

MOVING FROM AGEIST TO AGE-FRIENDLY POLICIES AND PRACTICES IN MANITOBA

TIME FOR REFLECTION, DISCUSSION AND CHANGE



Written by: Peggy Edwards
For the Centre on Aging, University of Manitoba

March 10, 2015

Centre on Aging



UNIVERSITY
OF MANITOBA

The Centre on Aging, established on July 1, 1982 is a university-wide research centre with a mandate to conduct, encourage, integrate, and disseminate research on all aspects of aging.

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The methodology used to prepare this paper included:

- a literature search with PubMed and Google Scholar using the search terms ageism; discrimination; and stereotypes in combination with “older adults” and older workforce; job-training; benefit loss; health care; hospitals; home care; medical students and attitudes; nurses and attitudes; doctors and attitudes.
- an ancestry approach (i.e., the citations from relevant research articles and reports were examined to find additional related articles). The primary focus was on research, articles and reports published in Canada in the last 10 years but international articles and articles published earlier on were also included if deemed relevant.
- a Google search to find recent media articles regarding ageism
- a review of policy documents and reports on aging from Canada and the World Health Organization.

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INTRODUCTION

Manitoba, like the rest of Canada, is undergoing an unprecedented demographic shift that brings ageing to the forefront of the health, labour and social policy agendas. Between 2006 and 2026, those aged 65 and older in Manitoba will increase from 14.1% of the population (161, 885 people) to 19.9% of the population (263,200 people).¹

Ageism— stereotyping or discriminating against people based on their age —affects us all and dealing with it is a collective responsibility. This paper is designed to stimulate reflection and discussion among government officials. The issues described in this paper also have relevance and implications for employers and unions, health care practitioners and managers, community organizations (groups of older adults and others), academics working in aging, and the public—people of all ages who care about older people, and their own future as older persons.

The objectives of this paper are to

- clarify what ageism is and provide examples of how it may be manifested
- discuss why it is important to reflect and act on ageism now
- suggest some ways to move from ageist to age-friendly attitudes, policies and practices—to the benefit of older Manitobans, their families and future generations
- encourage a broader discussion about ageist thinking and how a lack of awareness and critical analysis can lead to ageist policies and practices, even when this was never the intent.

How old is “older”?



This paper uses the terms “older person” to describe someone who is age 65 and over. However, this group is far from homogeneous. Women and men experience ageing in different ways. There are significant differences between life at age 65, compared to age 75 and 85-plus. These age groups are also heterogeneous, reflecting diverse values, ethnicity, educational levels, lived experiences and socioeconomic status. This paper aims to provide information qualified by gender and age cohort after age 65. However, some surveys do not provide this breakdown or use different age categories. For example, Statistics Canada defines the “older worker” as age 50-plus.

UNDERSTANDING AGEISM AND AN AGE-FRIENDLY APPROACH

Ageism

The term “ageism” was first coined in 1969 by Dr. Robert Butler to describe the process of systemic stereotyping and discrimination against older persons.² Ageism is commonly understood as prejudice and discrimination based on any age, but most often directed against older people. Ageism involves beliefs and attitudes (e.g., older people are lonely, depressed, sick, dependent, unproductive and unattractive; or in some cases, older people are wise, kind, and dependable).^{3, 4, 5}

The consequences of an ageist ideology are serious and may include:

- a lack of valuing and utilizing older people’s knowledge, experience and skills in the family, community and workforce
- the extension of sympathy and pity in the form of patronizing, demeaning language and treatment ⁶
- viewing and treating older adults as one homogenous group, despite the fact that there is enormous heterogeneity in abilities, socioeconomic status and cultural background ⁷
- judgments that devalue older people based on the link between age and social roles in society (e.g., after retirement people are judged to be “non-productive”) ⁸
- the perpetuation of misconceptions and myths about older people despite evidence to the contrary (e.g., older people are bankrupting our health care system) ⁹
- a denial and acceptance of aging as a natural and positive part of life (i.e., maintaining vigour and a youthful appearance are seen as the sign of success in a youth-oriented society)¹⁰
- triggering or exacerbating intergenerational conflicts over limited resources ^{11, 12}
- policies, programs and practices that perpetuate negative attitudes and discriminate against older people.

Ageist attitudes and beliefs give rise to age discrimination—actions that may advantage (positive discrimination) or disadvantage (negative discrimination) an older person. Age discrimination may be direct or indirect. Although both forms of discrimination may not be intentional, they nonetheless unfairly disadvantage people of a certain age group. ^{13, 14}

- Direct discrimination occurs when an older person is treated differently solely because of age or perceived age (e.g., an employer rejects a candidate for a job because she is over 50 and he thinks she will not portray the youthful image he wants for the business; an employee is overlooked for promotion because he is 61 and the employer thinks he'll be retiring soon).
- Indirect discrimination occurs when an older person is disproportionately disadvantaged by a policy or set of actions equally and universally applied to all age groups (e.g., universal policies regarding hospital release that fail to recognize the more complex care needs of some older adults; an employer requires that a candidate for a job has at least ten years' experience in a relevant field, when two or three years' experience would be adequate. This disadvantages younger people and is therefore indirectly discriminatory).

Systemic discrimination occurs when policies or procedures have a discriminatory effect on a specific group of people. Systemic complaints require extensive investigations, but resolutions can have a significant impact in addressing large-scale discriminatory issues. For example, after a complaint of systemic discrimination and successful human rights mediation, Manitoba introduced policies to increase the number of family members eligible to receive funds when providing non-professional home care services. Similarly, Winnipeg City Council approved a plan allowing people with Alzheimer's disease and other forms of dementia to use Handi-Transit.¹⁵

Attitudes toward aging are often gendered. Looking "old" is judged more harshly for women than men¹⁶ and the differing life experiences of older women are commonly ignored in older-age policy and program development. In a recent survey, Canadian women age 66-plus were more likely than their male counterparts to report being treated unfairly or differently because of their age (68% versus 57%); being ignored or treated like they are invisible (46% versus 32%); and to say people have assumed they are incompetent (32% versus 18%).¹⁷

Discriminatory attitudes also change over time as a result of cultural, legislative and historical influences on successive generations. Ironically, the Baby Boomers who railed against the social discriminations of previous generations— including sexism and racism —may have done much to perpetuate ageism. The mantra "Never trust anyone over 30" may have come back to haunt this huge demographic.

An age-friendly approach

The term “age-friendly” has been gaining traction since it was used in a worldwide study led by the World Health Organization in 2006.¹⁸ Governments, societies, researchers and older people in 33 cities (in 23 countries) collaborated to identify the characteristics of an age-friendly city. Later, Canadian researchers used the same process to describe age-friendly rural and remote communities.¹⁹ The concept of “age-friendly” has since been applied in business, hospitals and other settings.

Age-friendly policies, services, settings and structures support and enable people to age actively by:

- refuting ageism and age discrimination
- recognizing the wide range of capacities and resources among older adults
- anticipating and responding flexibly to aging-related needs and preferences
- respecting the decisions and lifestyle choices of older adults
- protecting older adults who are vulnerable
- providing safe, favourable physical, mental and social environments for older adults
- fostering intergenerational solidarity
- seeing aging as a lifelong process and attending to lifecourse transitions within that process in a flexible manner (e.g., school entry, employment, retirement, re-entry to school or work)
- promoting the inclusion of older adults in, and valuing their contribution to, all areas of life.



Building on a solid foundation

The ideas presented in this paper build on a solid foundation and commitment to countering ageism and adapting age-friendly approaches in Manitoba and Canada, including the following:

- The National Framework on Aging (1998) identified five underlying principles when dealing with older people: dignity, independence, participation, fairness and security.²⁰
- In 2002, Canada was a signatory to the United Nations Madrid International Plan of Action on Aging, which lays out a number of steps that can be taken to reduce ageism and promote age-friendly environments.²¹

- Healthy Aging in Canada: A New Vision, A Vital Investment (endorsed by the Federal/ Provincial/ Territorial Ministers Responsible for Seniors in 2006) provided a vision of a society which celebrates the diversity and contributions of older people, reduces inequities among older population groups and refutes ageism in society.²²
- The Age-Friendly Communities Research Alliance was a \$1 million, five-year program of research funded by the Social Sciences and Humanities Research Council of Canada under its Community-University Research Alliance (CURA) funding program. The project began in July 2007 with Dr. Verena Menec as the Principal Investigator and the Seniors and Healthy Aging Secretariat as the key community partner. The Age-Friendly CURA helped to underpin the Age-Friendly Manitoba Initiative with a variety of research, community development, and knowledge transfer activities.
- Led by the Seniors & Healthy Aging Secretariat, the Age-Friendly Manitoba Initiative was launched in 2008. The Secretariat works with partners and local communities to create age-friendly environments that value older adults and all members of the community. The goal of the Age-Friendly Manitoba Initiative is to make Manitoba the most age-friendly province in Canada.²³
- The 2009 report from the Special Senate Committee on Aging called ageism “pervasive and subtle”, and urged decision-makers to lead the way in ensuring that the full rights of older people are respected.²⁴
- In 2009, the Committee of Officials for the F/P/T Ministers Responsible for Seniors released The Seniors’ Policy Handbook: A guide for developing and evaluating policies and programs for seniors. The seniors’ policy lens in this guide is based on an understanding that “Seniors wish to be full and active members of Canadian society—a society that accommodates equally the needs and aspirations of all age groups. Seniors would also like to be appreciated for life accomplishments and be respected for continuing roles and contributions to family, friends, communities and society”.²⁵



Creating and nurturing age-friendly environments is in keeping with the World Health Organization goal of active aging: “to optimize opportunities for health, participation and security in order to enhance quality of life as people age”²⁶ and Canada’s vision of healthy aging: “a lifelong process of optimizing opportunities for improving and preserving all aspects of health, promoting quality of life and enhancing successful life-course transitions”.²⁷

What older people say

Countering ageism will be a vital part of keeping Canada's aging population healthy in the years to come, but social policy changes are needed now to open up the possibilities for older adults to participate more equitably in society.

—Norma Drosdowech, Chair, Manitoba Council on Aging, 2006

.....

We must ease the stigma associated with the "senior" and the notion that 65 years of age magically equates to withdrawal from productive life. We would not call for the diminishment of rights and benefits but would call for the removal of barriers, disincentives and discrimination perhaps un-intentionally imposed.

—Older person providing evidence to Senate Committee on Aging, 2007

.....

"I term all this negativity (about older women) a "culture of loss" which is ageist in its assumption that we all decline as soon as we reach age 65, and immerses all of us in the expectation of decrepitude as we age. This is not my experience as an octogenarian. I and numbers of my peers are living productive and confident lives, thoroughly engaged in our communities. I want to establish a strong case for how older Canadians are contributing to a "culture of gains."

—Lillian Zimmerman, scholar Simon Fraser University and author.

WHY WE NEED THIS CONVERSATION NOW

Some progress has been made in changing ageist attitudes and the way older people are portrayed in society. For example, there have been more positive portrayals of older people on television (e.g., *Murder She Wrote*), and the use of older people in news programs and in movies (e.g., *Amour*, *The Best Exotic Marigold Hotel*). An environmental scan of initiatives promoting positive images of aging to transform ageist attitudes prepared for the Federal/Provincial/ Territorial Ministers Responsible for Seniors identified 15 promising initiatives that dispute stereotypes and promote positive images of aging, including several that support intergenerational contact and understanding.²⁸

However, ageist attitudes are still pervasive in Canadian society. According to the Revera Report on Ageism:

- six-in-ten people aged 66 and older report they have been treated unfairly or differently because of their age
- more than one-third of Canadians admit to ageist behaviour
- 71% of Canadians agree older people are less valued in our society than younger generations
- 51% of Canadians say ageism is the most tolerated social prejudice
- 56% of people age 66 and older say that age discrimination comes primarily from younger people
- 27% of people age 66 and older say they've experienced age discrimination from government; 34% from health care professionals and the health care system; and 20% from employers.²⁹

Recently, age discrimination has become a more prominent concern, which is reflected in the media (see Sidebar) and in an increasing number of complaints by older people and their families about policies and practices in employment and health care. The increased visibility of ageism may be the result of a collision of three key factors:

1. The rapid aging of the population due to low birth rates, longer life expectancies and the boomers entry into the older years. In 2011, the first of the large baby boomer generation reached age 65. As they continue to age, the number of 65 to 74 year olds and 75 to 84 years olds will steadily increase. For example, the percentage of Manitobans aged 65 to 74 will increase from 6.9% in 2012 to 10.8% of the population by 2031.³⁰ Despite this rapid increase in the number and proportion of older people, there remains a lack of understanding of how to effectively deal with aging in our social, health and economic systems.

2. Concerns about the effects of a retiring workforce on productivity, labour shortages, living standards and the sustainability of social programs. In 2011, one in every six working Canadians was age 55 and over^{31,32} and that number is projected to climb to one in four by the year 2021.³³ Negative stereotypes such as age-related poor health, resistance to change and low trainability stigmatize older workers,^{34,35} and subtle discrimination in hiring practices discriminate against displaced older workers** who want to return to employment.^{36,37,38} Although employers agree that older workers are needed to counter labour shortages and maintain productivity, many are not seen as responsive to the needs of older worker.³⁹
3. A shift in health care needs from acute problems to more complex, long-term chronic conditions. As people age, they are likely to develop multiple chronic conditions such as hypertension, heart disease, diabetes, chronic lung disease and arthritis.⁴⁰ Canada's health care system, which is primarily designed to deal with acute, time-limited health problems, may be seen as discriminatory toward older people. Canadians now require a continuum of care with more emphasis on programs and policies that support independent living at home for as long as possible.



** "Displaced workers" refers to workers 20 years of age and older who have lost or left their jobs because their company has moved or closed, there was insufficient work for them to do, or their position or shift was abolished.

Source: Glossary, Bureau of Labour Statistics, www.bls.gov/bls/glossary.htm

Media headlines influence and reflect public concerns

Ageism in health care needs to end, doctor says

Some doctors are warning of a culture of ageism in the medical world, saying health workers commonly treat old people as though they don't deserve the same care as younger Canadians.

—CBC News, May 21, 2012

Discharged senior's death spurs calls for change at Winnipeg hospitals

David Silver, age 78, died outside his home after being discharged from the ER and sent home in a taxi. ...

—Winnipeg Free Press, January 10, 2014

One of society's last acceptable forms of discrimination

People who would be appalled at expressions of racism, sexism and homophobia still chuckle at ageism as something natural, instead of the affront to human dignity it is.

—Janice Kennedy, Ottawa Citizen, January 2014

The rise of the older worker—and age-discrimination lawsuits

Self-employed warehouse safety inspector Murray Etherington, 67 was moved out of his old job in engineering four years ago to make way for a younger, less expensive worker.

—Globe and Mail, January 13, 2014

Older workers taking jobs from the young? Not so much, study says

A surge of older people staying on the job has spurred what economists say is an unfounded fear that it will result in fewer jobs for the young.

—Canadian Press, January 3, 2014

11 sneaky ways companies get rid of older workers

Three friends of mine over age 50 have lost their jobs this year under the pretense of reorganization or have been told that their positions were being eliminated.

—Forbes Magazine, November 3, 2013

OLDER PEOPLE AND HEALTH CARE: IS IT AGEISM OR OUTDATED POLICIES OR BOTH?

Some issues

Barriers to appropriate health care adversely affect the dignity, self-worth, independence and full-participation of older persons,⁴¹ and may be perceived as discriminatory. These issues include the following:

Problems arising in the hospital environment

The literature points to concerns about the negative impact that hospital environments have on older people's physical and mental health, the frequency of preventable adverse events that occur in hospitals, problems with discharge when there is no support at home, extended bed wait times in emergency departments (EDs), and the tendency to move older adults with co-morbid conditions from ED to acute care hospital beds, even though they may not require or benefit from that intensity of resources and services.

^{42, 43, 44, 45}

Is this ageism at work or are older people's negative experiences with hospitals mainly due to a "poor fit" with the dominant model of acute care? Hospital employees can have negative attitudes toward older patients because they are not just old but different. They may take longer to heal, and have difficulty expressing their needs and following directions; they may be disruptive; they are less physically able to perform independent self-care; and they require more time, which is time away from other acutely ill patients.⁴⁶

Parke and Chappell argue that when older, vulnerable people who do not fit in as "ideal" patients in the acute care model collide with other pressures (such as the busy and chaotic nature of EDs), there is a synergistic effect that leads to problems, which may be seen as ageist. However, problems in hospital with older people is likely less about age and more about the efficiency-based "one-size fits all approach" that fails to take into account the complex situations of older individuals and the need for a continuum of care, in which acute care is one part.⁴⁷

The shortage of professionals trained in aging (gerontology and geriatrics)

Manitoba is facing a crisis in the supply of health professionals who are trained to deal with older people. There are currently only five geriatricians in the province, and further attrition is likely with expected retirements. This will leave the medical workforce considerably below the national average, and far below the numbers needed to deliver evidence-based care (an acceptable ratio is 1.25 specialist geriatricians per 10,000 older adults).⁴⁸ Researchers also point to the need for extra training in geriatrics and gerontology among nurses and family physicians. Is the low level of interest and engagement in geriatrics and gerontology an outcome of ageist attitudes or is it systemic problems that discourage health care providers from making the extra commitment to train in a complex field. For example, physicians who may consider this specialty are discouraged by a lack of support in training programs, workload, academic opportunities and income (e.g., older people require more time which is not recognized in a fee-for-service paradigm).



Comparatively limited support for home and community-based care as part of a continuing system of care

Home care is an array of services for people of all ages, provided in the home and community settings, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for family caregivers.⁴⁹ Community supports, such as those provided by the Manitoba Senior Support Services Program (SSSP) include Community Resource Councils, Congregate Meal Programs, Multi-purpose Senior Centre and Tenant Resource Programs. It is well known that most older people want to “age in place” and that home and community-based care is a vital to older people remaining in their homes.⁵⁰ It has also been shown that home care is a more cost-effective strategy than moving older people to residential care.⁵¹

Manitoba is a leader in Canada in recognizing the importance of home and community-based care to the well-being and quality of life of individuals and families.

- In 1974, Manitoba was the first province to establish a comprehensive, province-wide, universal home care program.
- In 1984/85, Manitoba Health introduced the Support Services to Seniors Program (SSSP) to assist communities in the delivery of services that support seniors in maintaining their independence in the community. The SSSP is delivered throughout the province in settings including senior centres, community centres, housing complexes and the homes of seniors. The program continues to offer a preventive focus on health and well-being that commands considerably less resources than a hospital/institutional-based model.

- The 2006 Aging in Place Long Term Care Strategy and 2011 policy Achieving Healthy Aging renewed long term care plans to meet older people’s growing needs for home and community-based care services.
- Advancing Continuing Care—A Blueprint to Support System Change (2014) incorporates strategies for aging in place at home, long term care and the range of community supports along the continuum. In the area of home care and community-based services The Blueprint specifically commits to
 - helping people stay at home by investing in community supports and focusing on wellness, capacity building and restoration when delivering home care
 - improving access to home care
 - strengthening co-operation among health care partners
 - expanding options for community-based housing as alternatives to personal care homes
 - making better use of technology to help improve the quality and co-ordination of care, make informed decisions and develop policy.⁵²

At the same time, spending on home and community-based care remains disproportionate in comparison to other forms of care. In 2011, Manitoba’s share of spending on home and community-based care as a share of total health care spending was 5.27%—a small increase from 4.94% in 1999.⁵³

Because 80% of home care clients are older people, the relative lack of support for home and community care may be considered ageist thinking. Or is it the result of outdated funding priorities in a system that has recognized but been slow to provide the resources needed to implement new age-friendly models of housing and care? Or is it both?

What older people say

Each of your patients is an original work of art, a person who has loved and been loved, who has known pain, suffering, joy, delight, despair. And if, as it might be, that the circle of life comes to an end when you are my caregiver, I want to know that the person beside me values and respects all that I have been, and all that I am in that moment in time.

—Norma Drosdowech, Manitoba Council on Aging speaking at Concordia Hospital, 2006

.....

Sometimes you have to wait because they are busy, but it's not like they don't care, they are trying but they are so busy.

—Older patient ⁵⁴

.....

My mother was 86. She had osteoporosis and multiple fractures. We were in ER all night. No one gave her any pain medication. Mom kept saying to me, "Oh, well, I'm old, they don't want to spend any money on me."

—Daughter of an older woman ⁵⁵

Myths and realities: Older people and health care

Myth

The growth in the older population will bankrupt our health care system.

Reality

Some of the best research shows that, although health care costs will rise as baby-boomers age, the impact will be modest in comparison to that of other cost drivers, such as inflation and technological innovation.^{56,57} Blaming older people for uncontrollable health care costs smacks of ageism.

Most old people live in long-term care (nursing) homes, paid for by the taxpayer.

The great majority of older Canadians live independently in the community. Over the last two decades the proportion of seniors living in long-term care homes has remained fairly constant at about 7%, although the degree of unmet need for such facilities is increasing. Not surprisingly, residents tend to be older. Still, only some 12% of the Manitoba population aged 75+ lived in personal care homes in 2010.⁵⁸ As the relative age of Canadians rises in the coming decades, the absolute numbers of older people needing daily care will put increasing pressure on the capacity of both community care services and long-term care residences.

Long-term care is not included under the Canada Health Act and, therefore, is not available on a universal basis. While there are government programs aimed at assisting Canadians with long-term care needs, these programs vary by jurisdiction and typically are income-based. In most cases, older people are responsible for the cost of their long-term care needs.

All older people in hospital are the same.

Parke and Chappell identified two different groups of older patients. Members of the first group are able to function independently, are cognitively aware, have access to social support, follow the expected medical course for their diagnosis and conform to hospital procedures. As such, they do not cause problems and are relatively well served by an acute care system. The second group challenges the hospital system. They may be frail and/or cognitively impaired making them unable to function independently while in hospital. Ironically, their disabilities are often exacerbated by hospital customs, traditions and expectations for a quick and predictable recovery. Because they require more time and attention and fail to comply with established regimes, they (rather than the challenges of the care) become labeled as the problem. They are designated as no longer a priority and may be isolated and ignored until the hurry-up time for discharge is announced.⁵⁹

TOWARD AGE-FRIENDLY SOLUTIONS IN HEALTH CARE

The move to age-friendly hospitals requires a paradigm shift in the culture and practice of event-driven acute hospital-based care. This includes putting policies in place to ensure care is free of ageism and respects the unique needs of older people and their caregivers. Huang and colleagues suggest that an age-friendly hospital is based on five principles:

1. A favourable physical environment
2. An integrated process to develop comprehensive services using principles of the geriatric approach across the entire institution
3. Assistance with decision-making (e.g., interventions and levels of care)
4. Fostering links between the acute care hospital and the community
5. Zero tolerance towards ageism at all levels of the organization: a) The “age-friendly” vision is fully endorsed as a strategic objective by the administration; b) Knowledge, skills and attitudes of all care providers along with training opportunities support this objective.⁶⁰

Several jurisdictions in Canada and in other countries have embraced the age-friendly hospital approach. For example, Ontario has put in place a process to ensure that within five years, all adult hospitals in Ontario will have initiatives in place to address five domains of a “senior-friendly” hospital.⁶¹

The Elder-Friendly Hospital Initiative (EFHI) was launched by the Winnipeg Regional Health Authority (WRHA) in 2005 to increase the capacity to provide the best quality of care to older adults in all nine hospitals in the Region. The EFHI was linked to the NICHE program from the John A. Hartford Foundation Institute for Geriatrics at New York University, which developed a “tool kit” of materials, and information that can be used by hospitals to improve the care of older adults.^{62, 63} The EFHI was based on the assumption that improving the care of older hospitalized patients requires geriatric knowledge on the part of front-line staff, and more specialized training in geriatrics (certification) for some nurses who can then function as resources to other staff, as well as consultation supports.

In a recent systematic review, researchers found that older people who are hospitalized with an acute illness or injury experience reduced falls, delirium and loss of function while in acute geriatric units compared with usual hospital care. The acute geriatric hospital unit included at least one of the following features: patient-centered care that aimed to help people keep the ability to do everyday activities; frequent checks by healthcare providers to reduce adverse effects of treatment; early rehabilitation; early discharge planning; or changes to surroundings to make moving about and understanding things easier. All of these characteristics could be implemented throughout the hospital (i.e., not just in a special unit) to the benefit of patients of all ages.⁶⁴

Increasing the supply of health professionals trained in gerontology and geriatrics will also require systemic changes. In traditional fee-for-service models, complex geriatric patients do not fit the one problem per visit goal, and flexible approaches to billing are needed to help compensate physicians more appropriately for dealing with complicated problems. It is also recommended that schools of medicine and nursing and other health-related training centres ensure that graduates receive appropriate levels of training on the needs and capacities of older persons, and that education on ageism and age discrimination is included within their curricula. Nurses, who play a key role in working with older people in hospital, community, and long term care settings will benefit from training and continuing education programs in aging and health.



The demand for home and community care is certain to grow in the coming decades. Manitoba is well placed to respond to this need, but the nature of resource allocation and funding amounts is still unknown. There is still uncertainty about how much government will invest in the sector, how much the public and insurers will be expected to contribute versus how much Manitobans will need or be willing to spend on the private purchase of services, how much health authorities plan to shift resources from acute care to home and community care, and what the programs will look like. Although more is being learned about the extent and consequences of unpaid caregiving, it is not clear whether the sizable reliance on family and friends to provide unpaid care will be realistic or appropriate in the future.

In a society that values older people and their right to services that are both good for them and for the economy, governments, employers, insurers, and families need to ensure the relative expansion of contributions for home and community care. Manitoba and Canada can look to places such as Denmark, which has successfully implemented an integrated system of care for older adults and people with disabilities that focuses on home care (including community support) and is cost-effective.⁶⁵

Unpaid caregiving and home care

Nearly 3.1 million Canadians are estimated to have provided some level of unpaid caregiving to home care recipients during 2007. This army of unpaid caregivers (many of whom are older people themselves) provided over 1.5 billion hours of home support and community care—more than 10 times the number of paid hours provided in home care during that same year. In Manitoba, almost three-quarters (73%) of those providing informal care to seniors were between the ages of 45 and 64; 15% were aged 65 to 74. This reliance on unpaid caregiving has costs—both personal (such as health and well-being and financial costs) and business costs (from lost productivity and turnover among employed caregivers). The future of this care is also uncertain. As families become smaller and more separated geographically, it is unclear if there will be enough unpaid caregiving supports to meet future needs.⁶⁶

OLDER PEOPLE AND EMPLOYMENT: IS IT AGEISM OR OUTDATED THINKING OR BOTH?

Some issues

Employment is fundamental to equal participation and opportunity in society and is central to a person's sense of dignity and self-worth. Increasingly, working longer is also a financial necessity for older Canadians.⁶⁷ This is especially true for women and immigrants who have lower incomes due to less years of employment and higher rates of employment in sectors that do not provide benefits or pensions.

In the past, it was accepted that people retired at age 65 or earlier, hoping to enjoy another 10 years (albeit with declining health), and time for leisure pursuits, family, friends and community involvement. Today's older workers are in a different situation. At age 65, Canadian men can expect to live an additional 18 years (12.7 of those in good health); Canadian women an additional 21 years (with 14.4 of those in good health).⁶⁸ In addition to financial need, many older Canadians want to continue working after age 60 or 65 because work offers personal fulfillment, dignity, stimulation and social inclusion. The evidence suggests that the Boomers are expecting to work longer⁶⁹ and to retire differently—preferring a gradual reduction in work hours, rather than abrupt retirement.⁷⁰



Governments, labour force analysts and employers agree that older workers are needed to ensure sustained economic productivity, the availability of skilled labour (especially in sectors facing labour shortages)⁷¹ and the viability of public pensions,⁷² as well as mitigating the loss of critical experience to organizations as large numbers of Boomers retire.⁷³

Older Canadian workers are protected from age discrimination under human rights law. The banning of mandatory retirement in Canada 2012 (with some exceptions) has been the most progressive policy change in terms of combatting age discrimination in employment. In addition, most organizations have an anti-discrimination provision in their collective agreements and/or human resource policies. Typically, these clauses state that discrimination based solely on age is prohibited. Despite these legal protections, however, the literature suggests that ageism affects recruitment, hiring, training, career assignment and lay-off practices, sometimes in subtle ways.^{74, 75}

Some populations of older workers are at greater risk of becoming unemployed and unable to find re-employment as a result of ageist thinking combined with other barriers. These high-risk groups include:

- displaced older workers (e.g., job loss related to layoff, plant closure, downsizing)
- older workers with chronic, prolonged or episodic illness, injuries, mental health issues, or disabilities
- older workers with low levels of literacy and skills
- older workers who are recent immigrants
- older Aboriginal workers
- older workers with family caregiving responsibilities.⁷⁶

Sometimes firms express the best intentions of hiring older workers but fail to carry through. The Manitoba Chamber of Commerce concluded that this discrepancy was based on three factors:

- business practices based on long standing theories about work, retirement and aging that do not reflect the current reality
- little analysis of the demographics of their workforce and the changes that need to be made to include and engage older workers
- stereotypical beliefs that older workers are less productive and unwilling or unable to adapt to new technologies and business practices.⁷⁷

Myths and realities: Older workers

Myth

Realities

Older workers are less productive.

Intellectual capacity and the ability to perform routine tasks are not influenced by age. Rather, research shows that workers who perform the same tasks for a number of years enjoy the benefit of accumulated work experience, which also benefits their employer. Most senior executives are over age 50 and, after many years climbing the corporate ladder, still put in long hours and cope well with high stress. However, physical strength does begin to diminish with age. Where physical strength is a key component of job performance, a slight decline in productivity may occur. This can be accommodated by adjustments in job tasks and scheduling.⁷⁸

Older workers won't stay on the job long.

Older workers are less likely than younger employees to frequently change jobs, especially when they know their efforts are appreciated. Employees are delaying their retirement. Many older workers plan on remaining connected to the workforce in some way when they retire from their primary career.^{79, 80}

Training older workers is not cost-effective, and they are less receptive to training.

In a knowledge economy, the payback period on investment in training is becoming shorter for all workers, meaning that spending money on training older workers is likely to be recovered before those workers retire. Older workers are generally eager to learn new skills.⁸¹

Older workers don't possess the same level of technical skills as younger workers.

Baby boomers have been working with technology since the '80s. They may not be as tech savvy as the under 25 crowd, but they're catching up. In fact, the Boomers are the fastest growing demographic on the Internet and social networking sites.⁸² Older employees are eager to master new skills and often have solid technical backgrounds.

Older workers are more expensive.

Business analysts conclude that the benefits of a stable workforce and avoiding turnover costs can exceed the incremental compensation and benefit costs for a 50+ worker.⁸³

Toward age-friendly solutions in employment and work

Moving from ageist to age-friendly policies and practices in work and employment may ultimately depend on new ways of thinking. The rise of the intergenerational workforce brings into question the very idea that long-standing practices based on chronological age and a “one path fits all” career trajectory is relevant in the face of the massive demographic shift now underway. Lifelong learning and a lifecourse approach to active aging (wherein people of all ages move back and forth in working, learning and caregiving roles) may be more in keeping with today’s workforce and employee needs. Smart businesses and organizations build on the power and productivity that intergenerational workforces offer by investing in people of all ages.

It is also time to replace stereotypical thinking with the realities of today. The Conference Board in the United States found in case studies with a number of companies that the most effective way to manage older workers is to treat them respectfully and dispense with stereotypes by working to understand their needs.⁸⁴ Business leaders and governments in Finland, Norway, the United Kingdom and Australia have adopted a framework that challenges conventional notions of aging characterized by the loss of ability to perform tasks with a shift to a positive focus on human potential at any age.⁸⁵

In Canada, several government programs have been implemented to address the needs of older workers, including the Third Quarter project and the Targeted Initiative for Older Workers. The Age-Friendly Manitoba Initiative: Business Dialogue on Older Workers carried out by the Manitoba Chambers of Commerce collected information on older workers and made recommendations for strategies for future action.⁸⁶

Several national groups have recommended the use of awareness campaigns to

- foster a general change in attitude towards older employees (and aging) in workplaces, and in society
- promote the strategic value of retaining, investing in, and more readily hiring older workers
- raise older workers’ awareness of their own potential and of the opportunities available to them.⁸⁷

They have also suggested a recognition program for industry leaders who have developed programs and policies to combat ageist beliefs, and accommodate and encourage older workers’ labour force participation.

While policies and practices that refute ageism and enable and encourage an extended working life are required, one also needs to consider that pressures to compress retirement and extend working life may discriminate against older people who already face inequalities accumulated through the life course. Many older workers who are displaced from their jobs turn to part-time, precarious employment that fails to meet their basic needs. Others with poor health and limited education levels and skills face major barriers to working past age 60. Women (who are more likely than men to have been employed in jobs that did not offer pensions) and displaced workers aged 60 to 65 (67 when the new rules for Old Age pensions come into force) are particularly at risk for getting caught between a “no pension” and “no work” zone while society urges them to age “successfully” and “productively”.⁸⁸

Aging and work: Some critical questions to reflect on

- * What are the social and economic implications of rising expectations about retirement? To what extent do these conflict with the extending working life agenda? Why work after 60? Enjoyment, debt, health bills?
- * What are the problems that might be encountered in implementing flexible employment policies such as gradual retirement? What incentives are needed to implement such policies?
- * Will retirement as an achievement of the 20th century be replaced by insecure employment and uncertain transitions in the 21st?

Source: Chris Phillipson presentation at Canadian Association Gerontology, 2014

CONCLUDING REMARKS

Attitudes toward aging are complex and multidimensional; they also change over time.⁸⁹ Ageism has typically been attributed to individual prejudices and judgments. While this does exist, this paper suggests that in some areas the manifestation of ageism may be rooted in outdated ways of thinking, systemic barriers and policies and practices that fail to take into account the changes that are required to deal with an aging society.

Ageism has no part in a society that embraces aging with optimism and reaches out to older adults as vibrant, important and valued contributors in our families, communities and workplaces. Now is the time to scale up the reflection, discussion and actions that will engender the political will, public support and personal commitment that is needed to move from ageist to age-friendly attitudes, policies and practices in Manitoba.



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