize and challenge internalized ageist attitudes; interactions within their communities were experienced as less gendered and less ageist, reinforcing more positive and empowered ageing identities. | Spain:<br>three cooperatives were selected: two urban cooperatives - a seniors cooperative and an intergenerational cooperative – in Barcelona (northeastern Spain) and a seniors cooperative in a rural area of Madrid (central Spain).<br><br>Health care context |
| 09_Orgad & Rottenberg, 2023 | **Study type**: Empirical<br>**Study design**: Longitudinal media analysis (Jan 2001–Dec 2021)<br>**Type of analysis**: Quantitative frequency analysis + qualitative discursive review of peak periods<br>**Sample / population:** 9,080 UK newspaper articles (headlines/lead paragraphs containing "menopause" or variants) from 8 major UK newspapers | To examine menopause's media visibility, framing, and the socio-cultural forces driving it by assessing whether coverage has increased, how it is distributed across newspapers, identifying peaks linked to specific topics or events, and analysing what these peaks reveal about the forces shaping menopause's current visibility. | There was a sharp increase in menopause visibility in UK newspapers over the 20-year period, driven primarily by celebrity narratives, policy attention, HRT debates, and neoliberal empowerment discourses (reported as absolute frequency). Rising visibility reflected broader social, cultural, and economic forces, including popular neoliberal feminism, celebrity culture, UK workplace and health policy shifts, biological womanhood framings, and the commercial influence of Big Pharma. | UK<br><br>Media, work and health (care) context |

**Table 1** (continued)

| | | | | |
|---|---|---|---|---|
| 10_Beck et al., 2018 | **Study type**: Empirical<br>**Study design**: Collective autoethnographic memory-work on applying for, producing, and disseminating a government-funded menopause research report, analysed through 13 autoethnographic vignettes<br>**Type of analysis**: Collective, autoethnographic and reflexive analysis of memory-work vignettes<br>**Sample / population:** 3 middle-aged, academic, cisgender women working in a British university | To examine how conducting a government-funded study on menopause and economic participation affected the researchers themselves, exploring how the research process shaped their identities, emotions, and understandings of gendered ageism, and demonstrating that research topics not only are shaped by researchers but also act back upon them. | The analysis revealed how conducting menopause research reshaped the researchers' own relationships to menopause: initial professional detachment shifted as they recognised their own symptoms and confronted the personal and political dimensions of the topic, though they repeatedly reverted to ingrained norms of academic objectivity. They also experienced the menopause taboo firsthand and occasionally reproduced stereotypical assumptions. Boundaries between public/work and private selves blurred throughout the project. Ethical tensions emerged, including unintentionally prompting audience self-diagnosis without counselling expertise. Finally, the researchers acknowledged the limited intersectionality of their work, noting that their perspectives - as cisgender, middle-class academic women - excluded dimensions such as race and sexuality. | UK<br><br>Work and health (care) context |
| 11_Earl & Taylor, 2016 | **Study type**: Empirical<br>**Study design**: Mixed-methods case study of one residential care organisation: pre-intervention Work Ability Survey (WAS) + follow-up focus groups<br>**Type of analysis**: Descriptive statistics from WAS; inductive thematic analysis of focus-group transcripts (coded thematically)<br>**Sample / population:** Residential-care workforce: WAS (2013) - 605 invited, 112 respondents (~18%); mostly full-time, roles: direct care workers (51%), nurses (25%); ages 18–62 (mean 46). Focus groups (2014) - 25 participants (10 direct care workers, 8 nurses/supervisors, 7 senior managers); predominantly older, long-tenured, female-dominated (4 men, all in supervisory roles) | To examine how age- and gender-based stereotyping shapes everyday supervision, status, and task allocation in an ageing, female-dominated residential-care workforce; to highlight that age discrimination affects younger as well as older workers; to show that older workers can also perpetrate age-based bias; and to use work-ability measures to inform organisational interventions and policy development. | Everyday supervision, status, and task allocation were shaped by strong age and gender stereotypes, with older workers both targeted by and participating in ageist and sexist attitudes. Maternal life experience was valued over formal qualifications, while younger and less-experienced staff were often devalued. Although workers reported high job meaning and satisfaction and low overall perceived discrimination, they expressed dissatisfaction with supervisor support, communication, and co-worker reliability. Tensions emerged between home/family expectations and professional workplace norms. | Australia<br><br>Work and health (care) context |
| 12_Cozza et al., 2022 | **Study type**: Theoretical<br>**Study design**: Theoretical / conceptual review<br>**Type of analysis**: Critical interdisciplinary analysis of biohacking as a case of transhumanism, focusing on enhancement and age-intervention goals<br>**Sample / population:** No empirical sample; analysis focuses on cultural discourses, the biohacking community, and the transhumanist movement | To critically examine biohacking as a transhumanist response to ageing and its sociotechnical implications | The study identifies four conceptual frameworks that shape biohacking's approach to ageing: molecularisation, functional age, optimisation, and quantification. It further outlines four major implications of biohacking for cultural understandings of ageing: (1) a tension between the narrative of liberation through enhancement and the reality of intensified self-disciplinary practices driven by bio-data; (2) the creation of hierarchies of human value based on modifiable fitness and performance; (3) the reinforcement of gendered ageism within enhancement practices; and (4) ethical concerns regarding potential harms and the challenge of exceeding perceived natural limits of human life. | Global, with examples from U.S., Finland, Sweden<br><br>Health (care) and work context |
| 13_Danylova et al., 2024 | **Study type:** Review<br>**Study design:** Systematic search in PubMed, Scopus, Web of Science, and Google Scholar using predefined search terms.<br>**Type of analysis:** Phenomenological, philosophical, hermeneutic, and inductive approaches within an interpretive research paradigm<br>**Sample / population:** Women over 40 | To unveil gendered ageism and to identify its negative impact on women's mental health. | The review describes gendered ageism affecting women over 40 across media, workplace, beauty norms, sexuality, and mental health. It argues that ageing women face a gendered double standard, social invisibility, and pressures to maintain youthfulness. Reported impacts include body dissatisfaction, anxiety, depression, and reduced career opportunities, with intersectional disadvantages for women facing additional forms of discrimination. The article assembles examples and secondary statistics but does not apply a systematic synthesis or analytical framework. | No specific geographic context mentioned or analysed; examples and cited studies primarily from Western/Global North contexts<br><br>Work, Health(care), media and other contexts |

**Table 1** (continued)

| | | | | |
|---|---|---|---|---|
| 14_Atkinson et al., 2021 | **Study type:** Empirical<br>**Study design:** Cross-sectional mixed-methods survey<br>**Type of analysis**: OLS regression, logit regression, factor analysis, thematic coding<br>**Sample / population**: N = 1,197 peri- and post-menopausal women in UK police forces | To explore embodied experiences of menopause in the workplace, examine gendered ageing, and analyse how gendered ageism operates through material-discursive processes in a male-dominated organisational context. | Menopausal symptoms (fatigue, sleep disturbance, cognitive difficulties) significantly affect workplace experiences but are shaped by organisational context and gendered age norms. Disclosure is limited due to stigma and a hyper-masculine, ideal-worker culture, reflecting clear gendered ageism and penalties for women whose bodies deviate from these norms. Supportive, age-positive or female-dominated environments mitigate negative experiences and enhance women's agency. | UK<br><br>Work and health (care) context |
| 15_Merodio et al., 2024 | **Study type:** Literature review of empirical studies (PRISMA)<br>**Study design**: PRISMA-guided database search (Web of Science Core, MEDLINE, SciELO), eligibility criteria applied, full-text screening, final sample: 43 empirical studies.<br>**Type of analysis**: Qualitative synthesis using an Excel-based analysis matrix (country, methodology, sample, incidence of ageism/sexism, intersections, positive experiences).<br>**Sample / population**: 43 studies; focus on women aged 65+; includes LGBTQ+ elders, ethnic minority women, women with disabilities, and both institutionalised and community-dwelling populations. | To map gendered ageism and intersectional inequalities in older women's health, examine the incidence of gendered ageism and related intersectional harms on the health and well-being of women aged 65+, and identify positive experiences and strategies to counter ageism and sexism across health, participation, and education. | Gendered ageism is widespread in health care and intersects with racism, ableism, heterosexism, and classism, resulting in treatment disparities, poorer mental and physical health outcomes, reduced access to services, and increased risk of abuse - effects further intensified during the pandemic. Social support structures and empowerment-focused activities appear protective. | Global<br><br>Media, work and health (care) and other context |

Note. For each study, the table summarises: (1) key study characteristics (study type, design, analytic approach, and sample/population); (2) the stated research aim(s); (3) major findings related to gendered ageism; and (4) the geographic and substantive study context. Context categories (e.g., work context, health(care) context, media context) reflect the primary domain in which gendered ageism was examined. Abbreviations: ANOVA = Analysis of Variance; CHD = Coronary Heart Disease; FSA = Fraboni Scale of Ageism; GOU = Grant-of-Use cooperative housing model; HRT = Hormone Replacement Therapy; LTC = Long-Term Care; NVivo = Qualitative analysis software; OLS = Ordinary Least Squares regression; PRISMA = Preferred Reporting Items for Systematic Reviews and Meta-Analyses; UK = United Kingdom; US = United States.

newspaper coverage [50] show that menopause and older womanhood are increasingly visible yet framed through youthfulness, neoliberal empowerment, and commercial logics that reaffirm gendered age hierarchies. Danylova et al., [20] further highlight how cultural expectations surrounding beauty, sexuality, and femininity reinforce psychological vulnerability and social marginalisation among ageing women.

Another group of studies investigates community-based and alternative care settings, including cooperative housing models and long-term care facilities. Girbés-Peco et al., [26] illustrate how collaborative living arrangements can challenge internalised ageism, support autonomy, and foster more empowered ageing identities among older women. In contrast, Loy-Ashe et al., [41] show that long-term care workers - many middle-aged women themselves - hold ambivalent attitudes that blend empathy with ageist and gendered expectations, influencing their interactions with older residents and shaping workplace cultures.

Finally, conceptual and critical analyses, such as Cozza et al., [18] and the reflexive autoethnography by Beck et al., [6], extend the field by interrogating the sociotechnical, ethical, and epistemic dimensions of gendered ageism. These contributions demonstrate how broader discourses - ranging from transhumanist enhancement cultures to academic research practices - produce new forms of age-gender boundary-making and self-regulation, revealing that gendered ageism is not only institutional but also deeply embedded in cultural narratives, technologies, and knowledge practices.

Although the geographical spread includes the US, Australia, and Spain, the evidence base is dominated by UK and Global North research [3, 5, 22, 26, 44, 50, 59], with several papers adopting transnational or theoretical lenses rather than a single-country focus (e.Merodio et al., [46], Yoeli, [67].

Methodologically, the reviewed studies show a mix of approaches, with a clear predominance of empirical research ($n$ = 9). This includes quantitative surveys [59], experimental vignette designs [3], cross-sectional mixed-methods workplace surveys [5], mixed-methods organisational studies [22, 41], qualitative community-based work [26], autoethnographic memory studies [6], and large-scale media analyses [44, 50]. Qualitative and mixed-methods designs therefore play an important role across workplace, community, and organisational contexts. A smaller number of contributions are purely theoretical ($n$ = 3), offering conceptual, feminist, or epistemic analyses [7, 18, 37]. Finally, several review-based studies ($n$ = 3) synthesise or critically discuss existing scholarship, including narrative, interpretive, and PRISMA-guided approaches [20, 46, 67].

**Table 2** Micro-, meso-, and macro-level dimensions of gendered ageism addressed in the included publications

| Study | Micro | Meso | Macro | Primary focus of analysis |
|---|---|---|---|---|
| 01_Targett & Beck, [59] | x | x | x | Meso level |
| 02_Yoeli et al., [67] | x | x | x | Macro level |
| 03_ [37] | x | x | x | All three levels |
| 04_Arber et al., [3] | x | limited | limited | Micro level |
| 05_Loy-Ashe et al., [41] | x | x | limited | Micro level |
| 06_McCartan, [44] | limited | x | x | Macro level |
| 07_Beck et al., [7] | x | x | x | Meso level |
| 08_Girbés-Peco et al., [26] | x | x | x | Micro level |
| 09_Orgad & Rottenberg, [50] | limited | x | x | Macro level |
| 10_Beck et al., [6] | x | x | x | Micro level |
| 11_Earl & Taylor, [22] | x | x | x | Micro and Meso level |
| 12_Cozza et al., [18] | x | limited | x | Macro level |
| 13_Danylova et al., [20] | x | x | x | All three levels |
| 14_Atkinson et al., [5] | x | x | x | Micro level |
| 15_Merodio et al., [46] | x | x | x | All three levels |

Most studies included in our scoping review are descriptive, which points to the lack of much needed intervention studies to evaluate the effectiveness of interventions simultaneously addressing gendered ageism at the micro, meso, and macro levels.

#### Gendered ageism as a phenomenon on the micro, meso-, or macro-level

Another objective of our scoping review was to examine at which levels gendered ageism is being investigated and discussed as a phenomenon within health care and health-related research. We categorized studies based on their analytical focus: micro-level investigations of individual experiences and interpersonal encounters, meso-level examinations of organisational and institutional practices, or macro-level analyses of broader social structures and cultural discourses. This categorization allows us to identify patterns in how researchers are approaching gendered ageism and to highlight underexplored dimensions of this phenomenon in health care and health-related contexts.

The three categories were defined as follows:

1) **Micro level**: studies examining individual experiences and perceptions of gendered ageism in personal or interpersonal encounters.
2) **Meso level**: studies examining gendered ageism at the level of institutional and organisational structures, practices, and guidelines.
3) **Macro level**: studies examining gendered ageism in the context of broader social discourses, cultural norms, public policies (national/global), structural inequalities, or media representation.

Our analysis (see Table 2) shows that ten studies discuss gendered ageism at all three levels, emphasizing the interrelatedness of gendered ageism as a phenomenon that operates at the different closely connected levels. In our analysis, we differentiate between the "primary focus of analysis" and the levels of gendered ageism addressed and acknowledged in the different studies (e.g., in the discussion and interpretation of the results). 13 studies address (amongst others) the micro-level, but only five studies primarily focus on gendered ageism on the micro level, i.e. how gendered ageism affects individuals (one study having an equally strong focus on the meso level). Three studies primarily focus on the meso level and focus predominantly on the macro level.

#### Patterns of exclusion and invisibility

Our analysis reveals systematic patterns of exclusion that render certain populations invisible in research on gendered ageism in health and health care. Nearly all studies operate within a cisgender, binary gender framework. Trans men, non-binary people, and gender-diverse individuals who experience menopause or ageing are systematically excluded, with their experiences remaining unanalyzed. While some studies acknowledge this exclusion as a limitation of their own study design, this acknowledgment does not translate into inclusive research practice.

Similarly, diversity of sexual orientation remains largely invisible across the included studies. Only one study [46] explicitly examines LGBTQIA+ older adults' experiences. The vast majority of studies assume heterosexual frameworks when discussing relationships, reproduction, and ageing, thereby rendering non-heterosexual experiences of gendered ageism invisible.

Intersectionality gaps constitute another significant pattern of exclusion. While some studies acknowledge intersectionality as important, most fail to more deeply

analyze how race, class, disability, and other identities intersect with gendered ageism. Study samples are predominantly white, middle-class, and from Western/Global North contexts. This geographic concentration results in the near-complete absence of voices from the Global South, creating substantial knowledge gaps about how gendered ageism operates in majority-world contexts. The overwhelming focus on Western and Global North perspectives (e.g. UK, US, Australia, Spain) limits our understanding of gendered ageism as a global phenomenon.

Even within the Global North, working-class and precarious workers remain underrepresented. Despite menopause and ageing affecting all women, most studies center the experiences of professional, permanently employed, middle-class women. Casual workers, though explicitly centered in one study (Yoeli et al.), remain understudied overall. Furthermore, studies focusing on media representations (McCartan; Orgad & Rottenberg) reveal how white, wealthy, celebrity women's experiences are amplified in shaping public discourse, while ordinary and marginalized women remain invisible. This amplification of privileged voices through media analysis may inadvertently reproduce rather than challenge existing hierarchies of visibility.

### Conceptualisations of gendered ageism across the literature

The included studies vary both in whether they define gendered ageism explicitly and in how the concept is (explicitly or implicitly) theoretically framed. Concerning the latter, three recurring conceptual positionings emerged. Turning first to the question of definitional grounding: Across the included literature, three papers provide an explicit definition of gendered ageism [22, 26]. Earl and Taylor, [22] locate gendered ageism in a "double jeopardy" framing, conceptualising it as the compounded disadvantage arising from the interaction of age- and gender-based discrimination [32]. By contrast, Girbés-Peco et al., [26] define gendered ageism as intersecting age- and gender-related biases operating across institutional, interpersonal, and self-directed levels, shaping older women's self-perception, confidence, and agency.

In addition, 10 papers invoke gendered ageism implicitly. For example, the term "gendered ageism" is used without a standalone definitional statement, but it is nevertheless mobilised in the framing or interpretation of findings (e.g., [3, 6, 7, 59, 67]). Finally, two papers do not define the concept at all: Cozza et al., [18] mention gendered ageism only briefly without conceptualisation or operationalisation, while Langmann et al., [37] include the term only as a keyword.

These conceptual and definitional tendencies reveal that gendered ageism is rarely theorised as an autonomous construct. Much more, most papers treat gendered ageism as a term, derived from the joint dynamics of ageism and sexism, rather than introducing it as a novel construct with its own boundaries, mechanisms, or operational criteria (e.g., [5, 7, 20, 46, 50]). Thereby the following three recurring positionings became visible:

1. Gendered ageism as ageism structured through sexism

   Most papers position gendered ageism as ageism whose content and penalties are shaped by gender-specific norms – including standards of appearance, credibility, and professional legitimacy. Ageism provides the logic of decline and diminished value; sexism determines the criteria through which ageing women are evaluated and penalised (e.g., youth and beauty standards, norms of bodily management, and credibility or professionalism). Gendered ageism is thus understood as a feminised variant of ageism rather than as a distinct intersectional process. One paper defines this relationship explicitly [26], while several others rely on the same framing without offering a standalone definition [5–7, 20, 59].

2. Gendered ageism as an age-gender interaction dynamic

   A second positioning uses gendered ageism descriptively, as shorthand for observed age-gender differentials in outcomes or treatment, without specifying the social logics that produce them. Disadvantage is inferred from its concentration among women at particular ages or life stages, for instance, in clinical decision-making patterns [3] or where menopause is treated as a salient life-stage marker shaping workplace experiences [5]. Here, the analytic emphasis lies on distributional patterning (meaning who is disadvantaged and when) rather than on explicating the social logics that produce that pattern. As a result, the "gendered" dimension is registered empirically, but the structuring role of sexism in shaping what counts as age-related decline, competence, or appropriateness remains largely implicit.

3. Gendered ageism as an intersectional construct

   A smaller subset conceptualizes gendered ageism as anchored within interlocking systems of

power, where intersectionality is not a contextual add-on but an analytical framework specifying for whom, under what conditions, and through which institutional arrangements gendered ageism is enacted. Intersectionality is here treated as the framework that stratifies, amplifies, or mitigates how this core intersection operates across additional axes. Merodio et al., [46] most exemplify this approach most fully, framing gendered ageism as "multiple discrimination" grounded in the interplay of ageism and sexism, and mapping its compounded manifestations across racism, heterosexism, ableism, and classism in health and care settings. Similarly, Yoeli et al., [67] situates menopausal experiences in precarious work within a wider matrix of intersecting inequalities, although the notion of "intersectionally gendered ageism" remains more invoked than defined. Girbés-Peco et al., [26] also gestures toward intersectionality as constitutive, but develops class and economic inequalities most concretely, while other axes remain less analytically elaborated. Thus, across the corpus, intersectionality is frequently acknowledged as relevant to gendered ageism, yet its analytic role varies: in several studies it appears primarily as background or limitation [6, 7, 20, 44], whereas a smaller subset uses it to structure analysis and to specify how gendered ageism is compounded through institutional arrangements and social positioning [46, 67]; with a more limited operationalisation in Girbés-Peco et al., [26].

Across the included studies, feminist theory provides the most visible framework in cultural-discursive accounts linking gendered ageism to norms of femininity and self-management [44, 50], while critical gerontology and ageing studies appear more as implicit background orientations than as explicitly elaborated frameworks across the corpus.

## Discussion

This scoping review mapped how the term *gendered ageism* is conceptualised and investigated in health-related research. A central finding is that the term is increasingly invoked but rarely defined or theorised in ways that specify mechanisms, boundaries, or analytic criteria. Across the included studies, *gendered ageism* often functions more as a broad label for age- and gender-patterned disadvantage than as a clearly articulated construct. Although the reviewed literature spans workplace contexts [5, 59], clinical encounters [3], community settings [26], and media discourse [44, 50], the evidence base remains small, heterogeneous, and predominantly descriptive. Together, these patterns indicate that gendered ageism is increasingly named in health-related research, but not yet consistently developed as an analytic construct.

### Conceptual uses and its consequences

Our analysis reveals three recurrent conceptual positionings across the included literature: gendered ageism as ageism structured through sexism, as a descriptive label for age-gender patterned disadvantage, and as an intersectional construct. These positionings are not merely terminological variants, much more they reflect fundamentally different assumptions about what gendered ageism is, where it operates, and what would count as evidence for it. This matters because when the same term is used to describe structurally different phenomena, analytic coherence is weakened and cross-study comparability becomes difficult.

The first two positionings, which together account for the majority of included studies, share a tendency to treat age and gender as analytically separable dimensions whose effects combine or stack. This is consequential: when gendered ageism is understood as feminised ageism or as observed age-gender differentials, the focus falls on who is disadvantaged rather than on the social logics producing that disadvantage. Mechanisms – the norms, institutional arrangements, and power relations through which age-based devaluation acquires gendered content – remain underspecified. As a result, findings across studies are difficult to compare, and the targets of potential interventions remain unclear.

The third positioning, though less common, points toward a more productive analytical direction. By treating the age-gender nexus as a site where multiple systems of power interact, intersectional accounts move beyond distributional description toward mechanism specification. However, even here, intersectionality remains more of an orientation than an operationalised methodological framework – acknowledged in framing but rarely built into study design, sampling, or analysis.

A recurring thread across these conceptualisations is the persistent reference to the "double jeopardy" model, which frames gendered ageism as the additive effect of ageism and sexism. While historically important in drawing attention to compounded disadvantage, "double jeopardy" has long been critiqued in feminist and intersectionality scholarship [19, 32, 62] for flattening complexity. Additive models imply that age and gender operate as separate systems whose effects merely "stack," rather than recognising their co-constitution - a point emphasised in Black feminist scholarship [15] and in critical gerontology, which argues that gender structures the very meaning of ageing [9, 14]. From this perspective, *gendered ageism* cannot be adequately understood as ageism plus sexism but requires approaches that analyse

how age-based devaluation is already gendered in content, form, and consequence.

This lack of mechanism specification is also reflected in the limited engagement with adjacent theoretical frameworks that could help explain how gendered ageism is produced and sustained. For example "doing gender" [61] could illuminate how age and gender norms are enacted in everyday interactions, while minority stress theory [43], and equitable ageing perspectives, including recent work on LGBTQIA+ ageing [51], could help specify how age-gender disadvantage is intensified through stigma, exclusion and institutional non-recognition. These frameworks were not explicitly mobilised in the included studies, although they certainly point to important resources for future theorization. At the same time, gendered ageism's distinctive contribution remains its explicit analytic focus on how age and gender co-constitute forms of disadvantage in health and health care contexts.

Overall, the conceptual landscape is fragmented. The same term is used to describe structurally different phenomena, weakening its analytic coherence and limiting its utility for cumulative theorisation. Studies focusing on interpersonal encounters [3], organisational culture [41, 59], or structural inequities in health systems [46] often operate with different assumptions about what constitutes gendered ageism yet rarely articulate these distinctions explicitly. As a result, outcomes, mechanisms, and levels of analysis remain difficult to align across studies.

This conceptual inconsistency also has practical consequences for intervention design and measurement. When the object of analysis is not clearly specified, the targets of change – whether stereotypes, workplace norms, clinical guidelines, or institutional structures – remain unclear. Similarly, measurement and operationalisation are weakened by the absence of tools that capture the gendered content of ageism. Most studies rely on generic ageism measures or ad hoc items not designed to detect gendered mechanisms or health-system manifestations, as seen in survey-based work on menopausal employees [59], cross-sectional police surveys [5], long-term care workforce studies [41], and clinical vignette experiments lacking gender-specific ageism constructs [3]. This constrains the field's ability to identify the gendered dimensions of ageist attitudes, compare effects across settings, or evaluate change following interventions.

Building on this analysis, we propose a working definition: gendered ageism refers to the processes through which gender norms configure the content, meaning, and impact of age-based evaluation, interaction, and resource allocation across micro-, meso-, and macro-levels of health systems. Unlike additive framings that treat gendered ageism as a derivative of ageism plus sexism, this definition views gender not as a variable that compounds ageism but as structuring the very logic through which ageing is evaluated and acted upon. This definition provides analytic boundaries flexible enough to apply across diverse contexts while sufficiently specific to guide measurement and intervention. Importantly, such clarity must extend to operationalisation: researchers should specify which dimensions of gendered ageism are being captured, at which analytical level, with which indicators, and through which mechanisms. Only through explicit operational markers - such as behavioural manifestations, institutional arrangements, or policy logics - can the construct be measured consistently, compared across studies, and translated into actionable intervention targets.

### Gendered ageism in health systems: interpersonal, organisational, and structural dynamics

Although both ageism and sexism are known to be highly prevalent in health care settings, relatively few studies have explicitly examined gendered ageism in this context. This scarcity is partly rooted in the way health research has historically treated age and gender as separate analytical domains - age being addressed within gerontology and later-life medicine, and gender largely confined to reproductive or women's health [13]. Such disciplinary silos leave little conceptual or methodological space for examining their intersection. Moreover, the dominance of biomedical framings in clinical research tends to foreground biological risks and individual pathology, rendering socio-structural mechanisms - such as gendered norms of credibility, embodiment, or suffering - less visible as objects of empirical study [24, 30, 48].

By contrast, areas such as work and media studies, where social inequality, representation, and power relations are central analytical concerns, have incorporated intersectional critiques earlier and more extensively, making gendered ageism more readily identifiable, measurable, and theorised (e.g., [19, 21]). This differential uptake is also linked to the disciplinary landscapes that dominate research in these domains. Media studies, labour studies, and organisational sociology have long foregrounded social stratification, symbolic power, and the cultural construction of bodies, positioning them conceptually closer to intersectionality than the more biomedical or epidemiological orientations typical of health research [25, 49].

The available evidence, though limited, consistently points to how gendered ageism manifests across levels. At the micro level, experimental evidence shows that midlife women receive less thorough clinical assessment for coronary symptoms than their male counterparts, underscoring how age-gender assumptions shape diagnostic pathways in real time [3]. At the meso level, organisational analyses reveal how institutional norms around credibility, embodiment, and suffering structure clinical

plausibility and the recognition of older patients' experiences [37]. At the macro level, precarious labour arrangements shape menopausal health and access to support in ways that exceed individual clinical encounters [67], while a systematic review of 43 studies documents widespread inequities – including diagnostic delays, heightened risks of abuse, and exclusion - particularly among LGBTQIA+ individuals, ethnic minority women, and women with disabilities [46]. Taken together, these findings suggest that gendered ageism in health systems is not reducible to interpersonal bias alone. Rather, what appear as individual clinical encounters are shaped by organizational norms and constraints, while those organizational patterns themselves draw legitimacy from wider societal narratives and policy architectures [35]. Understanding gendered ageism therefore requires attention not only to mechanisms within each level but to the ways in which these levels shape, amplify, and stabilise one another, producing system-wide patterns that cannot be addressed through micro level interventions alone. This also resonates with policy concerns about structural barriers to equitable care raised in WHO's *Global Report on Ageism* (2021), which documents the systemic and institutional nature of age-based discrimination in health systems worldwide. This implies that interventions focused only on individual attitudes are unlikely to be sufficient if organisational routines and structural conditions remain unchanged. Developing such a multi-level understanding, however, depends on first broadening the empirical and conceptual scope of the field – particularly with respect to which populations are centred and which remain invisible.

#### Exclusion, invisibility and the limits of current knowledge

To understand gendered ageism more fully, it is also necessary to examine who is currently recognised as a subject of research and who remains underrepresented in the evidence base. This requires a broader conception of who counts as a subject of gendered ageism. In line with earlier evidence [16, 17], our scoping review found that the existing literature on gendered ageism continues to focus predominantly on cisgender women, with little attention to men, transgender, non-binary, or otherwise gender-diverse individuals. This narrow operationalisation of gender reflects broader exclusions documented across global ageing research and restricts the scope of empirical work on how age and gender interact. A further gap concerns the life-course focus: studies largely concentrate on later life, while midlife-marked by shifting norms around work, embodiment, and care remains underexamined, despite evidence that age-related disadvantage can emerge long before chronological old age [31, 34].

These empirical omissions highlight a deeper conceptual issue: the lack of sustained integration between gender studies and ageing studies. Without theoretical frameworks that account for gender diversity and interlocking systems of inequality, research risks reproducing binary assumptions that obscure the heterogeneity of ageing experiences. This is particularly evident in health care settings, where age and gender shape clinical expectations, communication patterns, and access to services, but where gender continues to be conceptualised in limited, binary terms.

Intersectionality provides a conceptual foundation for addressing these limitations. Rather than treating gender as a binary variable that interacts additively with age, an intersectional framework analyses how gender, in its full diversity, is co-constituted with age, race, class, disability, and sexuality within specific institutional and structural arrangements [12, 19]. Applied to gendered ageism in health systems, this means moving beyond the question of whether cisgender women are disadvantaged relative to cisgender men, toward asking how age-based evaluation acquires different meanings and consequences depending on gender identity, embodiment, and social positioning. This shift is not merely about inclusion, but is analytically necessary, because binary framings of gender obscure the mechanisms through which gendered ageism operates and limit the field's capacity to specify for whom, under what conditions, and through which institutional arrangements age-gender disadvantage is produced.

A global lens further reinforces this point. Most studies in our review that explicitly examine gendered ageism originate from the Global North, while reports from international organisations consistently document gendered barriers to care - such as disrespect, delays, and limited autonomy - in low- and middle-income contexts (Help Age International, [29]; World Health Organization, [63]). These disparities suggest that research must attend both to gender diversity and to regional variation in health-system structures if it aims to capture the full range of mechanisms through which gender and age shape health care experiences.

Together, these considerations point toward a clear direction for the field. Addressing the empirical gaps documented in this review, i.e. the dominance of cisgender women, the concentration on later life, and the Global North bias, is not simply a matter of broader sampling. It requires theoretical frameworks that treat gender as diverse, relational, and co-constituted with age and other axes of inequality. Intersectionality provides precisely this foundation, enabling researchers to specify not only who experiences gendered ageism but how, under what conditions, and through which institutional arrangements it is produced and sustained across health systems.

### Limitations

This scoping review is subject to several limitations that should be considered when interpretating its findings. First, the underlying evidence base is small, heterogeneous, and predominantly descriptive. *Gendered ageism* is invoked inconsistently and seldom defined in the primary literature, limiting cross-study comparability and precluding formal synthesis or causal inference. Most included studies were cross-sectional or qualitative and rarely tested mechanisms or intervention effects. Measurement tools typically did not capture the specifically gendered content of ageism or intersectional dimensions, constraining assessments of prevalence, pathways, and change over time. Consistent with scoping methodology, we mapped concepts without conducting formal risk-of-bias appraisals or estimating effect sizes; our conclusions should therefore be understood as indicative rather than evaluative.

Second, reporting practices in primary studies further restricted analysis. Sex assigned at birth, gender identity, and other equity-relevant variables (e.g., race/ethnicity, class, disability, sexuality) were inconsistently collected, limiting intersectional analyses and potentially masking subgroup differences. The literature remains strongly skewed toward later life and cisgender women, with sparse data on men, transgender, non-binary, and otherwise gender-diverse adults, and on midlife. Third, the review design itself introduced additional constraints. Because the search strategy was intentionally restricted to the five electronic databases and studies explicitly using the term *gendered ageism*, relevant adjacent scholarship using other concepts or labels have been excluded. This applies, for example, to the work of Calasanti and colleagues [8]), as well as Pietilä and colleagues [55] on ageing masculinities and gendered ageism in health and health care contexts. The review was further limited to English-language, peer-reviewed literature indexed in the selected databases, which may have contributed to the underrepresentation of regionally published or non-English research and of work from the Global South. Although the review included studies from multiple domains (workplace, clinical, community, media), grey literature and non-indexed sources were only partially captured. Finally, substantial variability in health system structures, policy environments, and cultural norms across studies was seldom modelled, limiting the transferability of findings across settings.

### Implications for research, policy, and health practice

The multi-level dynamics of gendered ageism identified in this review underscore the need for coordinated progress across research, policy, and practice. For research, the most pressing need is a shift in study design. Almost all included studies are descriptive and none evaluate the effectiveness of strategies to reduce gendered ageism. Moving forward requires multilevel and mixed-methods approaches capable of linking macro-level discourses and policies to organisational routines and clinical decision-making, as well as longitudinal and interventional designs that can test mechanisms and evaluate change. Construct definitions should be stated explicitly, specifying which dimensions of gendered ageism are targeted, at which level, and through which indicators. Broader inclusion of men, transgender, non-binary, and gender-diverse adults, as well as research beyond the Global North and into midlife, will be essential for building a evidence base that reflects the full range of populations affected.

A constructive path forward is to adapt existing ageism measures by incorporating gendered modules that capture appearance and respectability norms, expectations around credibility and competence, menopause- or life-stage-related symptom appraisal, disclosure penalties, and "ideal worker" logics. Complementary to this, developing intersectionally sensitive item banks that can be disaggregated by race/ethnicity, class, disability, sexuality, and gender identity would substantially improve empirical precision. Ensuring content validity and cultural relevance requires participatory co-design with older women and gender-diverse adults. To empirically test cross-level mechanisms of gendered ageism, multilevel designs linking macro-level media and policy discourses, meso-level organisational routines, and micro-level interactions are needed.

At the policy level, a fundamental step is recognising gendered ageism as a distinct equity concern. Integrating age-gender indicators into quality assurance, patient-safety monitoring, and anti-discrimination frameworks would enable more systematic identification of disparities. Equity audits, public reporting, and funding structures aligned with the reduction of gendered ageism can drive organisational accountability. In health practice, reducing gendered ageism requires attention to how age and gender shape clinical reasoning, communication, and decision-making. Training that focuses on these mechanisms, together with affirming care for transgender and non-binary adults, can help disrupt entrenched biases. Embedding brief prompts for identifying diagnostic overshadowing or dismissal, updating care pathways where disparities are documented, and stratifying quality metrics by age-gender will support real-time improvement. Inclusive clinical environments, appropriate documentation practices, and reflective oversight processes - such as case reviews attentive to age/gender bias - can further embed equity into everyday care. Only coordinated action across research, policy, and practice, can shift the field from naming gendered ageism to systematically understanding, measuring, and reducing it across health systems.

## Conclusions

This scoping review demonstrates that gendered ageism is increasingly referenced in health research yet remains conceptually diffuse and inconsistently operationalised. The term is often used descriptively or framed as an additive "double jeopardy" of ageism and sexism, with relatively few studies defining mechanisms or specifying analytic levels. We note that ageism itself is not defined uniformly across the literature [33], and gendered ageism is marked by similar conceptual variation. Our proposed working definition is therefore intended as a pragmatic analytic resource for health research rather than a prescriptive, final resolution. Where evidence does exist, it consistently points to disadvantages at age-gender intersections, e.g. visible in diagnostic delays, clinical dismissal, credibility deficits, and poorer service quality across different settings. These processes operate through interconnected micro-level encounters, meso-level organisational norms, and macro-level policy and discursive environments, underscoring the need for multi-level analysis.

To build a cumulative and theoretically coherent evidence base, we propose the following working definition: gendered ageism refers to the processes through which gender norms shape the content, meaning, and impact of age-based evaluation, interaction, and resource allocation across health-system levels. Unlike additive framings, this definition treats gender not as a variable that compounds ageism but as structuring the very logic through which ageing is evaluated and acted upon. Progress requires clearer construct definitions, explicit theorisation of mechanisms, and the development of gender-sensitive, intersectionally adaptable measures capable of capturing credibility, embodiment, life-stage expectations, and organisational logics. Methodologically, multilevel and mixed-methods designs that link macro-level discourse and policy to organisational routines and clinical decision-making will be essential.

Empirically, future work should broaden its scope by including men, transgender, non-binary, and gender-diverse adults, extending inquiry into midlife, and conducting comparative, context-sensitive research beyond the Global North. For policy and practice, embedding age-gender equity indicators into quality and safety systems, updating clinical pathways where disparities are documented, strengthening mechanism-focused training, and creating affirming, inclusive care environments represent immediate priorities.

By mapping the conceptual landscape of gendered ageism and identifying where clarity, measurement, and action are most urgently needed, this review provides a foundation for that shift - from naming gendered ageism to specifying, measuring, and ultimately reducing it across health systems.

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**Author contributions**
All authors contributed to the conceptualization of the scoping review. HK developed the search strategy, inclusion and exclusion criteria, and the coding grid, with repeated feedback from NP and EL. HK conducted the literature search. Data analysis was carried out collaboratively by all authors. HK led the writing of the original manuscript draft, with all authors contributing text. All authors reviewed and edited the final manuscript.

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**Data availability**
No datasets were generated or analysed during the current study.

## Declarations

**Ethics approval and consent to participate**
No ethical approval was required for this study due to the nature of the scoping review, which involved no human participants or identifiable personal data.

**Consent for publication**
Consent for publication was not required, as this study is a scoping review of published literature and includes no individual data.

**Competing interests**
HK declares no competing interests. EL and NP serve as guest editors for the collection Gendered Ageism in Healthcare: A Critical Analysis of Structural Inequities. The editorial process for this submission will be managed independently of the authors.

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