

Using Ageism as a Lens for Analysing and Challenging Inequitiesⁱ

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Abstract

This paper argues that ageism is a social structural dimension that riddles Canadian society but has yet to be challenged in the ways that sexism and racism are in North America. However, how the effects of ageism are experienced, how these impact the quality of life of individual elderly persons, depends on their social location. Thus, developing an intersectional analysis is essential for resisting ageism.

The analysis builds on two of the author's recent research projects in the home care policy field. One project used a PAR methodology involving a half-dozen activist senior citizens over a three year period. The second project, building on the knowledge generated from the earlier project, mounted a multi-faceted community engagement campaign with diverse groups of senior citizens. The article analyses these data and the operation of ageism in everyday life.

Introduction

Population aging is a long predicted demographic fact. Demographers have been making fairly accurate forecasts about its dimensions since the middle of the last century. Countries like Canada are still fairly young; only 16.1% of our population is over 65 (Statistics Canada 2015). The population aging we will be experiencing in 2030 is occurring in many European countries today. Furthermore, countries like Japan (26% of the population is over 65 years) and South Korea (where women enjoy the world's longest life expectancy) are aging very rapidly compared to what Europe or North America are experiencing.

Given these facts, one has to question why population aging is seen as an unexpected, expensive and challenging problem facing countries like Canada. The increasing number of people over 65 is described as a silver tsunami that will tax health and pension plans not designed to handle such numbers. One possible response is to question why these programs are so out of touch with demographic realities. Why are we unprepared to address the needs of an aging population after decades of lead time?

However, instead of raising these questions, a discourse has developed that blames elderly people for using health services, for receiving pensions, for taking resources away from younger generations. In other words, the dominant response seems to be that of turning old people into the problem. Once a group is so categorised, stereotypes are developed and reinforced in popular discourse, the media, practices and policies. Fault and blame are focused on the designated group and directed away from larger society. In the case of older people, this dynamic can be named; it is ageism.

Population aging is not the cause of stretched health care budgets. Canadian research shows that population aging has contributed only modestly to increases in health expenditure to date, about 1% (CIHI 2016; Constant et al., 2011; Deraspe 2011). Instead, the evidence points to factors, such as general population growth and general health service utilisation patterns, which require Canada's health care system to change and adapt (CIHI 2011).

Furthermore, despite increases in home care funding in all provinces, it still makes up less than 5% of health care budgets. Up to 90 per cent of in-home care is still provided by families and friends, and it is anticipated that these unpaid hours of care will more than triple in the coming years, increasing from 231 million hours in 2008 to 756 million hours by 2038 (Manuel et al., 2016). Furthermore, the levels of care that home care clients require these days is increasingly complex. Caregivers are expected to handle medical routines like changing dressings and catheters (CIHI 2007; CHCA 2015). Ironically, programs designed to help families and friends in their role as care givers tend to focus on stress management and education

around how to cope with caring tasks rather than on increasing the hours of service help. When challenged by family members as to why resources are not more available, budget caps and priorities of need are the standard responses provided by governments and health facilities.

There are many justifications offered to explain the ongoing constraint in social and health care resources, sometimes referred to as a crisis in care. The common justifications noted above, namely a lack of resources and service priorities, are truthful administrative rationales but they do not address why this is the case. As the Canadian Institute of Health Information (CIHI) report on *Health Care Cost Drivers: the Facts* (2011) suggests, the issue is one of how resources are used. Changes in the organisation and funding of health are long overdue, but seem resistant to repeated calls for change. Addressing this issue entails a structural examination that acknowledges that ageism exists in Canadian society and that it serves particular interests, while disadvantaging and harming many. This kind of an analysis entails not only articulating what is achieved by marginalising old people, but also by documenting how this is done, the justifications for it and finally, who benefits from the status quo.

This article argues that ageism underlies the apparent inability of governments to develop the range and levels of social care and health care policies and programs that can meet the chronic care needs of elderly persons living in the community. Below, I summarise what the scholarly literature says about ageism, present data from a series of community consultations with senior citizens around how they experienced and addressed ageism, and then discuss how theories about aging reinforce ageism.

Understanding Ageism

In the field of gerontology, there has consistently been a critical thread exploring the ageism that runs through how we think about and thus act toward people over sixty-five. The term ageism was originally coined by Robert Butler (1969), one of the “Founding Fathers” of gerontology, who defined the concept as “systematic stereotyping and discrimination against

older adults because they are old” (Butler 1975, 12). Moreover, ageism constitutes “a set of oppressive social relations” (Laws 1995, 112) that distance older people from entitlements, needed resources and affirming identities at most levels of society. Some twenty-five years ago Bytheway and Johnson (1990, 37 as quoted in Hurd & Korotchenko 2016, 178) argued that:

Ageism generates and reinforces a fear and denigration of the aging process, and stereotyping presumptions regarding competence and the need for protection. In particular, ageism legitimates the use of chronological age to mark out classes of people who are systematically denied resources and opportunities that others enjoy, and who suffer the consequences of such denigration, ranging from well-meaning patronage to unambiguous vilification.

Differences exist all around us. Some differences are markers of power and privilege such as maleness or high status occupations such as stockbroker or lawyer. Other markers of difference, like being old, bear a negative stigma. Ageism, like racism or sexism has several dimensions:

- ▶ *Stereotyping* is the cognitive component of ageism; it is the process of applying stereotypic knowledge, or the cognitive structures that store one's expectations about the characteristics of older adults.
- ▶ *Prejudice* reflects the affective component of ageism; it is expressed through one's feelings towards older adults.
- ▶ *Discrimination* is the behavioural component of ageism; it is represented through actions towards older adults (Lassonde et al. 2012, 175).

In short, ageism is discrimination on the basis of age, based on stereotypes about aging that reproduces/reinforces negative attitudes about elderly persons, and it has clear consequences for those so identified at the level of popular culture, social norms, services and resources and policy.

Ageism also leads to a tendency to assume that to be young is the optimal state of being in which resources and opportunities are and should be available. In contrast, aging is viewed as a liability to society and to the individual and a popular discourse exists asserting that older people are a “drag” on society’s resources and solutions to the “aging problem” are very difficult to find. Neither stereotype is true. A large and growing portion of young people are systemically disempowered, lack adequate resources and supports and their futures hold little opportunity or promise. Older people have always been part of society, though not always constructed as a costly problem, and solutions abound in terms of redressing ageism and the associated inequities. Currently, these solutions are at odds with the dominant neoliberal ideology of individualism and market-rule, and hence they tend to be discounted before they gain sufficient traction to produce positive change.

In a conjoined strategy to blame the victims, aging populations are seen as responsible for poor economic performance in the past, leading to continuing and seemingly endless economic problems across society. Similarly, aging persons are held responsible for their own health problems and costs and as a consequence, larger society has a little interest in addressing the collective needs of senior citizens. In other words, ageism is about the disadvantage and denigration experienced by many older persons due to insufficient social services, disabling environments, lower income and social isolation. It results in deprivation of power, respect and basic human rights (Townsend, 2006). It impedes senior citizens’ capacity to engage in citizenship processes (Neysmith & Reitsma-Street, 2000), to make needed social changes in their own interests and in defense of others.

Many forms of stereotyping pivot on perceived and real physical differences. Physical differences themselves are just that — people are distinguished by many physical differences – but they need not result in disadvantage if suitable resources and affirming identities are part of the social fabric. Physical disadvantages, such as those associated with the aging body, are part of a process of binaries of healthy versus disabled. Healthy

bodies are the privilege accorded to some, and the degradation of those seen as un-healthy or disabled. These concepts need to be deeply interrogated for every age group. If the disability movement has taught us nothing else, it is that society manufactures disability and disadvantage, rather than inclusion and full social participation.

Everyone acknowledges the existence of stereotypes and deplors them but they persist, they seem so entrenched - why? Put in more structural language, why are older persons marginalised? Discrimination flows along the disparities that mark Canadian society. However, as we try to understand how discrimination works, it is important to flip it over, so to speak, and examine privilege, because the other side of discriminatory practices is the exercising or bestowing of privilege. Doing this might help us understand the grounds upon which discrimination is legitimated. What are the sanctioned practices that allow, perpetrate and benefit from discrimination?

Documenting how ageism is experienced

In 2015-2016, two seniors' organisations in Toronto, Care Watch, a home care advocacy group of seniors, and the Toronto Seniors Forum (TSF), a voice for seniors at City Hall, supported by a federal New Horizon's Grant, undertook a project on ageism called *Still Acting Out*. Seniors from Care Watch and TSF conducted in-depth community consultations with six seniors' groups (N=205), summarised and consolidated the consultation materials. They then worked with an expert in drama for seniors to develop four vignettes (skits) that captured the ageism that the consultations exposed; tested these skits with another seven diverse seniors' groups across the city (N=255), modifying them on input from the audiences; documented the process and developed a package of background materials about ageism which was published and distributed to seniors' groups throughout the city (Toronto, 2016). The final version of the learning module consisted of a written manual which contained materials on ageism, copies of the slides used in community presentations and the scripts for four vignettes on ageism. See Care Watch website:

www.carewatchontario.com.

In the community engagement project, we heard that:

- Most participants had experienced ageism;
- Participants recognised that ageism was everywhere – in the media, in our families, in our service providers and in ourselves;
- Most did not like how ageism made them feel e.g. old, useless, irrelevant; and
- Participants did not know what to do about ageism -- education was the most common suggestion as a way to address ageism.

Participants identified particular arenas in which they experienced ageism. Following are several key domains:

I. Society and family attitudes

- Lack of respect for senior citizens in society
- Society doesn't value experience
- Seniors feel largely overlooked or invisible
- Assumption is that seniors don't know what is going on and that they don't participate in the things younger people do (work, education, sex, etc.)
- Seniors are sometimes neglected, berated and abused – most often by their own families

II. Doctors and the health system

- Health providers often assume that seniors are ignorant or stupid
- Despite the fact that seniors are regular users of the health system they are not treated as “consumers” but as a burden - they are given last priority in terms of consultations, referrals and hospital care
- The attitude of some doctors is “what do you expect, you are old!”

III. Business, technology and media

- Seniors feel excluded from retail industry, the media and workplace

- Message from these sectors is that youthfulness is all important
- Techno gadgets are not made for seniors
- Models in seniors' magazines are not seniors
- Seniors are portrayed as stupid, irrelevant, a source of jokes
- Despite the fact that the population of seniors is growing, the “market” is not yet catering to the needs and desires of seniors

IV. Politics and policies

- Policies about seniors' issues do not make it to the planning table - seniors are not politically “sexy”
- Seniors are often not consulted on issues that are relevant to them – pensions, health care, etc.
- Seniors seem to be viewed as a “special interest” group – not a part of mainstream society
- Seniors often ignored or discounted by politicians - only considered at election time because seniors vote

V. Suggested strategies for change

- Articulate the problem
- Communicate that seniors want to be full members of society
- Advocate for change
- Educate ourselves, and educate the public.

Discussion

As the above summaries of consultation content show, participants experienced ageism in every domain of their lives. They had no trouble providing examples to back up their claims. The data is replete with compelling experiences and insights. Discussions about how to challenge ageism and what strategies to use, did not elicit the same ready responses, however.

The last question in all discussion groups involved asking participants to imagine a society where ageism did not exist, e.g., “What would life be like?”

How would it differ from what you are experiencing today?”. Participants had great difficulty imagining such a scenario. When encouraged to let their imaginations roam, the most common reaction was to take current ageist responses and say such behaviours/attitudes would not happen. In other words, ageist responses would cease.

What did not surface in the discussions was how or where social institutions would differ in a more equitable, non-ageist world. Imagining alternatives seemed to be a conceptual hurdle too high for participants to scale. Going back to the findings presented above, participants recognise that the status quo needed to change. It was how to do it and what change might look like that proved challenging. Despite the lack of an identified process to redress ageist inequities and stereotypes, the groups identified the following process as a beginning step for moving forward: articulating the problem; communicating that seniors want to be full members of society; advocating for change; and educating ourselves as well as the public. The Learning Module on Ageism produced was an attempt to start this process (please see website noted above). However, a start is the operative word. Despite a growing body of literature on ageism, change will be slow. Imagining alternatives, an important component for change, is not yet apparent.

Theories about aging all too easily reinforce the social structures that underlie ageism. For instance, a dominant model in gerontology is *The Life Course Perspective* (Elder et al. 2003). As the name implies, it postulates that people’s lives go through a series of phases that start with birth and end with death. These phases are often referred to as life stages e.g. childhood, adulthood, parenting, employment, retirement, and tend to be associated with chronological age. It bears noting that age is associated with physiological changes but more importantly, major social institutions use chronological age as a marker (for developmental milestones in childhood, start of school and pertinent to our discussion, age of retirement). One positive outcome of the debate around mandatory retirement at 65 has been the exposure of historical precedents as policy actors (In 1889 Bismarck set 70, later reduced to 65, as the age for receiving a pension). My

point is to underline the importance of social practices rather than physical conditions as definers of the meaning of life after 65. In Canadian society, we are unable to imagine aging in any other way than decline. Physical changes associated with the aging process are defined as decline; it is then a small step to extend age related decline to the realm of the social.

Another gerontology theory, *Successful Aging*, has been the dominant model since the mid-eighties, marked by the publication of Rowe and Kahn's book (1999). This book presented their findings from a large study seeking to clarify factors that contributed to mental and physical vitality as people aged. Other phrases that capture the same basic idea of ongoing vigor as the norm, are "active aging" with its overtones from activity theory, "productive aging", a phrase with market associations, or "aging well", with its implied comparator that one can age badly. The point is that the focus in all these constructs is on a lifestyle of prevention and activity, emphasising individual agency and the avoidance of dependence. A plethora of self-help, active life style and productive activity advice messages followed in the wake of the theory (for an in-depth analysis of this literature, see Lamb 2014). One of the consequences of this model is what might be called the extension of mid-life representations of well-being - until some event results in a person becoming dependent and therefore, unsuccessfully aged (Lassen & Moreira, 2014; Roth et al., 2012; van Dyke 2014). An understanding of the successful aging paradigm and its consequences is important for appreciating why ageism is experienced the way it is today (Trentham & Neysmith, in press).

What needs to be underlined here is what happens when a theory such as the Life Course Perspective in which change is associated with decline, intersects with a model of Successful Aging rooted in a society where individualism and independence rules. These models invoke older people to constantly strive to maintain their bodies to middle age norms; to stay independent. With sufficient resources and hard work, allegedly they can succeed - for a while - but inevitably they will fail, and the failure will be the fault of the individual. There is no option but to fail; one cannot succeed.

Aside from the physical changes associated with an aging body, that body also carries other signifiers of more or less value such as gender, race, sexual orientation, (dis)ability, etc. Scholars have coined the term inter-sectionality to capture this complexity and how these signifiers interweave in various contexts (Cho, Crenshaw & McCall 2013; Hill-Collins, 2000; MacKinnon 2013; McCall 2005). Over an individual's life cycle the significance of different identities on one's quality of life changes. Thus, the meaning, as well as the consequences, of old age is different for affluent women of colour than for homeless, white men. This is not to deny the effects of age discrimination but rather to highlight that it is experienced differently depending on the balancing, the modification and the intersection of these statuses over a lifetime. As we discovered in the course of this project, we all internalise ageist assumptions and thus it is not surprising that individuals often attempt to maximise the benefits of their privileged identities, while minimising those with negative implications.

Within these discourses and the practices and policies that flow from them, an aging body is seen as a social problem - at best a problem in-the-making. One avenue for dealing with a social issue is to turn a difference into an individual problem or a risk. This avenue is central to the neoliberal paradigm in which social problems are recast as individual failings and moments for market profit or risk reduction on the part of the state where services may exist. Risk assessments of various types pervade the field of gerontology. Risk assessment is never neutral. It is imbedded in a discourse that is all about maintaining independence - where any kind of dependency becomes suspect. These ideas reflect dominant values held in our society. They work together to devalue aging bodies and the people who inhabit them.

Certainly, living with chronic conditions is a challenge for the individual, even where comprehensive supports exist. The aging body however, is also seen as a social problem in the context of neoliberalism - because it is associated with costs, specifically in Canada; the use of public health resources. However, rather than engaging directly with the politics of health

care economics, the aging body becomes the problem. With this change of analytical focus the aging person becomes the subject of interrogation rather than the allocation of health resources. With the lens focused on the individual, in a society where individualism and independence are key values, it is but a small step to develop a climate wherein I, the individual aging person, is positioned as being responsible for avoiding risks and taking preventive steps to keep my aging body functioning optimally. Maintaining good health is now a private trouble rather than a public issue.

The myth of the independent individual not only shifts the focus exclusively to the individual – with the spotlight there, societal responsibility fades into the background. In such circumstances, it is too easy to “define away” current entitlements; the very rights and benefits for which the generation before us fought, on which many of today’s elders rely. Under the “aging as individual failure” model, social supports and services would not be required if one were "successful" in managing the aging process.

Conclusion

Blaming health and pension problems on an aging population takes the focus off institutional players who profit from the status quo. Acute care hospitals and private pensions reap many benefits from the current individualisation of responsibility and valorisation of market solutions to the natural processes of aging. These are powerful sectors that resist efforts to change or to alter their profit margins.

As scholars and community activists contemplate alternative visions of aging to those discussed earlier, it is easy to jump from the frying pan into the fire. At the micro-level, for instance, there is the oft noted alternative of celebrating/seeking wisdom. Wisdom, with its implied transcendence of the world, can be silencing, an enforcement of detached social roles. Others suggest that the problem will go away with the arrival of Baby Boomers, who will change how aging is perceived. The limited research available suggests otherwise - Baby Boomers are as ageist as others (Roth et al., 2012). Social psychologists know that being a member of a group does not

mean one becomes suddenly conscious of prejudices - one is just as likely to incorporate them. In this regard senior citizens are not exempt from the negative, ageist stereotyping that pervades the rest of society.

In order to develop a new paradigm where being old does not carry a stigma, new models of aging will need to be built on premises that will not be readily accepted within the current market-embracing, individualist context. Earlier we referred to the status quo providing advantages to those with privilege and harming all those having the audacity to age without serious personal wealth. As these privileges and the anti-equity discourses that underlay them are revealed, named and shamed there will be resistance, push back, even backlash from those who benefit from privatised services and eschew social inclusion and equity. These protests, and the anger that fuels them, is necessary if we are to shift society to a more socially just position on ageing. Hopefully, this anger will provide the energy to imagine and fuel building alternatives.

Endnote

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