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Chapter 1: Introduction: Toward A New Era of Human Rights

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Chapter One

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Case Study 1.1

Linda Krakowski, age 80, of Dutch heritage, lives with her husband Joseph, 81, who is second generation of a Polish immigrant family, in a single- family house on the west side of the city. Linda was referred to a local mental health facility by her family physician for home-based cognitive behavioral therapy for anxiety disorders. The social worker Ana Harrison came for the first home- visit this morning. John, Linda's oldest son, answered the door. He introduced himself and invited Ana to the living room, where Linda and Joseph were waiting. Ana explained the purpose of this first meeting and wondered whether Linda wanted the family to participate in the meeting. Joseph excused himself for a church volunteer obligation while John remained. John explained that he came home for their mother's big birthday on the last weekend. Concerned with his parents, he had changed his flight back to Dallas and stayed for extra days. John, 60, married, father of three adult children, is a mid-level manager at an IT company. Linda seemed upset. She apologized to John for the days he had to take off. Linda reported that she and Joseph have been married for 63 years. They have four children. John and his two younger brothers live and work in other states. Their oldest is Rita, 62, who is the only one who resides in the town. Linda and Joseph have lived in the house for 34 years. It was a surprise when children raised the question about their housing last weekend. Linda stated that Joseph has well managed high blood pressure and a heart condition, with medications and a bypass surgery last year, while she has been treated for type 2 diabetes and osteoarthritis. For the most part, Linda reported that they have been managing their daily lives independently without much trouble. She recognized that Rita has helped out here and there through the years. She lifted her left foot tightened by the ankle foot orthosis, then added that she broke her ankle last Tuesday when she was preparing for the party. She apologized to John that they had to handle all party business due

to her injury. She was just so happy to see her four children, seven grandchildren, and five great-grandchildren. Turning to Ana, she said that they have a family tradition that she and Joseph will update their advanced directives on one of their birthdays if children come to town. With hesitation, she lowered her voice and reported that before the advanced directive time, Rita and John took her aside. They carefully asked her what changes she has seen in their father. They found that Joseph seemed forgetful. He could not remember when Linda broke her ankle, and was confused about whether he had taken his blood pressure meds in the evening. John then revealed to Linda and Rita that he noticed Dad seemed to have great trouble to get up from the couch. Linda told Ana that she did not think Joseph had changed, and that everyone gets older and forgetful. The whole conversation and the advance directives were overwhelming her. She worried that she was watching over Joseph and concerned that he might really have shown dementia symptoms. She reported that she has trouble with sleep and has gained weight with the family gathering and her ankle problem. She wanted to talk with Joseph about the possibility of moving, at least downsizing, but it was a such stressful idea. She got irritated whenever she thought about it or children wanted to discuss it further.

Case Study 1.2

Jessica Horton is a program coordinator of the Elder Abuse Prevention Education program at the Area Agency on Aging. She is excited that the annual Elder Justice Conference is taking place today. After the afternoon breakout sessions, Dona Barrett, a volunteer, approached her. She asked Jessica whether she could have few minutes of her time at the end of the conference. She is a new volunteer. It appears that this is something important to her. Jessica agreed to meet by the reception table at 5.

Dona told Jessica that she was shocked when she saw a handout on forms of age discrimination in the workplace. Dona has been a German translator in a large company for the last 16 years. Business has been slow for her, which has impacted her performance, but she has picked up French. Early this year, her mother fell and broke her hip. It has been difficult for her mother and the family. When the question about early retirement was raised, Dona shook her head, and said that she even did not really remember how and by whom the question was brought up. She only remembered it went so fast. Before she knew it, she has already had several meetings with an HR officer where options were presented, including severance pay. She had started the process to retire "voluntarily." Today she is questioning whether her company might not have complied with the *Older Workers Benefit Protection Act (OWBPA)* because she was not informed about her rights when she signed the age discrimination waiver in the severance agreement. She also noticed that she did not have 21-day notice period. Dona told Jessica that at age 61, she was not sure whether she is ready for the retirement, even when her mother needs her for care. She is afraid that she has not financially prepared for the retirement she has been hoping for.

Jessica told Dona that although this is a complicated matter for the time they have today, she is more than happy to provide her local legal and human service resources for her and her family.

Meanwhile, she asked Dona when her retirement officially started because she might be able to revoke the severance agreement if it has not been seven days yet. Later, Dona also would learn that a 2009 US Supreme court ruling made it harder for workers 40 and over to prove age discrimination cases since the ruling requires the worker to show proof that age was the deciding factor rather than one of the factors in a dismissal, demotion, or other adverse personnel action.

Introduction: Toward A New Era of Human Rights

Population Aging in the United States

Mr. and Mrs. Krakowski are among growing number of older people in the world, as figure 1 shows. Like race and gender, age is a social category (Butler, 1969; Settersten & Godlewski, 2016). Currently, there is no universal agreement on what chronological age is considered as a definition of "elder," older person, or older adult. The United Nations (UN) considers 60 years as the cutoff to refer to the older population, while the United States (US) and other developed countries use 65 years as the threshold of older adulthood, and the World Health Organization (WHO) has chosen 50 years as the definition of older person in its Project on Minimum Data Set for Ageing in Africa (WHO, 2002). In the United States, the *Age Discrimination in Employment Act (ADEA) 1967*, the most authoritative anti-ageism law in the workplace, is based on the well-documented evidence that age discrimination in the workplace begins among workers in the 50s.

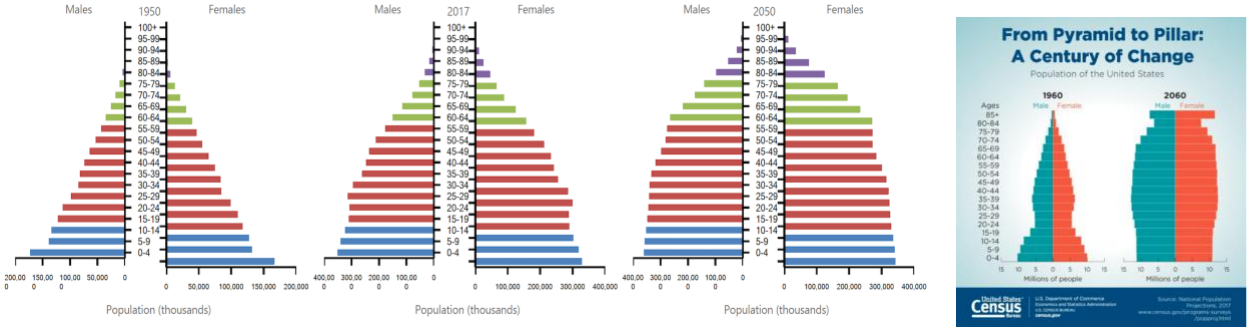
Key Drivers of Population Aging

It is generally agreed that population is aging globally. The latest available global data estimate that the life expectancy at birth (LEB) in 2019 was 73.4 years, and the corresponding values for females at 74.2 years and 69.8 years for males (WHO, 2020). Life expectancy (LE) is the average remaining years of life one can expect based on the mortality rate of the time for a given population. LEB is the most referred age-specific LE measure. It calculates the average number of years an individual may be expected to live at birth. Although LE data summarize more quantity than quality of average life span, and there is inconsistent evidence in understanding predictive factors associated with LE inequality (Akhter, 2018; Dywer-Lindgren et al., 2017), LE has been a basic vehicle for population analysis, policy making, and service

provision because it portrays aggregate human development outcomes, social inequalities, and individual quality of life (Boothe, Fierro, Laurent, & Shih, 2018; Rogers, Lawrence, & Hummer, 2018; Van Nuys, Xie, Tysinger, Hlatky, & Goldman, 2018).

Rapid population aging in the 21st century is an unpresented global shift. Generally, the decline of fertility and mortality rates, or increasing survival and life expectancy, are the top two reasons driving population aging. Fertility as a key indicator of population size and composition is mostly measured by total fertility rate (TFR), expressed by the average number of children per woman if she went through childbearing age, according to its age-specific fertility rates (Alkema et al., 2011). In 2017, American TFR dropped to 1.87 from 3.7 in 1960, lower than the global level of 2.44 (World Bank, 2018). Like the Krakowski family, American families have experienced decreasing family size. Meanwhile, global LEB was 72 in 2016, increased by 5.5 years since 2000, the fastest increase since 1960s. By comparison, American LEB was 78.4 in 2016, and LE at 65 were 18 and 20.6 for males and females, respectively (WHO, 2018). As figure 1.1 indicates, the median age in the US has risen from 35.3 in 2000 to 38 in 2016 (Burau of Census, 2018).

Figure 1.1: *Population Aging (World and United States, 1950-2060)*



Baby Boomers

In the US, aging baby boomers are another unique factor associated with aging population. American baby-boomers refers to a cohort born between 1946 and 1964. Up to 2018, they have been the largest living adult generation in the country. In 2016, there were an estimated 74 million boomers (Fry, 2018). Starting in 2030, all boomers, including Dona Barrett and Linda Krakowski's three older adult children, will be 65 and older. Older Americans then will make up 21% of the population, up from 15% in 2018. The U.S. Census Bureau projects that by 2035, older Americans age 65 and over are expected to number 78.0 million, which will outnumber children under age 18 (76.4 million) for the first time in the US history. By 2060, all Linda Krakowski's grandchildren will be older adults. Nationally, nearly one in four Americans will be 65 years and older, the number of 85-plus will triple, and the country will add a half million centenarians (US Census Bureau, 2018). Ample research has described and analyzed the cohort characteristics of baby boomers and their salient impacts on health and human service infrastructure and programming, for instance, retirement and aging in place (Dong, Wang, Pingen, & Sokas, 2017; Hewson, Kwan, Shaw, & Lai, 2017)

Aging population affects individual older adults and their family, as the Krakowski family and Dona Brett demonstrate. It poses greater challenges and opportunities for existing healthcare, in-home caregiving, and long-term care. It fundamentally influences economy and politics. It demands new social, political, and economic responses from all nations and cultures (Benglson, 2018; Bloom, Canning, & Lubet, 2015; Kunkel, Brown, Whittington, & Chahal, 2014; McGrattan & Prescott, 2017; Powell, 2017). Population aging influences changes in the American old- age dependency ratio (OADR), which has been increasing from 11 in 1940 to 22.1 in 2017 (Indexmundi, 2018; Ortman, Vekoff, & Hogan, 2014), and it is predicted to raise to 39 by 2060 (United States Census Bureau, 2018). The OADR is one of the dependency ratio

indicators that monitors structure changes in the population. It is used to measure the level of support available to older adults age 65 or over by *working age population*, which generally refers to population aged 15-64, and the US Census Bureau has used the age between 18-64 (Ortman et al., 2014). The above ratios mean that for each older adult the American working age population needs about 10 working- age persons to support in 1940, five in 2010, and 2.5 in 2060. The higher OADRs inevitably affect public policies such as Social Security (SS).

Healthy Life Expectancy

Globally, LE has been increased across developed and developing countries, and age, sex, and race groups since the 1960s. Meanwhile, longevity alone has become a less desirable characteristic of a good life. WHO has brought the incidence and prevalence of diseases and the consequential duration and severity of disabilities they cause into the longevity equation (WHO, 2015). Health-adjusted life expectancy (HALE) and disability-free life expectancy (DFLE) were two related *Healthy Life Expectancy* (HLE) attempts to estimate the average levels of population health of WHO member countries. Using the widely known Sullivan method, HLE calculates the equivalent number of years of life expected to be lived in full health for people at a given age, free from disease and disability (WHO, 2014). The most recent WHO estimates reveal that HLE at birth in 2016 was 63.3 years globally, even though the corresponding value of LEB was 72. At the country level, the US HLE and LEB in 2016 were 68.5 and 78.5, respectively. They mean on average the world lost 8.7 healthy years to diseases and disability, and the US lost 10 in 2016. Since HLE weighs life expectancy and health status of populations, or mortality and morbidity, it reflects quantity as well as health-specific quality of years to be expected, adjusted for major diseases or injuries and their impact on quality of life (Chang et al., 2013; WHO, 2015).

The WHO HLE estimates also reveal that on average people in longer-lived populations live more years with disabilities than people in populations where the lifespan is shorter (WHO, 2015). This makes it imperative for the US and other developed countries to reduce the number of years with disabilities. It also suggests that there are higher needs for social and health care services for older adults with disabilities in these countries.

The HLE data highlight urgency to change social landscape in response to population aging. For example, while the United States currently ranks number one economically in the world, its HLE ranked 39th in WHO 181 countries in 2016 (WHO, 2018), and its LE ranked 26th in the 35 Organisation for Economic Co-operation and Development (OECD) countries in 2015 (WHO, 2015). It sheds light on the inability of the current systems to address long standing health disparities and social injustice in the country. It leads to the unique reality that older Americans face greater challenging when lifelong social inequality adds to their aging experience where they enjoy longer LEB but lose more years to diseases and disabilities.

Health Disparities and Social Inequality

Using the human rights framework, the importance of HLE also lies in its ability to estimate future health and human service needs, identify trends and meaningful changes in health and health prevention programs, and monitor health inequalities and social injustice across countries, states, and social groups. HLE data over time have shown great and consistent disparities in health and quality of life among older adults (Crimmins & Satio, 2001; Chang et al., 2014; Murray et al., 2015). While global HLE in 2013 is 62, the WHO Africa region has a HLE of 50 and the Americas 67 (WHO, 2015). Similar gaps are also found among US regions and counties (Chang et al., 2014; Dwyer-Lindgren et al., 2017). Data reported that race/ethnicity and socioeconomic (SES) indicators, such as national and individual income and education

levels, are significantly positively associated with HLEs (Kim & Kim, 2016; Yang, 2018). It is evident that there are significant differences in HLEs for US adults and older adults due to differences in their sex, race/ethnicity, SES, and rural-urban proximity. For instance, non-Hispanic white adults have 2.6 more HLE years than Hispanic adults and 7.8 more than non-Hispanic black adults (Chang et al., 2014).

Case study 1.1 shows that Mr. Krakowski has heart disease, which is the leading cause of death in the US. He underwent a bypass and takes high blood pressure medication daily. It is well documented that while advances were made in reducing age- and sex- adjusted mortality rates due to cardiovascular diseases (CVDs), disparities have grown overall, and healthcare systems and environmental factors such as SES and race/ethnicity greatly contribute to such health disparities (Ski, Thompson, Fitzsimons, & King-Shier, 2018). If Mr. Krakowski were an African-American or newly immigrated Hispanic or South Asian, he would be more likely to have atypical presentation of cardiac symptoms, not have enrolled Medicare Plan B and D, have been diagnosed and/or treated too late, or not able to access to quality CVD facilities. All of these risk factors could lead to higher morbidity and mortality (Ski et al., 2018).

Ageism in America

Ageism has been identified as the most pervasive, deeply rooted, yet least combated socially structured form of prejudice and discrimination (Butler, 1989; Nelson, 2005; WHO, 2015). Robert Butler first coined “age-ism” as “another form of bigotry” (1969). Today, ageism is defined as an institutional and individual practice, attitudes, and belief that one age group stereotypes, prejudices, and discriminates toward people on the basis of their age, young or old. Ageism refers to a host of stereotypes, prejudice, and discrimination, but understanding of its cognitive, emotional, physical, and behavioral dimensions is a new chapter in human history. As

an interdisciplinary arena, existing knowledge built around ageism generally analyzes it in terms of a dichotomy between negative or positive, benign or malignant, explicit or implicit, overt or covert, and self or other-directed stereotypes, prejudice, and discrimination against individual elders or older adults as a group due to their chronological age or a perception of being "old" (Ayalon & Tesch-Romer, 2017; Butler, 1980; Levy & Banaji, 2002; Meisner & Levy, 2016; Palmore, 1999; São José et al., 2017).

Recognizing Negative Ageism

Ageism, including gerontophobia and explicit hatred toward older people as well as implicit/covert ageism or automatic and "unconscious operation of age stereotypes" (Levy, 2009), is underrecognized and understudied. For health and human services professionals, conscious awareness and combat of one's own ageist prejudice, belief, stereotypes, and their harmful consequences are part of ongoing professionalization. No matter which form ageist feeling, belief, and behavior are expressed through, they can be identified as disrespect, invisibilization, and infantilization of older adults, treating them as "others." They characterize older adults as dependent, incompetent, useless, asexual, frail, and incapable of change. Two most discussed discriminatory language styles are overaccommodation and *baby talk* or *elderspeak*, which are experienced by older adults in daily life as well as in healthcare and human services settings as people use simplified vocabulary, exaggerated tone, slower rate, and high pitch intonation when they converse with older adults (Kemper, 1994; Levy et al., 2016; Nelson, 2005).

Positive ageism perceives older adults as warm, wise, affluent, and caring people who less likely engage in criminal activities, participate more in voluntary activities, and receive more positive societal treatment such as senior discounts, pensions, social security, etc. (Levy et al.,

2016; Palmore, 1979, 1990). However, as Levy et al. (2016) stated, positive forms of ageism and their effects have not been as documented and understood as negative ageism. Existing research shows that positive age stereotypes and belief are associated with longevity, higher degrees of agency, and higher social engagement and cognitive performance among older adults (Barber, & Mather, 2014; Johnson & Mutchler, 2013; Levy & Langer, 1994; Levy, Slade, Kunkel, & Kasl, 2002; Levy, Slade, Pietrzak, & Ferrucci, 2018; Meisner, 2011).

Growing evidence has suggested that negative ageism not only reduces social and economic participation of older adults as well as their life satisfaction in the later life, but also is a risk factor for negative health, attitudes, cognitions, and behaviors, no matter whether ageism is a chronic or acute stressor (Allen Cherry, & Palmore, 2009; Levy, Zonderman, Slade, & Ferrucci, 2012). There is strong evidence to support the argument that negative ageism has a much greater effect on behavior among elders than positive ageism (Meisner, 2011). Such effects could be cumulative over time through the life course. It is recorded that socioeconomic and political marginalization and invisibility of older adults can change their self-image and biomarkers, and thus lead to self- discrimination, and physical and mental disorders such as Alzheimer's disease and anxiety (Levy et al., 2016; Levy, Zonderman, Slade, & Ferrucci, 2011).

Ageism in the Workplace

As one of the most systematic and institutionalized forms of prejudice (Butler, 1980, 1989), ageism for older adults is everywhere, such as employment, services, and housing, to name few. Case Study 1.2 gives a glance of ageism in the workplace. Under the provision of the *Age Discrimination in Employment Act of 1967 (ADEA),* a civil rights era product, it is unlawful for employers, who have 20 or more employees, to discriminate against an employee 40 or older because of her age with respect to any term, condition, or privilege of employment from hiring,

promotion to retention. The *Older Workers Benefit Protection Act of 1990* (OWBPA) amended the ADEA to further protect older workers' rights, particularly their rights to benefits.

However, workplace anti-ageism policies have not simply translated into pro-elder attitude and practice. Ageism and violation of older workers' rights are still prevalent. A majority of workers have witnessed or experienced age discrimination, and workers believe age discrimination in workplace begins as early as the 50s (Fleck, 2014). According to U. S. Equal Employment Opportunity Commission (EEOC) data, since 1992 there have been over 19,000 ADEA claims annually (EEOC, 2018). In many cases, older workers proved that they are subjected to arbitrary discrimination in employment, such as age preferences in job advertisements, pre-employment inquiries, denial of benefits, or layoff due to potentially costly health insurance (Terrell, 2017).

Today, older Americans work longer and earn more than before (McEntarfer, 2018), which means greater costs than younger workers for employers. Protection and advocacy for older workers' rights has become more pressingly urgent. Recent supreme court ADEA case decisions have made it harder for older workers to prove age discrimination in the workplace (Farrell, 2017). These decisions illustrate the difficulty in combating ageism and embracing an anti-ageism agenda. Jessica Horton in Case Study 1.2 was alert and strategic about ADEA claims, which certainly reflects the concern that age discrimination has not gained a civil rights statute (McCann, 2018). Ms. Horton's initial focus was Dona's concern whether she was "knowing and voluntary" with the ADEA specific requirements involving an ADEA waiver. To make her ADEA waiver valid, Dona must have been provided a period of at least 21 days to consider the agreement before she signed. Legally, following the execution of the agreement, Dona should have had a period of at least seven days if she decided to revoke the agreement.

Ageism in Health and Human Services

It is critical for professionals to face the fact that health and human services providers are not immune to ageism, and that discrimination against elders happens in the health and human services arena. The notion of *professional ageism* highlights ageist knowledge, attitude, behavior toward older adults held and presented by health and human services providers (Buttigieg, Ilinca, de Sao Jose, & Larsson, 2018; Nelson, 2005). Recent investigations, including systematic reviews and qualitative investigations, have confirmed that physicians, nurses, and social work and psychology students, faculty, and practitioners present ageist behaviors and attitudes toward elders (Wang & Chonody, 2013; Webb, Chonody, Rarzijn, Bryan & Owen, 2016).

Ageism perception and attitude in health and human services manifests as a barrier to working with older adults, as it can unconsciously impact communication patterns and professional judgment. It can result in different diagnoses and treatments (under or over), which can affect well-being and safety of elders, and raise ethical questions (Ben-Harush et al.; 2017; Conlon & Choi, 2014). Specific examples can include the overlooking of HIV/AIDS prevention and treatment among older adults or life-or-death decisions when health and human services providers underuse evidence-based guidelines for elders (Emlet, 2006; Nichols et al., 2002; Fassier, Valour, Colin, & Danet, 2016; Tan & Black, 2018). The dire consequences of frequent healthcare discrimination based on age have been documented as higher rates of disability, lower HLE, and lower rates of healthcare-seeking in older adults than their counterparts (Chrisler, Marney, & Palatino, 2016; Rogers, Thrasher, Miao, Boscardin, & Smith, 2015).

Most of all, ageism in health and human services places a higher value on disease and disease management than prevention and health (de Leo, 2018; Nelson, 2005). Adequate evidence points out that ageist bias and misconceptions about normal aging process can result in

and exaggerate preventable and manageable diseases often associated with aging, such as diabetes, high blood pressure, depression, and elder abuse and neglect (Band-Winterstein, 2015; Grant, 1996; Han & Richardson, 2015). Safe to say, life-long professional learning is required for every helping professional to consistently examine her/his own ageism biases and practices.

Genesis of Ageism

Ageism is difficult to combat, for ageism as a social disease is pervasive, it manifests at multiple levels, from older adults' individual lives to the societal beliefs and norms, and it has deep and complicated roots. Scholars, policy makers, and practitioners have examined the genesis of ageism in the modern societies, especially western societies. A number of theoretical explanations attempted to identify root causes of ageism. *Age segregation or separation*, *death fear or anxiety*, and *modernity* are such attempts.

Age segregation. Studies in health and human services education have long proposed age segregation or separation as the reason why future professionals resist gerontology and geriatrics. This approach adopts the hypothesis that social separation between old and young generations is the root cause of ageism. Advocated by Hagestad and Uhlenberg (2005), the social separation hypothesis suggests that the modern societies are arranged by age groups, and such age segregation prevents younger people from interacting with older adults institutionally, spatially, and culturally (Hagestad & Uhlenberg, 2006). Lack of personal and professional exposure to daily lives and realities of older adults, then, is associated with higher levels of negative ageism expression and lower rates of positive ageism expression (Allen et al., 2009). Meanwhile, the literature consistently agrees that exposure to the lives of older adults is one of the strongest predictors for interests in future career pursuit in gerontology and geriatrics (Smith et al., 2017; Wang & Chonody, 2013). This approach is also called "contact theory," with focus on more

exposure and contact rather than separation or segregation (Chonody, Webb, Ranzijn, & Bryan, 2014). Evidence- based educational research, therefore, has proposed to combat the age separation by providing college students and young professionals the opportunities to directly and indirectly encounter aging and older adults at personal and professional levels (Allen, Kelly, Brooks, & Barnard, 2014).

Death anxiety. Based on interdisciplinary empirical and theoretical work, Nelson (1992) theorized death anxiety as the root of ageism, by defining it as prejudice against our future older self. This hypothesis attributes ageism biases and one's tendency to avoid older adults due to the fear of one's own inevitable aging and mortality (Butler, 1990; Nelson, 1992). It stresses ageism as inherent to the human condition beyond national boundaries and cultures (Butler, 2009). In response to this hypothesis, some researchers have applied terror management theory in professional ageism (Chonody, Webb, Ranzijn, & Bryan, 2014; Greenberg, Schimel, & Martens, 2002). For example, using terror management theory, Chonody and Wang (2014) offered psychological anxiety about aging as an explanation for ageist bias and low perceived need for gerontological content in curricular among social work faculty. Evidence indicates that death anxiety among bachelor social work students is negatively correlated with their self-reported likelihood to work with elders in future careers, and positive experience is positively correlated with the future likelihood (Eshbaugh, Gross, & Satrom, 2010). Contradicting the age separation hypothesis, the death fear or anxiety hypothesis explains why for social workers who had working experience in the gerontological field, death anxiety predicts fear of the dying of others. The longer they have worked in the field, the greater levels of death anxiety (Greene, 1984).

Modernity. The third theoretical framework on the origin of ageism links ageism to the western culture of individualism. Fassier et al. (2016) call ageist attitude and behavior in the

healthcare system "bipolar social representation of ageing" in Western societies. This analysis believes that modernity, more specifically, its high demand for individuals to function and produce, as well as its preference for the nuclear family, explain age segregation as well as negative feelings, attitudes and behaviors toward older adults (Butler, 1990; Levy et al., 2016). Ageist culture conditions systematic stereotypes and discrimination against older adults through value, language, and media (Segal, 2014; Wilkinson & Ferraro, 2004). At the most extreme end of ageism spectrum, ageist culture gives permission to violence against older adults in the forms of elder abuse and neglect (Phelan, 2008). When analyzing the psychosocial process of aging, Levy and colleagues have proposed *stereotype embodiment theory* in which age-stereotypes become internalized by older adults who are targeted by surrounding ageist culture stereotypes, such that embodied stereotypes influence the functioning and health of older adults (Levy, 2009; Meisner & Levy, 2016). The cultural dimension of ageism highlights deep roots of ageism and the challenging nature of the anti-ageism agenda. It also questions the age separation assumption that personal experience alone can eliminate ageism. A unique feature of this approach is its cross-cultural research on ageism, including western-eastern comparison, which greatly contribute to knowledge of positive ageism and its effects (Levy et al., 2016; Levy & Langer, 1994; Löckenhoff et al., 2009).

Human Rights Approach to Anti-Ageism Campaign

Existing theoretical frameworks of genesis of ageism can be instrumental in the anti-ageism campaign. For instance, to combat stereotypes, prejudice, and discriminatory behaviors against older adults, health and human services professionals, students, and scholars have started examining personal and professional cognitive, affective, and behavioral responses to their interaction or lack of interaction with older adults (Allen et al., 2009; São José et al., 2017).

Many educators have purposefully facilitated future professionals' exposure to older adults in order to close the social gaps between young and old generations (Allen et al., 2014; Smith et al., 2017; Wang & Chonody, 2013). Some urge professionals to recognize their own unexamined death anxiety and terror so that they can demystify the fields of gerontology and geriatrics, and/or better serve older adults (Chonody & Wang, 2014; Chonody et al., 2014; Greenberg et al., 2002). Still others have taken the culture analysis approach to critically examine organizational cultures and language such as that found in curricula, textbooks, and policies in health and human services (Duffy, 2017; São José et al., 2017). However, a successful anti-ageism campaign requires meaningful social changes beyond merely understanding the genesis of ageism. It challenges the existing power arrangements that threat older adults' fundamental rights to be respected and understood. For this reason, health and human services professionals have to further integrate two silent and related pathways into the anti-ageism campaign: A human rights approach and fundamental understanding of older Americans.

Human Rights Approach

The human rights approach defends the full citizenship of older adults, and intends to change and end socially structured prejudice, discrimination, and injustice on the basis of age. It underscores that, like other people, all older adults have fundamental human rights, such as economic, social, cultural, and civic and political rights. For instance, the rights to an adequate standard of living and the rights to the highest attainable standards of physical and mental well-being (UN, 1976) can be translated to all people shall have the rights to have safe water, affordable housing, and cutting-edge healthcare. The human rights approach is new to the anti-ageism campaign in the history of health and human services professions, though Butler, as early as 1974, made the direct linkage between ageism and human rights of older adults with his early

articulation of the concept of ageism. He claimed that ageism subtly ceases "to identify with their elders as human beings" (Butler, 1974). We propose to recognize the anti-ageism campaign as part of the boarder human rights campaign. Based on the emerging arguments and proposals, it is clear that the human rights approach brings a new and core agenda to the anti-ageism campaign: The rights of older adults. This approach Furthermore, the human rights approach is a prescriptive theory rather than a descriptive one, since it goes beyond the removal of constraints to the affirmation of full humanity of older adults. It re-centers policies and practices on older adults, particularly their dignity and equal rights in pursuing their highest potential of well-being and health. Therefore, we adopt this approach as the overarching framework for this book.

The human rights approach to the anti-ageism campaign has emerged from well-developed theoretical traditions and practices. International human rights laws and standards such as *the Universal Declaration on Human Rights (UDHR)* in 1948, *the Universal Declaration and Bill of Rights (HDBR)* in 2011, *the Principles of Older Persons (POP)* in 1991, and the proposed *United Nations Convention on the Rights of Older Persons* (HelpAge Intl, 2009) have laid a principal foundation for the human rights approach in health and human services. Different from mainstream medical, psychological frameworks, the human rights approach has turned attention to rights and strength-based attitude, language and culture. Five principles prioritized in the *POP* exemplify such change: Independence, participation, care, self-fulfillment, and dignity (UN, 1991).

To relate these principles to Mr. and Mrs. Krakowski in Case Study 1.1. we can tell that they have the privilege to enjoy adequate food, water, clothing, house, retirement, healthcare, and caring adult children. They live independently in their long-time home, and participate in the community through church, volunteering, and family life. They have planned for their end of life

choices. However, they are experiencing challenges older adults often encounter: They felt their self-determination of independence and care was threatened when their children deemed they were no longer fit to live in the home. Although such a threat is different from what Dona Barrett experienced at her company in Case Study 1.2, it raises a series of fundamental questions in human rights-based health and human services. These questions might involve (1) Who is the decision maker in employment and retirement, living arrangement, or end of life choices? (2) Should older adults be protected from their "own bad choices"? For example, does involuntary treatment of opioid abuse promote or violate the older client's autonomy and dignity? Or (3) Are policies and practices able to balance independence and protection?

Professional identity and history are another foundation of the human rights approach. For example, since the International Federation of Social Work (IFSW) redefined social work as a human rights profession in 1988, there has been a significant amount of development in the profession that elaborates human rights as an inseparable part of social work, as well as contributions social work to human rights. Considering social work's commitment to social justice and oppressed population, and its foundational theoretical frameworks such as critical theories, it is not surprising that the profession is viewed as compatible with human rights. As the United Nations recognized, "Human rights are inseparable from social work theory, values and ethics, and practice. Rights corresponding to human needs have to be upheld and fostered, and they embody the justification and motivation for social work action. Advocacy of such rights must therefore be an integral part of social work" (as cited in Witkin, 1998, United Nations Center for Human Rights, 1992, p.10).

While many have applied human rights into social work practice, the leading figures have been Stanley L. Witkin (1994, 1998), Jim Ife (2001, 2012), Lynne M. Healy (2001, 2011), and

Elisabeth Reichert (2003). As Witkin first integrated human rights and social work in the areas of research and teaching, Jim Ife (2001) is the first to systematically incorporate the broader concept of human rights as a center for a new form of social work practice. Reichert pioneered human rights analysis of social policy, and argued human rights as the center of social policy and social work practice (2003). Carole B. Cox holds particular significance in human rights-based social policy analysis due to her studies of social policies around older Americans from a human rights perspective (2015). It is noteworthy that Cox's works illustrate changes in the anti-ageism agenda as she came from a needs-based approach in her earlier aging policy book.

Understanding Older Americans

The second pathway into the new anti-ageism campaign is to fundamentally and fully understand older adults as human beings and citizens, including their rights, unique characteristics, strengths, challenges, and opportunities. Table 1.1 captures key features of older Americans in 2016. It illustrates that statistically a "typical" older American in 2016 is a white female, 75 years old, married, living with spouse in the community. She has the median income of $18,380, mainly from SS. She has about 11 LE. It shows that the US is experiencing moderate growth in population aging, with fastest growth in the oldest old segment.

The portrait of older Americans. Different from deeply rooted and pervasive ageist beliefs, Table 1.1 reveals that (1) older Americans live healthier; (2) they generally live in communities rather than nursing homes; (3) they are more engaged, with near 1/5 in workplace, 70.9% general election turn-out rate in 2016, 1/3 caring for family members, over 1/5 volunteering, and at least 42% digitally connected; and (4) they are more educated and more diverse in age, gender, race/ethnicity, SES, marital status, living arrangements, geography, immigration history, religion/spirituality, and health status than previous generations. It

demonstrates older adults are a powerful political, economic, and social group in the contemporary American society. It highlights the continuous feminization of aging population, changing racial/ethnic landscape, higher visibility of older LGBT adults, and widening inequality in economic and social status. While the profile of older Americans in 2016 cannot quantify the discrimination they experienced, it does correspond to challenges they face, such as social injustice and health disparities, as two cases in this chapter suggest.

Table 1.1 *Older American Profile 2016*

Indicator	%		
Age			
Aging rate 2017	15.6	51.1 m	15 and 49.3 in 2016
Median Age		75 in 2015	
65-74		28.6 m	
75-84		14.2 m	
85+	0.2	6.4 m	
100+ of Aging Population		81,896	
Sex (M/F)	44/56	21.7/27.5 m	Ratio:0.79 at 65, 0.55 at 85 (Total pop:0.97)
LGBT APA		2.4 m	Self-identified
Race/Ethnicity			Diversity is growing
Non-Hispanic White	77	38.1 m	Predicted 54.6% in 2060
African-American (Non-Hispanic)	9		Racial/ethnic minority:11.1
Hispanic Origin	8		
Asian or Pacific Islander	4		
Native American and Hawaiian	0.6		

Two or more Races	0.9		
Marital Status			
Married M/F	70/46		Widowhood: 33% in 2017
Geography			
Rural/Urban 2014 HAC	25/75		Rural is older and aging faster
Top Aging States			FL, ME, WV, VT, MT
Living Arrangement			
Live with Spouse/Partner 2017	59	28.9 m	M: 72%; F 48%. F age 75+: 34%
Live Alone	28	13.8 m	F:9.3; M: 4.5; F age 75+: 45%
Institutionalized	3.1	1.5 m	65-74:1; 75-84:3; 85+:9
Financial Well-being			
Median Income for M/F		$31,618/18,380	Before adjusting for inflation
Median Household Income		$58,559	Racial disparities
Source: Social Security 2015	84	4.6 m	Gender & racial inequality widening
Mean Net Worth		$1.07 m	
Poverty & SPM	9.3: 14.5	4.6/7.1 m; $20,600	Inequality widening
Indebtedness at 75+	50		Mortgage, credit card, vehicle, and ed
Employment			
Working (M/F)	19.3	9.6 m (5.3/4.3)	6% of US Labor force
	(23.9/15.7)		Working longer, 5.3 m full-time 2015
Age Stop Working Kadlec	51	61-65	Projecting 66 in 2018, increased from 60 in
Retirement Age 2018	66 y+4m		1990
Education			

High School	86		More educated but racial disparities
Religion & Spirituality 2015 FRC			Considered most religious age group
Christian	83		
Jewish	3		
Buddhist	1		
Unaffiliated Religiously	12		
Other	1		Hindu, Muslim, other faiths & religions
Immigration History 2010	12	86,415	Mehta et al. 2016;
Vote 2016 Census	70.9		2016 election
Volunteer 2013	23.5-24.5	90 hours/year	US Labor Stats
Digital Connection PRC 2017	42	>50 internet use	Smartphone ownership18% in 2013
Health			
LE at 65 (M/F) ACL		19.4（18/20.6）	Gender gap is narrowing
HLE at birth WHO		68.5	
One Chronic Condition 2017	80		Top five chronic conditions in 2015: Hypertension (58%), hyperlipidemia (48%), arthritis (31%), ischemic heart disease (29%), and diabetes (27%).
NCAD	68		
Two Chronic Condition 2017		7.1	
Hospitalization 2015			
Healthcare Expenditure			
Of Total Expenditure	13.1		All consumers: 8
For Insurance	69	$4,159	
For Medical Services	15	$913	
For Drugs	12	$715	

For Medical Supplies	3	$207	
Out of Pocket Healthcare		$5,994	Total population: 4,612
Disability and Functioning			
Disability Rate	35		
Physical Functioning Difficulties	44.3		At 75+
Caregiving needs at 85+	22		65-74:3; 75-84:9
Caregiving at 60 2015		1 m	For grandchildren
		872,042	For IDD family members

To better understand older Americans and their challenges and opportunities, to work with older adults without professional ageism, special attention needs to be given to (1) diversity as a unique strength of older Americans and a powerful source of American gerontology and geriatrics, and (2) the influence of intersectionality between aging and gender, social class, race/ethnicity, immigration, rural-urban dichotomy, and sexual orientation and gender identity in the aging experience of minority older Americans. Like other older Americans, minority older adults are heterogeneous, and their experiences with human rights protection or discrimination are different. Extensive research recorded disparities among minority elders such as older women, racial/ethnical minority elders, rural elders, elders in lower social classes, and older LGBT adults (). Many have described social, economic, and health disparities between minority older adults and general population of older adults, as well as older minority subgroups and individuals, which are echoed by other empirical observations on differences and disparities in quality of life, health behavior, cognitive health conditions, caregiving needs (Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emlet, 2014; Marti-Pastor et al., 2018).

Intersectionality. We emphasize intersectionality as the key to understanding older Americans and their rights. Addressing and understanding the role of intersectionality in the rights and well-being of older American across the lifespan can uniquely equip future professionals to build a partnership with older Americans in all gerontological and geriatric settings. Gerontologists and geriatrics have applied and further developed the intersectionality theory (Crenshaw, 1989). Theories like *double jeopardy*, *diminished (economic returns*, and *minority stress theory* have provided theoretical frameworks to emphasize and understand the role of intersectionality in contemporary older Americans' aging experience, particularly rights and well-being of older blacks and LGBT adults (Abbruzese & Simon, 2018; Assari, 2018a; Yoon, Cohum, & Spence, 2018). For instance, the notion of *gay ageism* could be used to specifically gain insight about the unique intersectional stress of ageism and sexual/gender minority status (Wight, LeBlanc, Meyer, & Harig, 2015).

Awareness of intersectionality can also assist professionals to understand how life-long discrimination in education and workplace puts minority elders at financial disadvantage in all three legs of the US retirement income system: Personal savings/assets, pension, and social security income (Abramovitz, 2017; Bishaw & Posey, 2017; Blau, 2016; Maril & Estes, 2013; NWLC, 2017; Poterba, 2014; Rank, Hadley, & Williams, 2014; Stone, 2018; Venn, Davidson, & Arber, 2011). For instance, the SS income formula is based on one's earnings in the highest 35 years he or she earned income. If women leave the labor market fully or part-time for child raising or other types of family caregiving, their SS income will be lower than their counterparts who never have disrupted their work life. For Dona Barrett in Case Study 1.2, earlier retirement alone can be a reason for concern about her financial security in her later life. Assari and colleagues provided another example of the role of intersectionality in minority elders. Multiple

national representative datasets document that life- long employment status and cumulated high income do not protect Black Americans from risk of mental health issues, such as depression, or gain in life expectancy, as they do for white Americans (Assari, 2018a, 2018b; Assari, Lapeyrouse, & Neighbors, 2018).

Lastly, intersectionality highlights the strengths and resilience older Americans possess and present, even though acute and chronic discrimination and historical trauma, both deeply personal and collective, pose an array of risks for economic, physical, social and mental health for minority elders (Erdley, Anklam & Reardon, 2014; Orel & Fruhauf, 2015). For instance, it is recognized that rural elders and immigrant elders hold stronger filial beliefs and emphasize alternative coping mechanisms, such as informal assistance (Morton & Weng 2013; Savla et al., 2018; Weaver & Roberto, 2018; Weaver et al., 2018). Culturally competent health and human service professionals are able to empower older adults by recognizing and integrating cultural values and practices into policy advocacy, programming and treatment plans while ensuring equal accessibility of quality formal services.

Chapter Summary

Population aging calls for greater expansion of gerontology and geriatrics workforce. More deeply, it calls for meaningful changes in pervasive ageism against older adults. This chapter draws a portrait of older Americans who are more diverse, healthy, active, and also more unequal than ever. The characteristics of older Americans asks competent and ethical professionals to recognize and combat pervasive ageism in his or her own attitudes, emotion, beliefs, and behaviors as in the society and professional practice. Beyond the prevalent and descriptive orientations to anti-ageism in relations to age separation, death anxiety, and modality, this chapter highlights two essential pathways to the new anti-ageism campaign: Human rights

and fundamental understanding of older Americans and their intersectional lives. The human rights approach is proposed as a central proposition in the anti-ageism campaign so that health and human services providers are able to respect and celebrate older Americans' rights, and negotiate goals that ensure older Americans' highest potential of well-being and health.

Chapter 1 Review Questions

1. What might be an appropriate definition of “old age”?
    a. A chronological age.
    b. A social category for people aged 50 or older.
    c. Aged 65 or older.
    d. There is no commonly agreed definition.
2. What are three theories explaining ageism, according to this chapter?
    a. Age segregation, death anxiety, and modality.
    b. Activity theory, life course theory, and minority stress theory.
    c. Activity theory, age separation, and contact theory.
    d. Age segregation, death fear, and diminished return theory
3. What are the Five principles highlighted in the United Nation’s Principles of Old Person 1991?
    a. Competency, dignity, social justice, safety, and self-determination.
    b. Independency, participation, care, self-fulfillment, and dignity.
    c. Physical Safety, financial security, care, services, and self-determination.
    d. Self-determination, dignity and worth of the person, social justice, service, and competence.
4. Professional ageism refers to
    a. A social work intern convers with the older client with simplified vocabulary and high pitch voice.
    b. Ageist knowledge, attitude, and behavior toward to older adults in health and human services professionals.

   c. Negative ageist knowledge, attitude, and behavior toward to older adults in health and human services professionals.
   d. Positive ageist knowledge, attitude, and behavior toward to older adults in health and human services professionals.

5. Considering the high rates of chronic illness and disability among older adults, what are challenges do you think human rights-based vs. needs-based gerontology and geriatrics?
6. What is your goal for gerontology and geriatrics? Will your goal be different from older adults? Please provide rationales.

Additional Exercise

1. Take the Ageing Attitudes Quiz at http://www.who.int/ageing/features/attitudes-quiz/en/ and discuss the result with one older adult you know.
2. Print the Palmore Ageism Survey to the above meeting. Ask the older adult to fill out the Survey, then discuss the results and ways you both propose to change the treatments older adults receive in society.
3. Search all available job ads or job websites of 10 organizations of your choice, five each from private and public sectors, then analyze whether or not each and all might have presented age discrimination. Please provide concrete evidence to support your analysis.

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