



Original Article

Aging And Age discrimination: a regional case study in Southern Italy

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Abstract

Calabria, an underdeveloped region in the Southern Italy, represent a significant sociological context in which demographic pressure, institutional fragilities, and cultural representations of old age intersect, shaping the everyday service experiences of older people (School, Health, Mobility). This study analyzes the interpretations of a sample of Calabrian older adults residing in municipalities in the province of Cosenza regarding age, aging, and aged-based discrimination (ageism) on their access to health services. Our assumption is that ageism influences the social construction conditions of access to services for older adults in Calabria. The theoretical framework brings together studies on active and healthy aging in Italy and Calabria with ageism studies, and the new socio-materialistic approach known as Sociogerontechnology, linking the living conditions of older people to their use (or lack of use) of digital technologies. The study employs an exploratory qualitative design based on six Focus Groups conducted between November 2025 and February 2026 in a sample of 56 participants aged 60 and over resident in the City of Cosenza and other municipalities of Province (a mix of urban town and rural villages). Data were analyzed through a qualitative approach focusing on in-depth understanding of how older adults negotiate ageist stereotypes, articulate meanings of aging, and describe their encounters with healthcare providers and institutions. The findings highlight the interplay between personal biographies, cultural expectations surrounding old age, ageism and organizational constraints within Calabria's healthcare systems.

Keywords: *Sociology of aging; ageism and self-ageism; older adults in Calabria; Province of Cosenza; access to healthcare services; qualitative research.*

1.Introduction

In the context of international and European Union strategies (European Parliament 2021), healthy and active aging is defined as the ability to maintain functional capacity

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over the course of one's lifetime (WHO 2023). The *National Plan for Non-Self-Sufficiency 2022-2024* is Italy's contribution to specific aging policies, but its effectiveness is strongly affected by local contexts (Barbabella and Principi, 2020).

Aging is a biological process that is greatly influenced by social representations of what it means to be old. These representations, especially when permeated by *ageism* (a mix of stereotypes, prejudices, and discrimination related to age), generate strong and systemic inequalities in access to healthcare services and in their quality (Butler 1969; Yeves, Bargstead, and Marrero-Vega, 2025). Ageism is widespread in healthcare settings with increasing risks of disease, hospitalization, and biological frailty, leading to poorer health outcomes. The opposite occurs where aging is characterized by better health outcomes (European Commission 2023; The Lancet Health Longevity 2025).

This study aims to explore older adults' perceptions of age, aging, ageism and access to healthcare services in Calabria, a region where demographic aging is rapidly intensifying and creating emerging challenges for both society and the healthcare system. In Calabria today, the gap between northern and southern Italy is even more pronounced, even compared to the rest of Europe (Olivanti, 2021). Through an exploratory qualitative approach (six focus groups), the research investigates how a selected group of older adults living in urban/rural municipalities of the Province of Cosenza (N=56 people) interpret their own aging process, their experience of ageism, and how they deal with local health services.

The research question is: how do subjective representations of aging, such as self-ageism and digital ageism, shape older people's access to healthcare in the province of Cosenza?

We will hold that the social construction of access to services in the province of Cosenza stems from a combination of different forms of ageism (digital and self-ageism), use/non-use of technologies, community context, education, family networks and territorial infrastructure.

2. Aging in Calabria: a look at the province of Cosenza

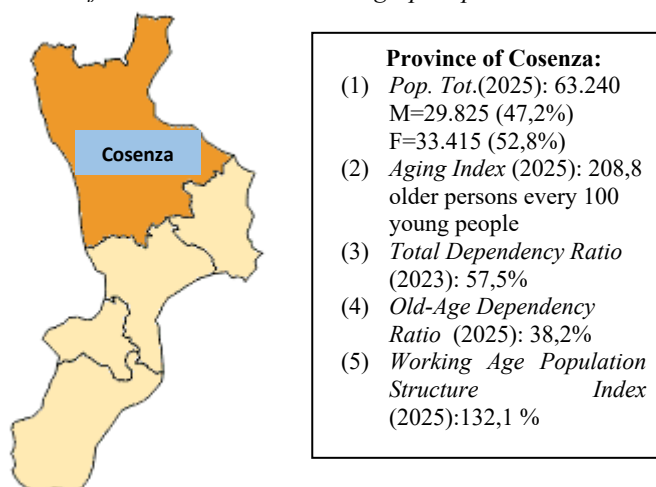
With the Law of 16 May 2018, no.12 The Calabria region (2018) has defined healthy and active aging as a series of integrated policies to enhance the value of older people, preventing dependency and promoting participation, autonomy and inclusion (Di Matteo 2020). When it was enacted in 2018, this legislation lacked regional funding. Only in 2024, after finally defining the 2024-2026 Operational Program, the Calabria Region provided it with substantial European funds that had been available for some time. Calabria is one of the poorest regions in the south of Italy, where structural deficiencies, territorial dispersion (a clear divide between urban and inland areas), demographic aging, youth emigration, the digital divide, and inadequate transport infrastructure all converge. Recent socio-economic and demographic studies also show that the region combines economic fragility and generational imbalances that are more pronounced than in other areas of southern Italy (Cersosimo and Licursi, 2023). This convergence of factors significantly complicates access to welfare services (education, healthcare, mobility) for the elderly population.

The demographic structure of Calabria is no doubt a privileged observatory of the dynamics of aging and inequalities in access to services. In 2025, there were 448,848 elderly people (aged over 65) in Calabria, accounting for 24,45% of the total population (TuttItalia 2025), and also estimating that this rate will reach around 600,000 (36% of residents) by 2050. In the same year, the regional old-age index stood at 196,7, lower than

the national average (199.8) but with strongly sustained growth over the twenty-year period (2004-2024): +78% compared to the national value of +64.2 (Istat 2025).

Given its territorial extent and the coexistence of urban and rural areas with very heterogeneous socio-economic characteristics, the province of Cosenza (Fig.1) represents a sociologically significant case study for the purposes of this document. The province of Cosenza has the highest old-age index (208.8), closely followed by the provinces of Catanzaro (206.2), Vibo Valentia (200.0), Reggio Calabria (184.8), and Crotona (168.6) (TuttItalia, 2025).

Figure 1 - Aging in the Province of Cosenza: the socio-demographic picture



Source: Tuttitalia.it (2025) Istat data processing.

De Rango et al. (2011) describes the specific features of aging in Calabria in terms of the living and sociodemographic conditions of older adults (aged 65–84) and very old adults (aged 85+) in the province of Cosenza, who were the sample group. Even though dated, the same study still confirms the mix of resilience factors (high longevity, active family networks) and structural vulnerabilities (isolation, limited access to services, fragile healthcare system).

The digital divide among older people in Calabria is equally pronounced, although there is a lack of public data broken down by age group (65-74 and 75+). In 2020, Calabria not only ranked last in the national index modeled on the European Union's *Digital Economy and Society Index* (18.8 points out of 100 compared to 72.8 for the regional leader, Lombardy), but also ranked first in terms of the proportion of individuals who have never used the internet (25% of the population), the majority of whom are plausibly elderly (Olivanti, 2021).

The usual means of accessing digital health services (FSE electronic medical records, S.P.I.D digital identity protection system, or C.I.E electronic identity card) are particularly complex for the elderly population. All these observations and the international literature (Ge et al. 2025) seem to suggest a greater risk of digital exclusion from healthcare services for Calabrians over the age of 65.

The municipalities of the province of Cosenza are divided into five project areas (Sila and Presila, Pollino, Sibaritide, Alto Ionio, Reventino-Savuto) of the National Strategy for Internal Areas (SNAI) (2021-2027) of the Department of Cohesion Policies (2026).

This Strategy categorizes municipalities as hub, belt, intermediate, peripheral, and ultra-peripheral, based on their functional distance from essential services (education, healthcare, mobility) and their degree of territorial marginality.

These are all key elements for assessing the socio-health vulnerabilities and inequalities in access to welfare services of elderly population in Calabria. The distribution of municipalities in the internal areas of Cosenza highlights significant concentrations of old-age index: 290.2 (Sila and Presila), 238.6 (Reventino-Savuto) and 169.7 (Alto Ionio). The SNAI classification was taken into account in the selection of the sample municipalities in which this empirical research was carried out, as described below.

3. Theoretical Framework

Three distinct lines of research are intertwined in the background of this study. The first focuses on aging as a global socio-economic issue. The second examines the inseparable creative relationship between old age, technology and ageism. The third is concerned with the transformation of welfare in southern Italy, particularly in Calabria.

Typically, major international institutions (World Bank, UN, WHO) consider aging as a sustainability issue, with high social costs for tax, healthcare (Lama 2023; Horvath et al.2025), and retirement system (Amaglobeli, Dabal-Norris and Gaspar 2020) systems. The rapid growth of the elderly population is therefore a factor of political and economic transformation, redefining priorities, investments, and welfare models.

In the socio-materiality perspective, aging is not a biological process but a co-construction of human actors, artifacts, and digital infrastructures (Cozza, Östlund & Peine, 2020). According to *socio-gerontechnology* (Peine et al., 2021), we are faced with a complex biopsychosocial condition, situated and relational, especially in relation to technologies. Digital technologies and devices for aging people redefine the organizational practices of health and social services and thus shape the daily roles, skills, and dependencies of older adults, and even the content and meaning of being active older adults (Cozza, De Angeli & Tonolli, 2017).

In different territorial contexts, this social process is mediated by bodies, cultural norms, institutions, family networks, infrastructures, and digital devices that legitimize and make accessible to older people values and behaviors that are socially considered “most appropriate” (Cozza et al., 2019). The social-material process of digital aging is shaped by the interplay between people, technologies, places, and institutions.

Within healthcare systems, ageism is a social determinant of health (Mikton et al., 2021) and has a global impact on access to healthcare services, quality of care, and psychological well-being. *Ageism* (age-based discriminations, prejudices, stereotypes) (WHO 2021, Chart of Florence Unger et al. 2024) and *self-ageism* (internalization of age-related stereotypes by older adults) (Köttl et al., 2023) manifest themselves at the macro level (resource allocation principles), intermediary level (organizational practices), and micro level (user-healthcare professional relationships) (Araújo et al., 2023; Fernández-Puerta et al., 2024).

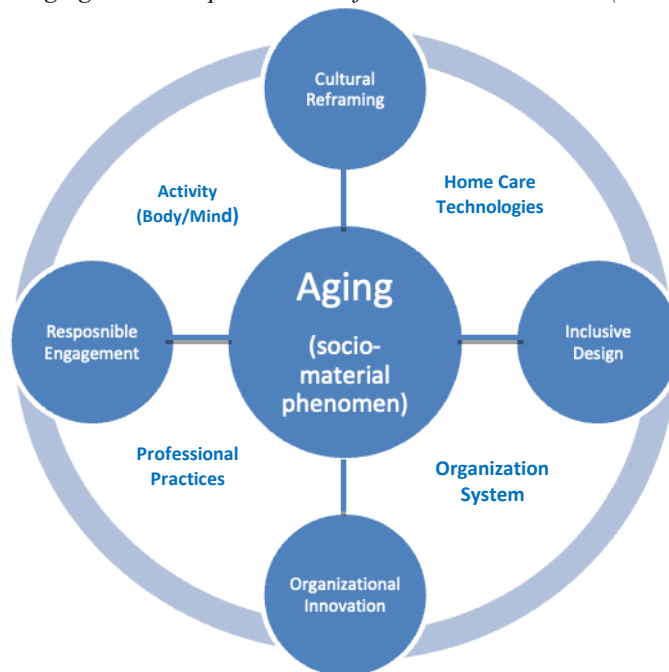
The well-known ageist representations of aging (people who are “frail,” “unproductive,” and “technologically challenged”) justify reduced care, exclusion from new therapies, and lower spending on prevention and rehabilitation, thereby increasing cumulative inequalities over the course of a lifetime (Estes, 1979; Calasanti and Slevin, 2001).

However, new forms of digital discrimination (digital ageism) arise if technologies and services are designed on assumption that users are young, competent, and connected,

and older people are uninformed and resistant (Rosales and Fernandez-Ardèvol, 2020; Mannheim and Köttl, 2024).

At the same time, *Technoagenarians* (Joyce and Loe, 2010) are spreading: non-monolithic groups of older adults who experience aging in complex digital ecosystems, using devices, spaces, and medications to negotiate the meanings of health and illness as conditions for accessing healthcare services. In this non-neutral perspective on technology, Cozza and Cersosimo (2023) propose an integrated model for combating ageism, structured around four dimensions: *responsible involvement*, *inclusive design*, *cultural reframing*, and *organizational innovation* (fig.2).

Figure 2 -Aging: the conceptual model of Cozza and Cersosimo (2023).



Source: adapted from Cozza & Cersosimo (2023).

In socio-gerontechnological studies, there is much debate about ageism affecting older people in social and health services (Whyman et al. 2018; Allegri et al. 2025).

An emerging phenomenon is digital ageism, which excludes older people from digital services because technologies are designed without taking into account their skills, pace, and material conditions. The digitization of public services therefore ends up amplifying inequalities, especially if access depends on platforms, apps, online portals, and digital reports (Rosales and Fernández-Ardèvol 2020).

The most recent literature on local welfare in Calabria highlights significant regional differences and the hardship experienced by elderly people in inland areas (Cersosimo e Licursi, 2023), whose remaining informal social networks are unable to fill the gaps in home-based healthcare and social assistance (Chiodo e Campedelli 2023).

In the three kinds of academic literature we have reviewed, social representations of older people are more often the implicit backdrop than the central object of analysis. From

Butler (1969) to Ayalon and Tesch-Romer (2018), studies on ageism document stereotypes and discrimination but rarely trace them back to service infrastructures.

In particular, there is no systematic analysis of how stereotypes and narratives of old-age actually shape access to local welfare services. This is precisely what this study aims to do.

4. Study design

Through an exploratory qualitative approach (six focus group), the research investigates how a selected group of elderly people living in rural/urban municipalities in the Province of Cosenza (N=56) interpret their own aging process, their experience of ageism, and how they navigate local health services.

Participants and sampling

A total of 56 seniors residing in urban and rural municipalities in the province of Cosenza took part to the study. The participants were selected based on age (range: [60-88]) and place of residence to balance representation between urban and rural contexts, following the aforementioned SNA's classification of the municipalities of Cosenza's Province.

Enrolment combined targeted and convenience sampling to enable participation of individuals with relevant experience, supplemented by snowball sampling during the recruitment phase to reach additional eligible respondents. The composition of the groups was carefully balanced to ensure territorial representation among elderly people living in urban and rural municipalities, as well as diversification in terms of gender, educational qualifications, housing conditions, and familiarity or unfamiliarity with digital technologies (table no.1).

Table no.1 Socio-demographic profile of the respondents. Participant demographic (N=56)

Characteristics	N.	%
<i>Age (year):</i>		
60-74	24	42,86
75-84	22	39,28
85-88	10	17,86
<i>Gender:</i>		
Women	39	69,64
Men	17	30,36
<i>Education:</i>		
Low (none or elementary)	21	37,50
Medium (High School)	24	42,86
High (University Degree)	11	19,64
<i>Income:</i>		
< 1.200 €	31	55,36
1.200-2.000 €	19	33,93
> 2000 €	6	10,71
<i>Housing condition:</i>		
live alone	31	55,36
with children, relatives, friends	25	44,64
<i>Digital Technologies:</i>		

Familiar	11	19,64
Unfamiliar	46	82,14
<i>Total</i>	56	100

Source: author's elaboration.

Data collection

Six focus groups were held using a semi-structured interview guide to explore experiences of aging and simple and digital forms of age discrimination in accessing healthcare. Each focus groups consisted of 8-10 participants and last about 60-90 minutes. Two groups were attended in person (FG1, FG2) and four online (FG3, FG4, FG5; F6) with the aid in talent-scouting of a group of local volunteers. All sessions were recorded with the consent of the participants, transcribed verbatim, and anonymized before analysis.

The conduct of two in-person focus groups and four online focus groups required careful reflection on potential differences in interaction dynamics. This was particularly important given the limited digital literacy of some of the older participants. The assessments carried out did not reveal systematically higher digital skills among the members of the online focus groups; in fact, in many cases, access to the platform was facilitated by family members or caregivers. The topics discussed in the online focus groups did not differ from those gathered in-person, although interaction was slightly less spontaneous in the remote groups.

The Focus Group outline guided participants through six successive stages: an introduction on spontaneous images of aging, followed with exploring age perceptions and local definitions of “elderly” and healthy aging models. It then deepened the exploration of experiences of ageism, including stereotypes, infantilization, and discrimination in health services. From there, it moved on to the central section on the four remedies proposed by Cozza and Cersosimo (responsible engagement, inclusive design, cultural reframing, and organizational innovation). After that, they tackled the topic of access to healthcare services, focusing on care pathways, logistical obstacles, and the role of informal networks. The closing section put together proposals and messages for decision-makers to highlight the needs, desires, and priorities from the perspective of older people.

Data management

Audio files and transcripts were encrypted and stored. Identifiable information was deleted from transcripts and replaced with unique participant codes. All data management was consistent with institutional data protection standards to protect confidentiality and integrity.

Data analysis

The data were analyzed using the six-step thematic analysis theorized by Braun and Clarke (2006) and refined by Naeem et al. (2023).

The researcher performed separate and independent open coding using qualitative analysis software (Nvivo) to identify significant excerpts related to aging and ageism. The codes were iteratively grouped into preliminary themes and refined through ongoing comparison. During the data collection phase, the author was supported by a collaborator who prefers to remain anonymous and was involved only in the facilitation of the focus groups and in the initial interpretation of the material. Discrepancies were resolved through iterative refinement of code definitions. The author is the sole person responsible for the study design, the final analysis, and the drafting of the manuscript.

The analytical process generated a final coding framework with six main themes (e.g., aging, age discrimination in healthcare, age discrimination in the digital world, etc.). The final coding documentation, available upon request, ensures transparency and reproducibility.

Ethical considerations

The study involved human participants and adhered to ethical research standards. All participants provided informed consent after receiving comprehensive information about the study objectives, procedures, and potential risks. Identifiable data were encrypted and anonymized. Participants were informed of their right to withdraw at any time without consequences.

5. Results

The stories we collected reveal some significant differences between age groups, regions, and levels of digital literacy, depicting a complex and nuanced picture about how people see aging, their experiences with healthcare, and their relationship with digital tech. These narratives draw attention to the subtle but recurring dynamics in the construction of internalized prejudices that can compromise the effectiveness of healthy and active aging policies.

The comparison between older adults (over 70) and young older adults (60-69) revealed subtle and recurring dynamics in the social construction of internalized prejudices that hinder healthy aging. For simplicity and clarity, only a few excerpts from the Focus groups considered relevant in relation to the issues identified are included below. Respondents are identified by an anonymous code (gender, age, residence in urban or rural areas) shown in brackets at the end of each excerpt. The study identified seven main thematic areas.

5.1. Aging is not tiring... but it is offensive.

In social representations of the elderly, conformist stereotypes, infantilizing practices, distorted media narratives and imposed identities contribute to the social construction of (unnatural) fragility and infrastructural deficiency.

“I don't feel ‘fragile,’ but everyone considers me to be so... an excuse to make you do what they want!” (M, 75, rural community).

“They talk to you as if you were slow. First, they see your age, and then they see you...” (F, 80, urban community).

“On TV, older people are either wise or senile and always laughing... but what's so funny when you can't find a doctor and you can't go shopping on your own?” (M, 68, rural)

There is also a clear misalignment between participants' perceived identity and the expectations of service providers, which generates frustration and resignation.

“In our area, services always arrive late and no one does anything for us older people. It's better to limit ourselves” (M, 83, rural).

“They don't think much of us and you can't change their minds... it's better to just give up” (F, 71, rural).

Among younger participants (60-74), the desire not to lose their independence is mixed with the fear of being considered “truly elderly”:

“I don't feel old, but at the office counters they look at me as if I've lost my companion. That's why I give up and do it myself” (F, 67, Urban).

"I'm not old enough to be treated like an "old man", but that's how my doctor makes me feel when he spreads his arms and tells me, "It's just the aches and pains of old age". I feel like I'm wasting my time." (M, 66, rural).

5.2. Ageism, self-ageism: feeling "not a priority"

Forms of ageism (simple and digital, self-ageism) generate dependence on informal networks and mistrust of institutions. This is due to digital exclusion, institutional micro-ageism, the blaming of older people, and the presence of technological barriers.

One of the most recurring trends is the self-perception of older people as "not a priority" for the healthcare system.

"At my age, I can't expect too much. There are more important people" (F, 81, urban).

"I didn't want to bother the doctor about something that is natural for my age" (M, 78, rural).

The elderly Calabrians interviewed, perceiving themselves as non-priority, internalize stereotypes about age in different ways, attributing to themselves limitations that actually derive from external barriers. In their stories of resignation, the reasons are intertwined with opposing perceptions: not wanting to burden the system, feeling abandoned by institutions.

"At my age, it's normal not to understand these things... better to let it go" (M, 77, Urban).

"I felt tired, but I didn't go to the doctor because I thought it was my age" (F, 83, Rural).

Ageism can be divided into two types: "conflictual" (mistrust and self-exclusion) and "kind" (gratitude and renunciation).

"Over 70 kilometers for physiotherapy... my son's work is more important" (M, 78, Rural).

"The services don't think much about us older people. It's better to settle for what you have" (M, 83, Rural).

Ageism is implicit in interactions (tone, language, looks) but explicit in organizational practices (fast pace, lack of explanation, reliance on technology).

Some report that health professionals use age as an interpretative shortcut:

"At the doctor's or in hospital, it's always the same story: "It's your age"... but in this way they don't get to the bottom of things" (M, 74, rural).

"They always talk to my grandson as if I were invisible... yet I used to be a nurse" (F, 69, Urban).

Self-ageism also influences relationships with healthcare professionals, causing misunderstandings that reproduce new forms of ageism.

“Out of politeness, I told the nurse to skip the tests. She didn't understand me when she said, ‘You're right, ma'am, don't stress yourself out with all these tests’.” (F, 70, rural)

“I didn't want to bother the doctor, but I expected him to understand, and instead he ended the conversation.” (M, 68, urban)

Such episodes demonstrate the intentional use of ageism by operators, creating a spiral of mutual confirmation that results in less intensive and personalized care pathways. In fact, self-ageism reduces self-efficacy and causes preventive renunciation both in the use of technology and in the request for health services. All this produces inequalities in access and a sense of internalized inadequacy.

5.3. Normalizing decline and giving up on treatment

Many interpret symptoms and ailments as a natural sign of aging, leading to dangerous delays in diagnosis (The Lancet, 2019).

“I have some ailments... normal for my age... doctors ask me to have more check-ups. But how can I? ...too much confusion, waiting lists... I give up... as long as I can walk and move, it's fine” (F, 68, Urb.).

“I don't want to go back to hospital and suffer. Treatment is for young people” (M, 92, Urb.).

The narratives then allow us to reconstruct at least three paths of normalization characterized by decreasing levels of internalized ageism (which instead increases with age) and different motivations for giving up treatment. These paths can be schematized thanks to the fluid classification of old age (“Third Age”) proposed by the Italian Society of Gerontology and Geriatrics (2018). “Young old people” (aged 64-74) consider decline to be “manageable” and refuse treatment due to the complexity of services and waiting times (urban profile) or due to limited access and a culture of not disturbing others (rural profile). The “old” (75-84 years) consider it “limiting” and do not seek treatment due to mobility difficulties, fear of burdening their children (urban profile) or a mixture of fatalism and distance from services (rural profile). For the “very elderly” (85-99 years old), decline is “natural and definitive” and they no longer believe in treatments that are perceived as useless (urban profile) or no longer suitable for their age (rural profile).

The tendency to normalize decline is consistent with the literature on life courses documenting the influence of biographical interpretations on the demand for care (Clemente and García-Pereiro 2020).

5.4. Access to services and technology: some ambivalence

Access to services is affected by asymmetries in digital skills, which then translate into waiting times, bureaucratic and mobility barriers, selective access through relationships, non-inclusive digitalization, and formal rights only. The digitalization of health services (single digital booking centre, digital reports, apps) is not neutral but defines who can access them easily and who cannot.

“I don't know how to use the app... it's a system that doesn't work for us old-fashioned people!” (F, 70, Urban)

“The report is on the internet? ... but here the connection is intermittent” (M, 73, Rural).

Many respondents use digital technologies to maintain relationships with distant relatives (messages and video calls) or for pure entertainment (games and TV shows). However, the use of more complex technologies (online booking of medical appointments, use of apps, SPID) raises concerns, cultural mistrust and lack of confidence in their own abilities among respondents, particularly those over 70 compared to those in their 60s, even if only due to visual impairments. And sometimes this can create tension with services and operators.

“I use my smartphone for everything, even booking appointments. But when I'm at the counter, they treat me condescendingly... as if I don't understand anything!” (M, 68, Urban)

“With my “modern” mobile phone... I play games, I see my relatives in Milan... the other gadgets (SPID, apps) are not for me!” (F, 75, Rural)

“I use my phone to check my test results, but then at the CUP they tell me it's better if I bring someone younger... so why bother learning?” (M, 67, Rural)

“I feel capable, but then the doubt of the counter staff convinces me that it's not for me” (F, 71, Urban).

Technology becomes a filter for healthcare citizenship, especially in rural municipalities in inland areas where connectivity is less stable. Digital infrastructure (connection, devices, skills) is a constituent factor of the experiences of aging.

5.5. Techno-aging citizens (60-69 years old)

There is also an active group of *technoagenarians*, young “tech-savvy” seniors (aged 60-69), who demonstrate solid digital skills and are proficient in using all digital technologies (smart phones, computers, SPID, Electronic Health Record (FSE) and online services), including for previous work skills (employees) or family experiences (digital advice from children or younger relatives). These people demonstrate the empowering capacity of technology, but with accessible services (simple and user-friendly interfaces, training support, service design for different levels of competence).

“I use the FSE and book everything online, but then I have to fight with the incredulous offices” (F, 62, rural).

“With SPID, I renewed my driving license from home... it was great’ (M, 66, Urban).

“I book everything online, it's more convenient” (M, 66, Urban).

“I use WhatsApp, PEC and SPID, and when in doubt, I ask my granddaughter. My older sister, on the other hand, is completely lost” (F, 69, Urban).

The sixty-year-old technoagenarians of Calabria oppose to the internalization of feelings of inadequacy experienced by those over seventy with the creativity of their life projects

and social commitment, thus confirming the reconstruction of new imaginaries among older people in southern Italy (Cersosimo 2022).

“Everything is digitized in the association... even the organization of trips' (M, 65, Urb.).

“I have reclaimed my time and, thanks to technology, I invest it in volunteering” (F, 64, Rur.).

These narratives confirm the dynamics of digital ageism described by Selwyn (2004), Rosales & Fernández-Ardèvol (2020/2023) and Gudynaite et al. (2025). Episodes such as these confirm, in Cozza's socio-material perspective, the lack of integration between institutional expectations and the digital skills of older people.

5.6. Older people and anti-ageist strategies in Cozza's model

In order to assess the contribution of older people to aging policies, respondents were asked to express their opinion on the importance or otherwise of the four constituent dimensions of the socio-gerontechnological model developed by Cozza and colleagues (Fig. 2).

Responsible engagement

'When the doctor explains things to me clearly and asks me what I think, I feel respected. It's rare, but it happens' (65, F, Urb.).

Cultural reframing

“Here, older people are still seen as ‘old people’, not as people who can and want to still do something for the community. We should change the way we talk about age” (F, 65, Rur.).

Inclusive design

‘Facilities are not designed for people who have difficulty moving around. Stairs, high counters, uncomfortable chairs. It wouldn't take much to make us feel considered’ (M, 74, Urban).

Organizational innovation

‘For us older people, we need specific services with calm, educated and kind staff. We cannot be treated like everyone else; we have different needs and special requirements’ (M, 74, rural).

5.7. The intertwined nature of education and mobility as social determinants of access to healthcare

The interviews clearly show that low educational attainment and transportation difficulties do not operate in isolation but reinforce each other in limiting access to services. Poor health and digital literacy complicate the management of administrative procedures and appointments, while poor public transportation and distance from healthcare facilities translate this vulnerability into forgoing care. Here are some interview excerpts:

“I didn't go to school, I don't know how to use a computer, and without a car I can't go anywhere. So I end up skipping my appointments” (F, 78, inland area).

“To understand healthcare paperwork, you need an education; to get to the clinic, you need a car. I have neither” (M, 82 years old, suburban area).

“If you don’t fully understand the letters from the ASP and can’t get around, you feel cut off. It’s as if healthcare isn’t for us” (F, 74, mountainous area).

These testimonies show how the interplay between education and mobility produces a multiplier effect on inequalities: those with low levels of education who live in outlying areas experience greater difficulty in understanding healthcare instructions, booking appointments, and reaching services, resulting in missed appointments, delays, and worsened health outcomes. As a consequence, *schools* and *mobility* together form a *structural mechanism* that produces *institutional ageism*.

6. Discussion

The narratives highlight significant differences between age groups, territories and levels of digital competence. All these aspects warn us of the subtle and recurring dynamics of internalized prejudice, which can hinder the effectiveness of healthy and active aging policies. Digital infrastructure (connection, devices, skills) plays a key role in the aging experience. The data reveal that the intertwining of institutional ageism, self-ageism and digital ageism reduces the demand for care, encouraging people to give up, delay diagnosis and, in general, receive less personalized care pathways. Non-inclusive digitalization acts as a filter for health citizenship, disadvantaging above all the over-70s and residents of rural areas with poor connectivity. Digital skills (or lack thereof), level of education and the presence of family networks lead to dependence on informal intermediaries and improve the effectiveness of access to services.

Finally, technoagenarians (60–69) report that autonomy and the fight against self-exclusion can be enhanced by inclusive design and training. The spiral of mistrust that reinforces inequalities can be broken by making operators accountable for factors such as tone of voice, continuous reliance on technology and incomplete explanations.

Final Observations

The study contributes to sociological debate on aging illustrating how demographic change and subtle ageism shape older adult’s lived experiences of care and their perceptions of institutional responsiveness. Focus group analysis reveals how the experience of aging is profoundly intertwined with social, material and technological conditions. In addition to a biological process, aging is above all a socio-technical position, constructed through the interaction between bodies, health services, digital infrastructures, social expectations and technological devices, in line with the theories of Cozza and colleagues.

The thesis is confirmed: access to services in the province of Cosenza is socially constructed by the intertwining of forms of ageism (including digital and self-ageism), use/non-use of technologies, community context, education, family networks and territorial infrastructure. To reduce inequalities, targeted redesign of services and greater training in both digital skills and anti-ageist practices are needed.

Technologies are far from neutral because they are continuously adapted, rejected, reinterpreted and modified in everyday practices. Their use depends not only on individual skills but also on family context, social support, infrastructure, public policies, technological design and economic conditions. Digital adoption is a relational process, not a personal deficit, as explained by socio-gerontechnology.

Perceptions of residuality with regard to services are fuelled by cultural narratives that highlight two aspects. The confirmation of the symbolic marginalization of southern elderly people with regard to services (Cersosimo 2022). The intertwining of the territorial fragility of Calabrian welfare in inland areas (Cersosimo and Licursi 2023) and the association between aging, decline and loss of social value.

Limitations and future research directions

The research has clear limitations: the results cannot be statistically generalized given the qualitative data collected and the small, unrepresentative sample, as well as the possible self-selection bias among participants. The gender imbalance in the sample (69.64% women; 30.36% men) presents both a limitation and an analytical opportunity. On the one hand, the female over-representation reflects a structural pattern in aging studies, where older women are more likely to participate in community-based research studies and are more frequently in contact with health and social services. On the other hand, this imbalance allows for a closer look at the interaction between gender and ageism, as highlighted in the literature (Holman & Walker 2021; Cotterell, Buffel & Phillipson 2018). Women's life trajectories—marked by fewer educational opportunities, more intensive caregiving roles, and greater mobility limitations—contribute to shaping access to services, health literacy, and exposure to forms of institutional discrimination in specific ways. Including this perspective strengthens the interpretation of the results and situates the sample within broader socio-structural dynamics.

However, what has been discussed here is useful in highlighting the variety of meanings assumed by the relationship between aging, ageism and access to healthcare services among the elderly Calabrians interviewed.

Further elements and future research (quantitative survey with a representative sample and comparative analysis of three southern regions with a special focus on gender differences) are needed to enrich the discussion. This will make it possible to evaluate experimental interventions in inclusive design and digital training, studying the longitudinal impact of family networks and infrastructure on the demand for care.

Declaration of conflicting interests

The author declares any potential conflicts of interest with respect to the research, authorship, and/or publication of this article. The author is the sole person responsible for the study design, the final analysis, and the drafting of the manuscript.

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