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Aging as a Social Process

Canada and Beyond

Andrew V. Wister

Seventh Edition

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Contents

Preface

> *To be able to learn is to be young, and whoever keeps the joy of learning in him or her remains forever young.*
>
> — J.G. Bennett, 1897–1974

The objective of this book is to present a synthesis and interpretation of social behavioural research concerning individual and population aging, with a focus on aging in Canada but one supplemented with international knowledge positioned in a global context where applicable. The emphasis is on identifying, describing, and explaining patterns, processes, and current issues in aging. This approach enables students and practitioners to acquire fundamental knowledge about older people and to develop a broad understanding of aging processes and issues that may be experienced across the life course. Reading the book involves more than accumulating information for a midterm or final examination. As you read, personalize the information so that you are prepared to move through life with reflection and understanding, to help family members as they age, to participate in an aging society as an employee or as a volunteer serving older adults, and to engage in aging-related issues confronting your community, region, or province—or the world.

This is the seventh edition of this textbook. The 1983 edition was the first textbook on aging in Canada and was written at a time when few scholarly resources about aging in Canada were available. The second and third (1990 and 1998) editions reflected the growth of Canadian research about aging, and the fourth edition (2004) included even more "made-in-Canada" knowledge about aging. That is why, for the first time, the book was subtitled *Canadian Perspectives*. These first four editions were solo-authored by Barry McPherson, who, along with Victor Marshall, taught the first courses on aging in Canadian universities.

I was invited to co-author the fifth edition (2008) with Barry and gladly accepted, in part because of my long history with both the author and the book. I met Barry McPherson in 1985, at which time I began a post-doctoral fellowship at the University of Waterloo under his direction. The first course that I taught in the area of sociology of aging (starting in 1985–86) was in fact Barry's course, a course that I have taught in different forms for more than 30 years. Over the years of my academic life course, I reviewed subsequent editions of the book, so it was a natural process by which I eventually became a co-author on the fifth edition. We significantly revised the structure of that edition in response to suggestions from students and faculty who had read previous editions, including adding a new chapter on health and aging, expanded sections about the aging baby boom generation, Internet resources, a glossary, and updated literature on every topic.

With Barry in partial retirement mode and busy cycling the highways of North America and Europe, I assumed the role of lead author for the sixth edition. It was further enhanced with expanded sections addressing poverty, gender, ethnicity, and their intersections; new research and program developments in areas such as longevity, innovative care models, and elder abuse; and an updated timeline of historical developments in the study of aging phenomena, with a focus on Canada. In this current seventh edition, I have assumed the role of author, and Barry has helped to make the transition that started with our partnership on the fifth edition natural and seamless. Building on the essential material covered in the previous editions, the current book has integrated considerable new literature and knowledge in this

burgeoning field. The change in subtitle, replacing "Canadian Perspectives" with "Canada and Beyond," reflects the positioning and contextualizing of knowledge internationally with a world view. The seventh edition has been updated to capture new science, emerging challenges, and shifting paradigms in aging, including gendered processes, intersectionality of characteristics of vulnerable groups, such as those who are socially isolated older adults, models of resilience and adaptation, health-care integration and reform, end-of-life care, and global aging. These developments not only reflect my exposure to interdisciplinary research, policy, and practice, but also my fruitful experience as chair of the National Seniors Council of Canada (2012–16), as well as my active involvement with the Canadian Longitudinal Study on Aging for more than a decade.

The field of social gerontology has grown exponentially, developing into a new interdisciplinary phase that makes research in, and the study of, all key areas challenging. We have maintained a Canadian focus without sacrificing developments in the field globally. In addition, where available as of February 2018, all data in the text have been updated based on the 2016 Canadian census, labour force surveys, the Canadian Community Health and General Social Surveys, and international data from the Population Reference Bureau and US Bureau of the Census. Each chapter opens with "Learning Objectives and Key Facts," a preview of some of the major issues, ideas, and facts discussed in the chapter. And to encourage debate and reflection and to develop critical thinking and observational skills, each chapter concludes with a section entitled "For Reflection, Debate, or Action." Hopefully, these two sections will enable you to become a more critical reader who questions commonly held assumptions, myths, and erroneous beliefs about aging and older people, both in your family and in your community. In each chapter, references are cited in the text or in a note. These serve a twofold purpose. First, they provide theoretical or research support for the ideas. Second, they are a resource to help you locate and use primary sources in the basic literature if you are required to write a term paper on a specific topic or if you wish to acquire additional information about a particular subject.

Before social policies and programs for older Canadians can be initiated, we must identify and verify that a problem or a situation exists. We must understand why and how the problem or issue evolved, clarify the role of complex and interacting elements, and then propose alternative innovative solutions relevant for a specific social and/or geographic context. New information must be produced through research and then applied if efficient and effective policies and programs are to be developed and implemented. Moreover, research can refute prevailing myths or misconceptions about older persons, thereby changing or eliminating some of the negative stereotypes that we may hold about aging and about the later stages of life.

This book uses a variety of theoretical and methodological orientations to describe and explain aging processes. Although it might be desirable to write a book from a single theoretical perspective, our ability to do so is limited, since the social science literature about aging and later life requires a number of perspectives, from a variety of disciplines, if we are to have a more complete understanding of aging phenomena. However, throughout this edition, the life-course perspective is employed as an overarching integrative framework, since events, decisions, behaviours, constraints, and opportunities at earlier stages in life often have cumulative positive or negative effects at later stages, both for aging individuals (namely, you) and for aging birth cohorts (the baby boomers, Gen X, Y, Z, and A). Moreover, this approach emphasizes the agency that older people, the general public, and you as students have in shaping the direction of society against the backdrop of population aging. The material in this book is based on the

premise that aging, as a social process, involves multi-level and complex interactions between individuals and various social structures and systems; within changing social, economic, political, policy, and physical environments; and across diverse cultural contexts, all of which vary at specific periods in history, as well as across one's life course. It therefore recognizes the contributions of a wide variety of methodologies and the value of integrating knowledge from different sources and perspectives. This book has three general objectives:

1. To provide you with basic concepts, theories, and methodologies that can be used to help you to understand social phenomena related to individual and population aging and to develop critical thinking and observational and interpretive skills. Moreover, with this knowledge, you will be better prepared to identify, deconstruct, and refute common misconceptions about aging and growing older. Where possible, the book presents alternative explanations for aging processes rather than a single description or interpretation of a process or problem.
2. To sensitize you to the fact that aging is not just a biological process but an equally complex social process. In fact, you may be left with the impression that there are more gaps in knowledge than answers. Herein lies a challenge to the curious innovative reader who may wish to pursue a career in this field.
3. To make you aware of the dynamic interplay between your individual life course and the local, national, and global historical and cultural forces that shape your life experiences and opportunities. Aging, as a lifelong process, must be of interest and concern to people of all ages and in all communities, cultures, and countries.

In conclusion, knowledge about social, and related, processes of aging in Canada and beyond has grown exponentially. Continued integration and synthesis of ideas from what previously were thought to be separate disciplines with distinct pillars of knowledge have resulted in innovative developments at the crossroads of disciplines. Critical thinking and reflection are essential skills to acquire, since gaps in knowledge, differing opinions and interpretations, and even controversy concerning issues, processes, programs, or policies for aging adults or an aging society are prevalent in contemporary Canadian society. Thus, we encourage you to become a critical imaginative reader and thinker, to ask questions about what you read, and to discuss with others the validity and applicability of research findings presented in any single study. One published article on a particular subject does not represent the absolute truth. Indeed, even many research studies on a topic may not provide a complete and valid explanation of a specific process, pattern, or problem. To illustrate, many studies describe only one slice of a social setting or community at one point in time. Other relevant social, individual, cultural, structural, or historical factors may not be considered in the analysis and interpretation of the results. Therefore, we encourage you to search for and debate the merits of alternative explanations and to be cautious in what you accept as fact—including what you read in this book.

Finally, the test of how well a book serves as a learning resource is whether students find the material useful, interesting, clearly written, and comprehensive. Please provide feedback about this book to your instructor and to the author:

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October 2018

Acknowledgments

The writing of the seventh edition of *Aging as a Social Process: Canada and Beyond* required intensive work over a long period. It could not have been completed without the support and assistance of family, friends, and colleagues. First and foremost, I would like to thank my wife, colleague, and life partner, Barbara Mitchell, for providing the inspiration, time, and feedback needed to tackle this project. Her expertise in the sociology of the family, theory, and policy helped me fine-tune sections of the new edition. My daughter, Kayzia, a recent university graduate (married to husband Eric), provided the student audience perspective. Over my career, I have also enjoyed the support of my parents, Stephen and Iris Wister. I wish to acknowledge the continuing involvement of Barry McPherson, the originator of the text and my co-author on the prior two editions, who provided conceptual and editorial input. I am indebted to Barry for this opportunity. Thanks are also due to the many professors, students, and practitioners across Canada who submitted constructive criticisms about the content and structure of previous editions. Aman Chandi, communications officer at the SFU Gerontology Research Centre assisted with the "Multimedia Resources" at the end of each chapter; and Ray Adams, prior information officer, assisted with the updating of the Web-based resources shown in the Appendix. On the production side at Oxford University Press, we thank the many staff who contributed to the editing and production of this book, in particular Ian Nussbaum and Rhiannon Wong. We are also deeply appreciative of the assistance provided by Judith Turnbull, a freelance copyeditor, who significantly improved the manuscript with her creative, constructive, and rapid copyediting.

Developments in Social Gerontology since 1940 That Have Had a Major Impact on Canadian Research, Policy, and Practice

1940

1945 Establishment of the Gerontological Society (later named GSA "of America") to hold annual meetings to promote the scientific study of aging from multi-disciplinary perspectives, and to stimulate communication among scientists, researchers, teachers, and professionals.

1948 O. Pollock/*Social Adjustment in Old Age*. This landmark report of the US Social Sciences Research Council shifted focus from problems of aging to the process of aging and led to several theoretical developments in social gerontology.

1948 Founding of the International Association of Gerontology in Liege, Belgium.

1940 Publication of the journal *Geriatrics*.

1945 The first issue of the *Journal of Gerontology*.

1950

1953 R. Havighurst and R. Albrecht/*Older People*.

1959–60 These handbooks summarized the knowledge about a number of gerontology topics in the late 1950s: J. Birren, Ed./*Handbook of Aging and the Individual: Psychological and Biological;* C. Tibbitts, Ed./*Handbook of Social Gerontology: Societal Aspects of Aging;* E. Burgess, Ed./*Aging in Western Societies*.

1959 Ontario Longitudinal Study on Aging initiated under the leadership of L. Crawford. Followed 2000 men from 1959 to 1978, with follow-up in 1990.

1959 L.D. Cain Jr., Ed./*The Sociology of Aging: A Trend Report and Bibliography: Special Issue in Current Sociology*.

1960

1962 The "Aging in the World" series included papers from the Fifth Congress of the International Association of Gerontology held in 1960. These volumes, which illustrated the increasing global interest in aging and the growing interdisciplinarity of the field, included the following: C. Tibbits and W. Donahue, Eds/*Social and Psychological Aspects of Aging;* J. Kaplan and G. Aldridge, Eds/*Social Welfare of the Aging;* N. Shock, Ed./*Biological Aspects of Aging;* H. Blumenthal, Ed./*Medical and Clinical Aspects of Aging*.

1961 *The Gerontologist:* A second journal published by the Gerontological Society to focus on applied research, model programs, and policy initiatives for professionals working with and for the aged.

1961 E. Cumming; W. Henry/*Growing Old: The Process of Disengagement*. The first attempt to develop a social gerontological theory to account for satisfaction in the later years.

1961 First US White House Conference on Aging. These conferences are held every 10 years in the United States to draw scientists and professional workers together to make recommendations for consideration by Congress.

1965 D. Schonfield/"Memory Changes with Age." Article published in *Nature* by a Canadian psychologist who mentored many first-generation gerontologists in Canada.

1967 E. Youmans/*Older Rural Americans*. One of the few studies to consider aging in a rural context.

1968 B. Neugarten, Ed./*Middle Age and Aging: A Reader in Social Psychology*. The first collection of readings on the social psychology of aging.

1968 E. Shanas et al./*Older People in Three Industrial Societies*. A cross-national comparative study of the social situation of older people in Denmark, Great Britain, and the United States.

1968 M. Riley; A. Foner, Eds/*Aging and Society,* Vol. 1: *An Inventory of Research Findings*. This landmark volume presented and interpreted the empirical findings of social science research to this date.

1969 R. Havighurst et al./*Adjustment to Retirement: A Cross-National Study*.

1969 M. Riley et al., Eds/*Aging and Society,* Vol. 2: *Aging and the Professions*. A statement of the concerns and involvement of a number of professions in the care of older adults.

1970 E. Palmore/*Normal Aging: Reports from the Duke Longitudinal Studies, 1955–69*. The first interdisciplinary longitudinal study.

1970–72 First sociology of aging courses taught in Canada by B. Havens (University of Manitoba); B. McPherson (University of Waterloo); and V. Marshall (McMaster University).

1971 Manitoba Longitudinal Study on Aging initiated. Elderly individuals living were interviewed first in 1971 and later in 1976 and 1983.

1971 Founding of Canadian Association on Gerontology.

1972 R. Atchley/*The Social Forces in Later Life: An Introduction to Social Gerontology*. The first textbook written exclusively for undergraduates in social gerontology courses.

1972 M. Riley et al./*Aging and Society,* Vol. 3: *A Sociology of Age Stratification*. Presents a model of aging that stresses the interaction between history and the social structure as it affects various age cohorts.

1974 National Institute on Aging (NIA) established in the United States to promote research on all facets of aging.

1974 D. Cowgill; L. Holmes/*Aging and Modernization*. This book popularized modernization theory to explain the changing status of the elderly in primitive and developing societies.

1965 1970 1975

1976 J. Schulz/*The Economics of Aging*.

1976 R. Butler/*Why Survive? Being Old in America*. This book won a Pulitzer Prize, bringing aging to the attention of the media and the public of all ages.

1976–77 These handbooks represented the state of knowledge up to the mid-1970s: R. Binstock and E. Shanas, Eds/*Handbook of Aging and the Social Sciences* (1976); J. Birren and K. Schaie, Eds/*Handbook of the Psychology of Aging* (1977); C. Finch and L. Hayflick, Eds/*Handbook of the Biology of Aging* (1977). Subsequent editions have been published every five to seven years.

1979 *Research on Aging: A Quarterly Journal of Social Gerontology* first published.

1979 Social Sciences and Humanities Research Council of Canada (SSHRC) Strategic Grants Committee on Population Aging was established to fund research and to assist in establishing aging centres across Canada.

1979 Program in aging established at the University of Toronto.

1986 N. Chappell; L. Strain; A. Blandford/*Aging and Health Care: A Social Perspective*.

1986 Butterworths Perspectives on *Individual and Population Aging* published under the editorship of B. McPherson. The series, which ended in 1992, published a total of 15 monographs on major aging topics. The first monograph was by S. McDaniel/*Canada's Aging Population* (1986). Selected monographs are included in this timeline; and a summary of developments on most of the topics since the series ended appeared in *CJA*, 30 (3): 2011, edited by H. Northcott; M. Rosenberg.

1975 — 1980 — 1985

1975 Association for Gerontology in Higher Education (AGHE) formed to facilitate leadership development for training programs that were being established in universities and colleges.

1975 R. Rapaport and R. Rapaport, Eds/*Leisure and the Family Life Cycle*. The first examination of leisure within the family context across the life cycle.

1980 Gerontology Research Council of Ontario established.

1980 The National Advisory Council on Aging (NACA) of Canada created to assist and advise the federal government on seniors' issues.

1980 P. Lawton/*Environment and Aging*. Development of person–environment fit theory.

1980 V. Marshall/*Aging in Canada: Social Perspective*. This was the first reader presenting a collection of articles pertaining to aging and the aged in Canada. Second edition published 1987 with considerably more Canadian content.

1982 *Canadian Journal on Aging* first published.

1982/83 Gerontology centres and programs funded by SSHRC established at Guelph, Manitoba, Simon Fraser, Toronto, and Moncton universities.

1983 B. McPherson/*Aging as a Social Process: An Introduction to Individual and Population Aging*. First Canadian text, now in seventh edition (2019).

1984 J. Myles/*Old Age in the Welfare State: The Political Economy of Public Pensions*. Early development of pension issues and challenges in Canada.

Mid-1980s
Undergraduate programs developed at McMaster University, the University of Waterloo, and St Thomas University.

1987 US Bureau of the Census/*An Aging World*. This is the first of nine publications on global aging, the most recent by K. Kinsella; W. He (2009).

1987 E. Gee; M. Kimball/*Women and Aging*. Butterworths Series.

1987 W. Forbes; J. Jackson; A. Kraus/*Institutionalization of the Elderly in Canada.* Butterworths Series.

1987 N. Chappell; L. Driedger/*Aging and Ethnicity: Toward an Interface*. Butterworths Series.

1988 J. Birren; V. Bengtson/*Emergent Theories of Aging.*

1988 M. Novak/*Aging and Society*.

1988 Research Centre on Aging, Sherbrooke, QC, established, funded by Fonds de recherché en santé du Québec (FRSQ).

1988 L. Plouffe; F. Béland, Eds/*Canadian Journal on Aging Special Issue—Francophone Research in Gerontology in Canada* 7 (4). This was an important issue of CJA that attempted to make French-language gerontological research more widely known.

1990 CARNET: The Canadian Aging Research Network established.

1990s–present Several graduate programs in Gerontology were MA/MSc/PhD, established in a number of Canadian universities.

1991 L. McDonald/*Elder Abuse in Canada.* Butterworths Series.

1991 A. Martin-Matthews/*Widowhood in Later Life*. Butterworths Series.

1991 M. Minkler; C. Estes/*Critical Perspectives on Aging: The Political and Moral Economy of Growing Old*. Development of a critical perspective in aging.

1991 Canadian Study of Health and Aging initiated. A ten-year study with a focus on dementia and its care.

1995 S. Arber; J. Ginn/*Connecting Gender and Aging: A Sociological Approach*.

1996 B. Spencer; F. Denton/Independence and Economic Security of the Older Population (IESOP) Program. Led to SEDAP in 1999.

1996 D. Foot/*Boom, Bust & Echo: How to Profit from the Coming Demographic Shift*. First Canadian book to envisage population aging as the primary driver of social and economic change.

1996 Quebec Network for Research on Aging established, funded by FRSQ.

1997 E. Gee; A. Martin-Matthews, Eds/*Canadian Public Policy/Canadian Journal on Aging Joint Issue–Bridging Policy and Research on Aging*. Vol. 23 (CPP)/Vol. 16 (CJA).

1997 E. Moore; M. Rosenberg; D. McGuinness/*Growing Old in Canada: Demographic and Geographic Perspectives*.

1998 J. Giele; G. Elder/*Methods of Life Course Research: Qualitative and Quantitative Approaches*. Connected life-course theory and methods.

1999 R. Friedland; L. Summer/*Demography Is Not Destiny*. This was the first book to address apocalyptic demography.

1999–2003 B. Spencer; F. Denton/*Social and Economic Dimensions of an Aging Population* (SEDAP), Vols 1 & 2 (2005–11), a multi-disciplinary SSHRC-funded research program. Supported a network of researchers from across the country to develop a series of major papers on this topic.

1990 1995 2000

2000

2000 Canadian Institutes of Health Research (CIHR) created. The Institute of Aging (IA) was one of 13 institutes created by the CIHR to stimulate research on health issues related to aging.

2000 E. Gee; G. Gutman/*The Overselling of Population Aging: Apocalyptic Demography, Intergenerational Challenges, and Social Policy*. First Canadian book to critique population aging as apocalyptic.

2002 J. McMullin; V. Marshall/*Workforce Aging in the New Economy* (*WANE*). Project funded by SSHRC. One of the largest funded studies by SSHRC in aging.

2001 17th World Congress of the International Association of Gerontology (IAG; now IAGG, Geriatrics added), Vancouver, Canada. This was the first IAGG conference in Canada.

2001 A. Martin-Matthews; F. Béland, Eds/*Canadian Journal on Aging*, *Special Issue—Northern Lights: Reflections on Canadian Gerontological Research,* Vol. 20.

2001 I. Connidis/*Family Ties and Aging*. Developed out of the original Butterworths Series (1989). Second edition published 2010.

2001 G. Kenyon/*Narrative Gerontology: Theory, Research and Practice*. A first Canadian examination of narrative theory and analyses.

2001 Initial developmental meeting of the Canadian Longitudinal Study on Aging, CLSA, Alymer, QC.

2003 N. Chappell; E. Gee; L. McDonald; M. Stones/*Aging in Contemporary Canada*. Second edition 2008, without E. Gee, who died in 2002.

2003 V. Marshall; W. Heinz; A. Verma/*Restructuring Work and the Life Course.*

2003 W. Heinz; V. Marshall/*Social Dynamics of the Life Course: Transitions, Institutions and Interrelations.*

2004 J. McMullin/*Understanding Social Inequality: Intersections of Class, Age, Gender, Ethnicity, and Race in Canada*. Second edition published 2010, third edition 2017 (with J. Curtis).

2006 B. Mitchell/*Boomerang Age: Transitions to Adulthood in Families.* A life-course analysis of family transitions.

2006 Government of Canada. *Healthy Aging in Canada: A New Vision, a Vital Investment from Evidence to Action.* Provided the basis for the Healthy Living and the Canadian Age-Friendly Community Initiatives.

2005

2005 National Initiative for the Care of the Elderly (NICE). National network funded by the Networks of Centres of Excellence—New Initiative Program.

2005 A. Wister/*Baby Boomer Health Dynamics: How Are We Aging?* First Canadian book addressing health of the baby boomers.

2005 Public Health Agency of Canada/*Report on Seniors Falls in Canada*.

2007 National Seniors Council of Canada established, replacing NACA. Numerous reports were produced covering several areas, including elder abuse, volunteerism, older workers, and social isolation.

2008 N. Keating/*Rural Ageing: A Good Place to Grow Old?* Developed from an original Butterworths book (1991) focusing on rural aging in Canada.

2008 A. Martin-Matthews; J. Phillips/*Aging and Caring at the Intersection of Work and Home Life: Blurring the Boundaries.*

2010 Alzheimer Society of Canada/*Rising Tide: The Impact of Dementia on Canadian Society.*

2010 G. Gutman; C. Spencer/*Aging, Ageism and Abuse: Moving from Awareness to Action*.

2011 H. Northcott; M. Rosenberg, Eds/*Canadian Journal on Aging Special Issue—Individual and Population Aging: Commemorating the Butterworths Series and the Founding of the CJA.* Many of the original topics in the series are revisited.

2016 Canadian Longitudinal Study on Aging begins collection of first follow-up data.

2016 V. Bengtson; R. Settersten, Eds/*Handbook of Theories of Aging,* 3rd edn. First edition published 1999, second 2009.

2016 Alzheimer's Society of Canada. 2016. *Prevalence and Monetary Costs of Dementia in Canada: Population Health Expert Panel*.

2017 CIHR funds 25 research teams with CLSA catalyst grants to develop new research networks aimed at mining the CLSA data.

2017 21st World Congress of the International Association of Gerontology and Geriatrics; IAGG North American Region hosted conference in San Francisco, USA.

2010 — 2015 — 2020

2009 Canadian Longitudinal Study on Aging (CLSA) launched. This will be the largest longitudinal study on aging in Canada with 50,000 participants aged 45 and over followed for 20 years.

2012 Canadian Longitudinal Study on Aging begins collection of baseline data.

2012 The Canadian Frailty Network was established under the Government of Canada's Networks of Centres of Excellence program.

2013 S. McDaniel; Z. Zimmer, Eds/*Global Ageing in the Twenty-First Century.*

2015 Canadian Longitudinal Study on Aging begins collection of first follow-up data.

2015 The Canadian Age-Well Technology and Aging Network was established under the Government of Canada's Networks of Centres of Excellence program.

2018 M. Novak; H. Northcott; L. Campbell/*Aging and Society: Canadian Perspectives,* 8th edn (first edition published 1988).

2018 Canadian Longitudinal Study on Aging begins collection of second follow-up data.

2019 A. Wister/*Aging as a Social Process: Canada and Beyond,* 7th edn (first edition published 1983 by B. McPherson).

Part I

Interweaving Individual and Population Aging

For centuries, humans have sought ways to prolong and enhance their life. The search for a magic elixir—through healthy lifestyles, drugs, surgery, the fountain of youth—has been primarily pursued from a biological or medical perspective. Increasingly, however, researchers have discovered that social aspects of aging—such as social relationships, culture, and environmental factors, as well as biological factors and disease states—influence both individual and population aging in any society or community.

We are transitioning into the fastest pace of population aging ever in Canada and in the world, which will require an increase in knowledge about the aging process and innovative solutions to emerging issues that can have an impact throughout the **life course** (note that terms in bold throughout the text are defined in the Glossary), but especially in the later years. For students, there has never been a time as exciting as this to engage in the study of aging. The journey you are about to begin by reading *Aging as a Social Process: Canada and Beyond*, seventh edition, will be different for each person. By acquiring knowledge, separating facts from myths, and applying this information, you can enrich your own life, as well as the lives of older adults in your personal family and social networks and in society at large. Whether you are a student thinking about your future, a concerned citizen, a practitioner working with older adults, a person caring for an aging parent or other relative, a policy-maker, or a researcher, knowledge about individual and population aging is a lifelong pursuit and investment.

Part I of this book consists of four chapters that introduce facts, trends, and ways of thinking about aging and about growing older in a global society. Chapter 1 introduces the concept of aging as a social process, distinguishes between individual and population aging and elaborates linkages between them, defines four types of aging, and identifies some major challenges and opportunities, as well as images and myths about aging in Canada. In addition, the chapter introduces arguments as to why it is important to understand aging phenomena throughout the life course from a number of disciplinary and theoretical perspectives (see also Chapter 5).

Chapter 2 illustrates the diversity in the aging process and in the status of older people across time because of cultural differences and historical events. A major change in the status of older people is alleged to have occurred as societies moved from pre-industrial to industrial to postmodern states, especially after the onset of modernization. Within a

multicultural society such as Canada, the process of aging varies within Indigenous, language, ethnic, rural, and religious subcultures.

Chapter 3 briefly describes how the various physical and cognitive systems of the human organism change and adapt across the life course. The focus is on how physical and cognitive changes, which may or may not occur in all aging individuals at the same rate or to the same degree, influence the nature and frequency of social relations throughout the life course but more so in later life. Some of these natural and inevitable changes lead to a loss of independence, a lower quality of life, and a need for informal and formal support from others to complete such activities of daily living as dressing, eating, and bathing. For others, positive adaptations to these changes enable aging individuals to maximize well-being and fulfill their potential as human beings.

Chapter 4 presents an overview of demographic processes and indicators that describe the size, composition, and distribution of the population by age. Demographic facts from both developed and developing countries are introduced to place the Canadian situation in a global context. Demographic processes are dynamic, and this chapter discusses the implications of demographic changes over time, especially with respect to fertility, **mortality**, and immigration rates. The final section of the chapter examines the geographic distribution of populations by age across provincial and rural–urban boundaries and illustrates how immigration contributes to the diversity of Canada's older population.

1 Aging as a Social Process

Learning Objectives and Key Facts

By the end of this chapter, you will be able to do the following:

- Explain the concept of aging as a social process, including distinctions between individual and population aging.
- Explain why it is important to study aging and understand several major issues addressed in *Aging as a Social Process* (in particular stereotypes and ageism).
- Describe some implications of an aging population for society.
- Understand the life-course perspective as a principal theoretical framework to describe the aging process.
- Understand the development of the discipline of gerontology to help you place the knowledge into a broader perspective.

continued

Key Facts

- In 2016, almost one in six Canadians was 65 or older (5.99 million people), representing about 16.9 per cent of the total population.
- There were 8230 Canadians 100 years of age or older (i.e., centenarians), according to the 2016 census.
- In 2016, baby boomers (born between 1946 and 1965), comprising about 27 per cent of all Canadians, began to turn 65. As a result, between 2011 and 2016, the 65 to 69 age group was growing most rapidly, followed by centenarians.

Introduction: Challenges and Opportunities within an Aging World

The world is growing older as the number and proportion of older people in each country increase. In developed countries like Canada, this growth has occurred over the past 50 years as fertility rates decreased after the **baby boom** of 1946–65, while mortality rates have gradually declined. The boomers comprise 27 per cent of the total Canadian population—about 10 million individuals in 2016 compressed into the relatively narrow age range of 51 to 70. As additional cohorts of the baby boomers turn 65 and beyond, the proportion of persons 65 and over in the population will grow significantly. This growth is expected to level off after 2031 when baby boomers reach advanced age and their numbers begin to shrink. However, aging-related issues will continue beyond this point, since the back end of the baby boom generation will be experiencing many heightened aging-related issues as they move into their seventies, eighties, nineties, and beyond, well into the current century.

In developing countries, much of the increase in population aging will occur over the next 25 to 40 years as fertility rates decline and sanitation and public health improve. That is, with fewer births, older people begin to comprise a larger proportion of the total population, and with improved sanitation and public health, people will live longer, also increasing the proportion of the population that is older. Population aging in these countries will occur at a faster pace than in more developed countries because of more rapid drops in fertility and mortality rates. This global phenomenon, known as **population aging**, is illustrated by the following facts or projections (He et al. 2016).

- In 2015, 8.5 per cent of the world's population was 65 years of age or older, estimated at 617 million individuals.
- By 2050, there will be approximately 1.6 billion persons 65 and older, representing about one in six people in the world, or 16.7 per cent.
- In developed or modernized countries, 16.5 per cent of the population is 65 or over (He et al. 2016). In some of these countries, the proportion is projected to reach one in four, one in three, or even one in two during the next 35 years.
- In comparison, only about 7 per cent of the population in the less-developed nations is 65 and over. However, this percentage will rise quickly over the next several decades.
- In terms of total numbers, about three-quarters of the world's older population lives in developing countries, given their large populations.

In 2016, 8230 Canadians were 100 years of age or older—an increase of 41.3 per cent since 2011—compared to more than 60,000 centenarians in Japan, the country with the highest life expectancy. We live not only in an aging world but in a society in which older citizens are healthier and more active. As individuals and as a society, we cannot ignore the challenges of population aging and the needs of older adults. Understanding and developing a society for all ages is essential. The effects of population aging permeate all spheres of social life: work, the family, **leisure**, politics, **public policy**, the economy, health care, housing, and transportation. Consequently, both challenges and opportunities exist for aging individuals, as well as for family members, politicians, employers and employees, health and social services personnel, and public policy–makers. Indeed, aging issues are linked to many of the well-known challenges facing societies, including **gender** and LGBTQ2[1] (also termed LGBTQ) inequality, intergenerational family relations, **retirement** and economic security, disability, universal access to health care, and social assistance in later life, to name but a few.

We do not age in a vacuum. Rather, individually and collectively (as a family, **community**, or society), we live in a social world. In our lifelong journey, we interact with other individuals and **age cohorts** across time and within a unique culture, social system, and community. Just as individuals change as they grow older, so do **social institutions**—such as the family, the health-care system, the labour force, the economy, and the educational system. In short, we do not age alone, nor do we have total freedom in selecting our lifestyle or **life course**. There is constant interplay among individuals and various social processes and social

Highlight 1.1 • Why Should We Study Aging and Older Adults?

- To understand diversity in aging experiences and to situate your own life with those around you.
- To challenge, refute, and eliminate myths about aging and older people.
- To assist and support older family members as they move through the later stages of life.
- To serve as an informed and effective volunteer in your community while assisting older adults.
- To prepare for a job or career (as a practitioner, policy-maker, or researcher) in which the mandate is to address aging issues or to serve an older population.
- To identify and understand significant changes in patterns of aging and in the age structure.
- To understand intergenerational relations and the status of older adults in a multicultural society.
- To critically evaluate policies and practices for an aging population and to identify where and why the needs of older adults, especially those who are most vulnerable, are not being met.
- To understand aging and older people from an interdisciplinary perspective—their potential, their competencies, their history, and the complex interactions of physical, social, and cognitive elements.
- To help Canada become a healthy and active older society.

institutions across the life course (Mitchell 2003; Dannefer and Settersten Jr. 2010; Komp and Johansson 2015). To illustrate, the state of our health at any stage in life is linked to early life experiences; lifelong personal decisions about diet and lifestyle; the cost, quality, and availability of food; and the quality of care provided by the informal and formal support systems and by the multiple components of the health-care system. It was C. Wright Mills (1959), a well-known sociologist, who first stressed that we must understand and appreciate how and why the "private troubles" or personal experiences of individuals interact with the "public issues," or public responsibilities, of a society—at the local, regional, national, and global level. This dialectical private–public debate and process of inquiry pervades the study of individual and population aging, and it should be on the agenda whenever policies or programs for older adults are being debated. Highlight 1.1 summarizes why the study of aging processes and the social world of older adults is important—to you personally, to your family, and to your community and the larger society.

Population Aging: Adding Years to Life

Throughout history, humans have been preoccupied with searching for a fountain of youth, for ways to look younger in later life, and for ways to prolong life (Gruman 2003; Fishman et al. 2008). However, it was not until the twentieth century that enormous gains in longevity were achieved, as evidenced by an increase in the average and maximum lifespan of humans, in the average life expectancy at birth, and in the number of **centenarians**—those who reach 100 years of age and beyond. While each centenarian has a different life history, their longevity, in general, can be attributed to some combination of genetics, environmental factors, diet, and lifestyle choices.

Lifespan is the fixed, finite maximum limit of survival for a species (about 20 years for dogs, about 85 for elephants, and about 120 for humans). The longest-living human with a verified birth certificate was Madame Jeanne Calment, who was born in 1875 in Arles, France—before films, cars, or airplanes had been invented. She died at the age of 122 in 1997. Today, the oldest living woman and man are about 116 and 112 years of age, respectively, living in Italy and Israel. The oldest living Canadian in 2016 was a woman aged 111, but the oldest Canadian in recorded history lived until 117 in Quebec. The maximum lifespan for humans is unlikely to increase to any great extent in the immediate future because there are natural limits that are embedded in genetic, lifestyle, and environmental factors that cannot be easily altered.

Life expectancy is the average number of years a person is projected to live at birth or at a specific age (such as 65). Average life expectancy has increased in the past 60 years and will continue to increase, although more in developing nations where life expectancy is still quite low because of high infant mortality rates, AIDS, and poor living conditions. In the early 1800s, average life expectancy in Canada was about 40 years; by the late 1800s, it had reached about 50 to 55; and by the late 1900s, it was 75 to 80. Life expectancy in China and Vietnam was about 40 years in the 1950s versus 70 years in Sweden; today, life expectancy has increased to 75 years in China and 73 in Vietnam but only to about 82 in Sweden (Population Reference Bureau 2015). These dramatic increases are part of an evolving demographic and health transition in which there are fewer deaths at birth and in infancy, and more individuals reaching advanced age. Not surprisingly, these gains in life expectancy have stimulated dreams of even longer lives but without all the physical changes that occur with age. To satisfy these wishes, entrepreneurs market anti-aging products that claim to

slow, stop, or reverse the physical process of aging (Fishman et al. 2008). However, there is little or no scientific evidence for the majority of such claims; indeed, some of the products or treatments (such as drugs or cosmetic surgery) have serious risks associated with their use (Mehlman et al. 2004).

Life expectancy varies by gender, culture, geographic region, ethnicity, race, education, personal habits (such as diet, exercise, smoking, and drinking), and birth cohort. Based on 2007 to 2009 data, the average life expectancy at birth for Canadian women was 83 years; and for men, 79 years (Statistics Canada 2012). But among Indigenous Peoples of Canada (referring to First Nations, Inuit, and Métis groups), life expectancy is lower—about 78 years for women and 73 for men (see full discussion in Chapter 2). And because of the diversity of genetic, environmental, and lifestyle factors, some Canadians will die before reaching the average life expectancy for their group, and few will ever approach the theoretical maximum lifespan.

Increased life expectancy (i.e., lower mortality) is only part of the reason that the proportion of older people in a society increases. The most important factor is a significant decline in the **fertility rate**, which has the most direct and largest effect in shaping the age structure. For instance, the large baby boom generation was the result of increased fertility rates occurring after the Second World War. In 2015, Canada's birth rate was about 11 infants per 1000 population, down from a high of 26.9 per 1000 in 1946 when the baby boom started (Population Reference Bureau 2015).

Figure 1.1 shows the actual and projected growth in Canada's older population from 1921 to 2041. As the baby boomers age, the population of those 65 and older is projected to reach about seven million in 2021 and nine million in 2041 (almost one in four Canadians).

Population aging began in Canada after the end of the baby boom period (1946–65) when a "baby bust" period (from about 1966 to 1980) began. During this period, women had fewer than two children on average, and the first pregnancy was often delayed until a woman was in her mid- to late thirties (McDaniel 1986, 96). This "baby bust" period was followed

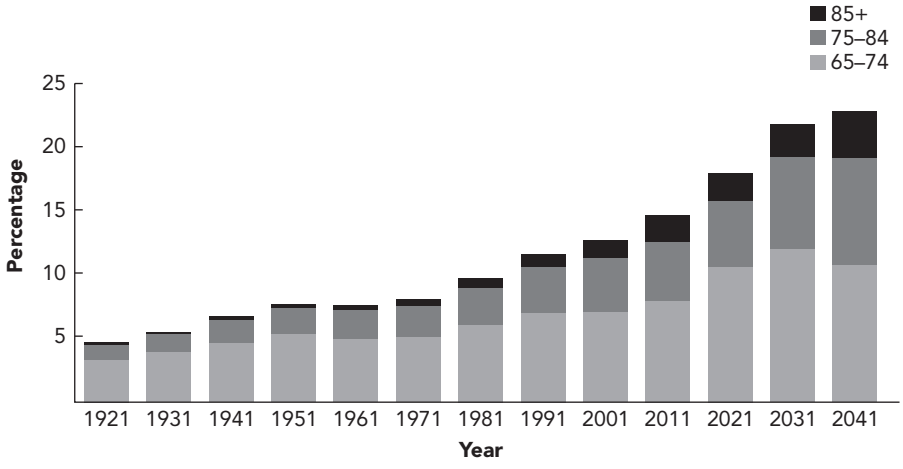

Figure 1.1 Canada's Aging Population, 1921–2041

Source: Public Health Agency of Canada, *Canada's Aging Population* (2002). Reproduced with the permission of the Minister of Public Works and Government Services Canada, 2013.

Highlight 1.2 • Journalistic Views of Population Aging

Raise Seniors' Taxes*

Ottawa should hit older people and their estates with new taxes to pay down the national debt, says a top tax lawyer. Seniors have benefited from a lifetime of economic growth boosted by government spending, and it is now time for them to pay the country back. . . . The $500-billion federal debt "belongs" to older Canadians, but younger generations are being asked to pay for it.

(*Toronto Star*, 11 November 1994)

When a Stagnant Health System Meets an Aging Population, Disaster Awaits

Canada's "silver tsunami"—the massive wave of people who will turn 65 in the next 15 years—hasn't made landfall yet but is already causing grief.

(Globe Editorial, *The Globe and Mail*, 16 January 2015)

The Boomer Shift: As the Baby Boomers Retire, the Threat of Intergenerational Inequality Looms

Here in Canada, the exit of the boomers from the labour force is already setting off a chain reaction of slower growth, low interest rates, weaker investment returns, a budget squeeze for governments and growing intergenerational tensions.

(Barrie McKenna, *The Globe and Mail*, 6 November 2015)

Canada's Looming Pension Wars: Boomers Are Only Now Starting to Take Stock of Retirement and Many Don't Like What They See

With the first wave of Baby Boomers heading into retirement, Canadians are only now starting to take stock of what kind of lifestyle they can afford with their savings. Many worry

by a small "baby boom echo" from about 1980 until the mid-1990s. However, the number of "echo" births was only about 30 per cent of the number in the original baby boom. Since the mid-1990s, fertility rates have fallen further to about 1.6 children per woman, but has stabilized near that level over the last decade. This low fertility rate is below the "replacement rate" of at least two children per woman that is needed to replenish the population when normal fertility and mortality rates prevail. However, some of this population decrease is offset by immigrants arriving in Canada, which results in modest positive population growth.

Public discourse by some politicians, media personnel, and educational environments claim that this rapid aging of the population will weaken the viability of the Canada Pension Plan, the Canadian economy, and the health-care system; that it will cause an enormous demand for long-term care and social support of older adults; and that it may lead to intergenerational inequities and/or conflict. Indeed, some consider population aging, and particularly the aging baby boomers, an impending crisis for our society. At the turn of the millennium, Ken Dychtwald, an influential futurist in the US, contended that American baby

that the grumblings of pension envy today will eventually explode in a full-blown crisis as young workers, saddled with student debt, mortgages and stagnant incomes, age into retirement.

(Tamsin McMahon and Ken MacQueen, *Maclean's Magazine*, 3 June 2014)

Rising Prevalence of Dementia Will Cripple Canadian Families, the Health-Care System and Economy

A report released by the Alzheimer Society today to mark Alzheimer Awareness Month reveals alarming new statistics about the projected economic and social costs of dementia in Canada.

(Alzheimer Society of Canada, *The Medical News*, News medical.net, 4 January 2010. Retrieved from www.news-medical.net/news/20100104/Rising-prevalence-of-dementia-will-cripple-Canadian-families-the-health-care-system-and-economy.aspx)

Canadians Ill-Prepared for the Inevitable

The strain this lack of preparedness puts on family members at one end of the patient-care spectrum and medical professionals on the other could become intolerable in Canada.

(Editorial, *The Gazette*, Montreal, 23 July 2010)

It is argued that the very old (typically women) who enter hospitals do so with multiple chronic conditions that cannot be cured. This leads to wasted health-care dollars on these "bed blockers."

(M. Wente article, *The Globe and Mail*, Thursday, 11 November 2010)

*Source: Reprinted with permission from Gee and Gutmann 2000, 6–7, with additions by authors.

boomers will face a pandemic of chronic disease and mass dementia, a caregiving crunch, conflict with other generations, and inadequate pensions, among other crises. He stated, "When I look into the future, I see a number of train wrecks about to happen—all of which are preventable, but only if we fully understand the relationship between our current decisions and their future outcomes and only if we initiate corrective action now" (Dychtwald 1997, 11). His views were based on selected demographic and social "facts" and tended to be exaggerations that instilled fear in society. Thus far, his predictions have not been borne out in reality. Highlight 1.2 features newspaper headlines and comments showing that these views continue to reappear whenever new statistics indicate an increase in population aging, a rise in public debt, or a perceived crisis in the social welfare or health-care systems.

Fears about population aging can interfere with rational policy-making by focusing only on sheer numbers instead of taking into consideration other important social changes (Cheal 2003a). For instance, more careful and detailed analysis has demonstrated that with health promotion and health-care improvements, increased savings and private investments,

higher levels of education, and creative and timely policy planning, an older population will not be a drain on societal resources. Indeed, healthier, better-educated, and more active older people are an untapped societal resource who can serve as volunteers, caregivers, or paid workers when the labour force shrinks (Gee 2000; Cheal 2003b; Fast et al. 2006; Gottlieb and Gillespie 2008; Morrow-Howell 2010).

This labelling of older people as a burden to society has been called "apocalyptic," "catastrophic," or "voodoo" demography, which results from a process of exaggerating or misinterpreting population statistics. Gee (2000, 5) describes apocalyptic demography as "an ideology. . . a set of beliefs that justifies (or rationalizes) action . . . wherein the beliefs converge on the idea that an aging population has negative implications for societal resources—which get funneled to the sick, the old, and the retired at the expense of the healthy, the young, and the working." This way of thinking has been influenced by public policies designed for hypothetical average or typical people and by simplistic projections of the number of people who must be supported by public funds in the future. The media and policy-makers, faced with an increasing number of older people, ask such questions as the following:

- Will there be sufficient funds in the public pension system when future cohorts reach 65, or will the C/QPP (Canada/Quebec Pension Plan) become bankrupt while supporting the large baby boom generation that will retire in significant numbers over the next 15 to 20 years?
- As longevity increases in society, will hospitals disproportionately serve frail older people and make it difficult for those in other age groups to receive hospital treatment?
- Will the number and proportion of individuals with Alzheimer's disease due to population aging create an economic and social crisis?
- Who will provide home care and social support to the large number of aging people, especially with a decline in fertility, more dual-career families, and an increase in older people experiencing singlehood and divorce?
- Will conflict emerge between younger and older generations over what are perceived to be intergenerational inequities favouring older people?
- Will an older society become economically stagnant as the baby boomers move out of the labour force?
- Will baby boomers place greater demands than earlier generations on the health-care system?
- How will Canada provide a dignified and effective "end-of-life" for elderly Canadians who need medical and social support in their dying days or weeks?

Some of these apocalyptic fears are magnified when there is a global or national economic recession or instability in global markets, and high government debt. These economic conditions, combined with projections of exponential increases in per capita costs for economic, health, and social support services, encourage governments to propose reducing economic support for older people. Governments also employ these arguments as they attempt to download more of these costs to lower levels of government or to individuals and families. To illustrate, in the past decade when governments were faced with an increasing public debt, they built fewer long-term-care facilities and reduced the operating budgets of existing facilities, thereby forcing seniors and their families to be involved, at greater personal and financial cost, in the long-term care of aging individuals. Furthermore, in lieu of significantly expanding the number of more costly institutional or facility beds, many provinces have opted to build or foster the

development of public and private assisted or supportive housing complexes that provide only a lower level of care (e.g., home support, congregate meals, security, etc.) for older adults who can manage to live semi-independently. However, these arrangements, which can only provide community-based service supports, are often temporary because of the changing health needs of this population and place greater demands on families to provide supplementary support, and financial demands on individuals to pay or co-pay for these services, unless the services are subsidized for those who are poor (see chapters 7, 8 and 12). This issue of public support for older Canadians is a classic example of the debate proposed by Mills (1959) as to whether support in a welfare state should be a "public responsibility" of the state or a "personal responsibility" of the individual and the family.

Despite questions about the sustainability of Canada's universal pension and health-care systems, there is increasing evidence that the significant growth in population aging over the next 30 to 40 years will not bankrupt the pension system, will not be a major contributor to escalating health-care costs, and will not cause intergenerational conflict (Gee 2000; Hébert 2011; Myles 2002; Cheal 2003a, 2003b; Chappell and Hollander 2011; Wister 2011; Wister and Speechley 2015).

In the health-care domain, Hébert (2011) argues that the disproportionate use of health services by older adults in the future will not be a problem. He stresses that the demand for services will not be as high as projected, that there will be improved efficiencies in the health-care system, and that there will be greater use of home-care services to offset the need for costly hospital and residential care. However, the aging of the baby boomers, coupled with increasing longevity of Canadians, will necessitate significant investment by governments to make the health and community care systems more innovative, efficient, and effective (Wister and Speechley 2015).

Consequently, despite periodic fear-mongering by politicians and the media, we should not fear population aging or view it as a crisis. Instead, we should look at population aging as a significant but manageable challenge. This will be especially true when baby boomers retire, since the sheer size of this cohort will require reallocation of health and social resources. But members of this generation will spend their retirement years in better functional health with more education and economic resources, and they will be more physically and socially active than previous cohorts of older adults. Moreover, as they have done for most of their adult lives, they will continue to spend their wealth on leisure, travel, and health-care products. As Gee (2000) and others (Friedland and Summer 1999; Longino 2005) have concluded, "demography is not destiny." Changes in the age structure can be managed by policies, programs, and changes within social institutions; however, these changes require careful planning and considerable effort by both the public and private sectors, as well as by aging individuals and their families. More will be said about these institutional changes and public policies in later chapters.

Individual Aging: Adding Life to Years

Scholars and policy-makers at one time focused mainly on the biomedical and biological (Kaeberlein and Martin 2011) aspects of aging that caused illness, frailty, dependence, and death in later life. Today, **individual aging** is viewed as the interaction of interrelated biological, clinical, psychosocial, and societal factors that affect aging over the life course and that may manifest themselves differently among tomorrow's older adults (Raina et al. 2009). We experience biological aging at different rates and with varying degrees of disease states. These changes often occur dynamically within social, cognitive, and environmental

contexts that influence our **life chances** and **lifestyle**, including our degree of independence. For instance, depending on when we were born, whether we are female or male, and where we live out our lives, our health, lifestyle choices, and life chances as we age will be affected by unique social conditions and social change. Events such as economic depressions, natural catastrophes, wars, baby booms, technological revolutions, or social movements mould the life trajectories or pathways of individuals or age cohorts. The impact of these events on a given individual or age cohort usually depends on the chronological age or stage in life when the event is experienced.

To understand aging individuals and older age cohorts, a historical, dynamic, and developmental perspective is required. These criteria are met by the **life-course perspective**, which examines the interplay among individual life stories, our social system and institutions, and environments, and also looks at the effect of specific historical events at particular times in the life course of individuals or age cohorts. Through this approach, we understand how the problems, advantages, disadvantages, needs, and lifestyles of later life are shaped by earlier life transitions, decisions, opportunities, and experiences within specific historical or cultural contexts (Dannefer 2003; Settersten 2005; Dannefer and Settersten 2010; Marshall and McMullin 2010; Grenier 2012). Individuals are connected to one another because of the timing, direction, and context of their trajectories or pathways—what has been called "linked lives" (see Chapter 5). The life-course perspective provides a framework for understanding age-related transitions that begin with birth and entry into the school system and conclude with retirement, widowhood, and death in later life. This perspective reflects the heterogeneous, fluid, and interrelated nature of life transitions. It also recognizes that transitions can be reversible. For instance, an individual who retires from one employer may decide to re-enter the paid workforce after a period of time, or a person who is divorced or widowed may remarry, even in later life.

The life-course construct also enables us to observe and analyze how different individual or societal events create variations in the aging process within and between cohorts and individuals. Some events (a social movement, an economic depression, an epidemic, or technological change) will have an impact on some age cohorts but not on others or on only specific individuals within an age cohort. For example, the feminist movement that started in the 1970s has had a profound influence on the life course of women born just before and after the 1970s. But in general, the feminist movement has had only a modest influence on most women who are now in the later stages of life (80 and older).

Figure 1.2 illustrates the cohort effects of being at a particular stage in life at a particular time in history. For example, during the late 1990s, a period of economic restructuring and high unemployment in Canada, members of cohort A, born in the early 1940s, were probably at the "empty-nest" stage and within 5 to 10 years of retirement. Many were likely coping well with the prevailing social and economic conditions, assuming they did not lose their job to downsizing by their employer. By the time the 2008 economic recession hit, they were probably retired. In contrast, some members of cohort B, born in the early 1970s, experienced unemployment or underemployment in early adulthood, and many delayed getting married and buying a house. They would have been mid-career by the time the 2008 economic downturn occurred, and many of them would likely have felt the effects in terms of declining investments and savings, job loss, and job stress. Cohort C, born in the early 1990s, entered the workforce (often only as part-time employees or in minimum-wage positions) or post-secondary institutions during the early 2010s at a time when there was a significant downturn in the economy, and many needed to work part-time in order to cover increasing educational

costs. Today cohort C are challenged by a highly competitive labour market, higher housing and living costs, and uncertainty over the future outlook of the economy. Thus, past and current social conditions, as well as life histories, can have an impact on different age cohorts. Some of these factors have an influence on most members of an age cohort throughout their lives (e.g., cohort B in the example above); others are affected at only certain periods of their lives. Or an event may have an effect only on some segments of a birth cohort (depending on attributes such as social class, gender, education, race, ethnicity, or geographical location).

At the societal level, your life course will be different from that of younger and older age cohorts and from others of about the same age in other countries and perhaps even in other parts of Canada. Such differences result from cultural, regional, economic, or political variations in opportunities, lifestyles, values, or beliefs. The events a person experiences throughout the life course will vary as well because of particular social or political events that affect some but not all individuals or age cohorts. The study of aging as a social process seeks to identify patterns in life-course trajectories and link them to their causes and consequences.

Personal biographies interact with structural, cultural, and historical factors to influence how we age across the life course. Thus, we need to understand why there is diversity in aging among individuals in the same birth cohort (all those born in the same year) and in different birth cohorts (those born at different points in history—you, your parents, your grandparents). Much of this diversity arises because of where an individual or a cohort is located in the social structure.

Social structure pertains to those elements of social life and society that constrain, promote, and shape human behaviour. Whether based on gender, age, class, or ethnicity, social structure creates or limits life-course opportunities and leads to common ways of behaving and acting among segments of the population (Giddens 1984). The structural elements provide a set of guidelines or expectations concerning behaviour, and they may set limits on life chances and lifestyles. People's everyday actions reinforce and reproduce a set of expectations—the social forces and social structures that guide our daily lives. These elements, or rules of social order, can be changed—and are changed when people

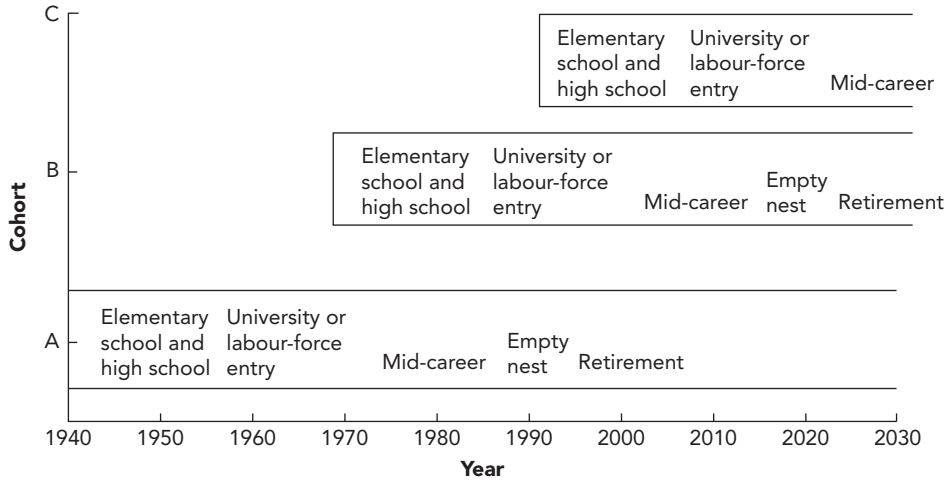

Figure 1.2 Cohort Differences and the Aging Process

ignore them, replace them, or reproduce them in different forms across their life course. These structural factors interact and become cumulative as we age, often leading to extreme differences in the quality of life among older adults. For example, in later life there can be a cumulative advantage or disadvantage associated with income and poverty across the life course (O'Rand and Bostic 2016). For instance, a single mother in middle age can become a single individual living in poverty in her elder years.

While living within a social structure, we are not merely reactive puppets to social forces around us. Individuals in similar situations can act in different ways and make different decisions. Within the life-course perspective, this process is known as **agency**. Glen Elder, a pioneer in the study of the life course, argues that agency is a "principle," one of five defining principles of the life course (Elder and Johnson 2003, 57–71). These principles are described in Chapter 5. Elder defined *agency* as a process in which individuals construct their life course by making choices and taking actions. These intentional choices and actions are strongly influenced by the constraints and opportunities of social structures, by personal history and past experiences, and by significant others in our daily lives (Bengtson and Settersten 2016). Marshall (2000, 11) states that agency refers to the human capacity "to act intentionally, planfully and reflexively, and in a temporal or biographical mode throughout the life course." Marshall (2000, 9–10) also stresses the personal responsibility that we inherit to invoke agency:

> Agency has been seen as the production of a life. The agent is the producer; human development (the lived life, the narrative) is produced by agency . . . people not only react but act and, in acting, produce their biographical selves . . . agency refers to a culturally legitimated responsibility to act—on behalf of others, of organizations or ideas, or of one's own self.

Through agency we create unique identities, develop personal meanings and expectations and decide which social groups are significant in our lives (Hitlin and Kwon 2016). Considerable variations in lifestyles, experiences, and quality of life evolve within different age cohorts in the older population. Consequently, Canada's population of older adults is a diverse group that, as we will see throughout the book, varies by chronological age, gender, sexual orientation, culture, wealth and social status, health status, type and place of residence, and living arrangements. Treating older adults as a homogeneous group with common needs, interests, and experiences can lead to ineffective policies and programs. Some older adults are poor, and some are wealthy; some live alone, and some live with a partner; some live in urban areas and some in rural or remote communities; some are active, mobile, and independent, and some are sedentary, disabled, frail, and dependent; some are a visible-minority or racialized group, and some are not; and most fall somewhere in between these extremes. Chapter 6 elaborates further on the relationship between the social structure and individual aging, and Chapter 8 explores the relationship between the individual and his or her lived environment (the search for person–environment "fit"), while Chapter 12 addresses policy issues for a diverse aging population.

Interacting Aging Processes

Although there are a number of separate aging processes, they do interact. For example, a decline in vision (a biological change) may lead to an inability to read or drive a car, thereby restricting a person's mobility, independence, and social interaction. Similarly, mandatory

retirement (a social act) may have positive or negative psychological, economic, and/or social outcomes for individuals and for a society. Furthermore, there is variation within and among individuals in the onset and speed of aging among the various processes, which are introduced under separate headings below.

Chronological Aging

The passage of calendar time from one birthday to the next represents **chronological aging**. Our age in years determines our rights (often through legislation) and influences the way we live. Chronological age serves as an approximate indicator of physical growth and decline, social and emotional development, and expected patterns of social interaction. However, chronological age can be deceiving. A 60-year-old with facial features more like those of a 70-year-old may behave and dress more like a 40-year-old. Some may consider this person to be "old" for his or her age, while others may consider him or her to be "immature." Similarly, a person who appears "middle-aged" from his or her physical appearance may actually be much older and exhibit attitudes or behaviours that are more consistent with much older adults. The social meaning or value attached to a specific chronological age is fluid over time; for instance, as the baby boomers move into their "senior" years, chronological age markers are being redefined.

Chronological age defines "legal" age and thereby provides social order and control in a society, although it can sometimes cause conflict between generations when special benefits and privileges (discounts, free drugs) are provided to those at or beyond a specified age. However, legal definitions based on years since birth may be necessary for the enactment of a particular policy—for instance, mandatory testing of driving ability at age 80 and beyond. Laws or regulations based on a specific chronological age—for example, the age we enter school or are eligible to drive a car, vote, purchase or consume alcohol or marijuana, or retire—are established according to what was considered the best, or "normal," chronological age for the specific event at the time the law was passed. For example, legislation requiring individuals to retire at age 65 was originally passed at the beginning of the previous century when life expectancy was considerably lower. Age is used in law to assign advantages and benefits or to impose obligations or restrictions (Law Commission of Canada 2004; Kapp 2006). These can also vary across province, country, and even occupational sector, and are often contentious. For example, mandatory retirement for pilots is dependent on the airline company's home country/region and may fall between 60 and 70 years of age. For pilots flying for Air Canada, the stipulation of mandatory retirement for pilots at age 60 under their collective agreement has been recently removed by the Canada Human Rights Tribunal, thus eliminating a mandatory age of retirement.

Sometimes legal age is based on the best available knowledge about capacity or potential at a specific age or on **chronological age norms**—how most individuals behave in a given situation or perform a particular task at a specific age. Or legal age may be influenced by functional age—how well an individual performs specific physical, cognitive, or social tasks (e.g., driving a car after 80 years of age). Or a law based on age may be established according to what is considered, at least by some, to be best for the society (e.g., mandatory retirement).

Functional age is often a more useful guideline than chronological age. It is based on the fact that aging is a multi-faceted, diverse process in which individuals at a specific chronological age are either "older" or "younger" than age peers in terms of some relevant skill or

ability. For example, the right to continue working might be based on a person's ability to work effectively and efficiently, rather than on a specific age cut-off. But how we objectively measure physical and cognitive abilities is a difficult and so far unsolvable problem. Hence, functional age, as fair as it seems, has not received much support from employers, unions, or policy-makers. Some have argued that the traditional marker for "old age," 65 years, should be revised upward because of gains in both life expectancy and disability-free life expectancy (Denton and Spencer 2002). This has occurred in the United States, where the eligibility for full social security pension benefits is being increased gradually (through to 2027) from 65 to 67 years of age for those born after 1966. In Sweden, eligibility for pension benefits is indexed to gains in life expectancy. Others contend that flexibility is needed in accessing public pensions in order to reflect the diversity in working conditions experienced by older baby boomers, especially women (Moen 2016).

Biological Aging

Internal and external biological changes influence behaviour, longevity, and one's quality of life. **Biological aging** includes genetic and environmentally induced changes in the cellular, muscular, skeletal, reproductive, neural, cardiovascular, and sensory systems. The rate and occurrence of biological changes influence the number of years a person is likely to survive and the extent to which he or she is likely to experience illness or disability, including the onset of dementia. These changes and their accompanying adaptations interact with the social and psychological processes of aging. For example, visible changes, such as greying of the hair, wrinkling of the skin, and reduced physical stature influence whether we are viewed by others to be young, middle-aged, or elderly. Similarly, our lifestyle, including the amount of stress or depression we experience, can slow down or accelerate the biological processes of aging. Although a detailed discussion of biological aging is beyond the scope of this book (see Timiras 2002; Tollefsbol 2010; Kaeberlein and Martin 2011), we should not ignore the effect of such changes when studying aging as a social process. In Chapter 3, we examine the influence of physical and cognitive changes on social behaviour and social interactions.

Psychological Aging

Changes in learning ability, memory, and creativity occur across the life course (Craik and Bialystok 2006; Schaie and Willis 2015). **Psychological aging** involves the interaction of individual cognitive and behavioural changes with social and environmental factors, such as the loss of a spouse or a change in housing that affects our psychological state. A decline in memory or attention span can reduce or eliminate a lifelong interest in reading or learning. This in turn changes an individual's leisure habits and may lead to boredom, depression, and a deteriorating quality of life. Similarly, a stressful life event, such as divorce, the death of a spouse, or a serious health problem, alters the emotional, behavioural, and cognitive processes of an individual at any chronological age. Adapting to stresses often depends not only on personal psychological capacities but also on the amount and type of social support and assistance received from the family and others in the community. Psychological aging is influenced as well by cultural differences, such as whether or not older people are valued. Chapter 3 describes some of the cognitive and personality changes associated with aging.

Social Aging

Social aging is more diverse than biological or psychological aging within and across societies and cultures and across time. Thus, an identical twin separated at birth from a sibling and raised in a different family and community would exhibit behaviour, values, and beliefs that were more similar to age peers in his or her own social world than to those of the sibling.

Patterns of social interaction across the life course are learned within a social structure, whether it be the nuclear family, the workplace, the local community, or Canada as a whole. The age structure of a society is stratified like a ladder. While earlier societies included only a few strata (childhood, adulthood, and old age), modern societies involve many **age strata**—infancy, early childhood, preadolescence, adolescence, young adulthood, middle age, early late life, and very late life. The behaviour and **status** of the members of each stratum are influenced, at least partially, by the rights and responsibilities assigned on the basis of age or age group and by attitudes toward specific age groups as defined by that society. In some societies, for example, older people are highly valued; in others, they are considered less attractive and are therefore less valued than younger people. In the latter society, being defined as "old" often means that one is marginalized and stigmatized (see Chapter 2).

Within each culture, social timetables define the approximate or ideal chronological age when we "should" or "must" enter or leave various social positions. Some of these transitions involve institutionalized rites of passage, such as a bar mitzvah, a twenty-first birthday party, a graduation from university, a wedding, or a retirement party. Within an age cohort, the meaning and significance attached to a rite of passage or to a particular age status also varies by social status. For example, marriage early in her twenties for a woman without much formal education may be considered more "on time" than it would be for a woman of the same age with a university degree because of class-based norms or values about the right age for women to marry. The meanings attached to membership in an age stratum or to specific events change as a society changes. For example, some people in your grandparents' generation may have believed that a woman who was not married by her mid-twenties was, or would become, an "old maid." Today, a single woman in her early or mid-thirties may be viewed as independent, "liberated," and modern. She may be praised for not rushing into an early marriage and for pursuing a career.

These variations in social values illustrate why chronological age is a poor indicator of the needs, capabilities, and interests of adults across the life course. Increasingly, the time when major life events take place is no longer dictated by chronological age. For example, women may give birth for the first time in their teens or in their early forties; parents may become grandparents as early as age 30 or as late as 70; and marriages take place at all chronological ages, including a first marriage or a remarriage for those in their sixties, seventies, and eighties.

No cohort ages alone. Aging involves interaction among cohorts and cohort succession. Each cohort is integrally linked to others through social interaction in family, work, or leisure settings. These inter-cohort relations have the potential to create both co-operation and conflict between generations (O'Rand and Bostic 2016). This is especially true if social differences in a society create age strata with higher or lower status and therefore greater or lesser power. In societies where older people are highly valued, intergenerational relations are generally positive, and each cohort moves from one age stratum to the next with little

or no conflict. In contrast, in societies where youth is valued more highly than old age or where elderly people are marginalized, intergenerational rivalry and conflict are more likely. In such societies, elderly people often resent the loss of the status and power they once held. It was this resentment and concern that launched the "grey power" movement in the 1970s and an awareness of growing generational inequities in the 1980s and 1990s (Bengtson and Achenbaum 1993). More recently, the pendulum has swung in the other direction, with younger generations concerned that the high cost of housing places them at a disadvantage, whereas it has benefited the older generations who mostly own homes with significant equity.

The Social World of Aging

Historical, Cultural, and Structural Dimensions of Aging

Aging and the status of older people in everyday life are linked to the period of history in which we live and to the culture and social structure of the society or communities where we are born and live out our lives. Our place in history and our culture influence the type and quality of life we experience, as Chapter 2 illustrates in more detail. For now, think of the differences in how we might age or spend later life if we lived at a time when we either did or did not experience or have access to drugs (for cancer, heart disease, or AIDS) and such medical devices as pacemakers and artificial hips and knees; to mandatory retirement and a universal pension system; to nursing and retirement homes; to technological devices, such as computers, smartphones, smart home systems, and microwave ovens; and to subsidies for older adults for transportation, home care, or long-term care. As you consider aging issues, think about history and culture globally and locally to understand fully the circumstances in which older adults in a particular society and as a member of a specific cohort spent their earlier and later years. **Culture**, the way of life passed from generation to generation, varies within societies and changes across time in a society. Our culture creates ideas, beliefs, norms, values, and attitudes that shape our thinking and behaviour about aging and about being old. Thus, to understand the lifestyles of individuals as they age and the views of a society about aging, one needs to consider the cultural elements prevailing at a particular period in history and the changes that occur in cultural values and meanings across generations.

Diversity in aging experiences and the considerable heterogeneity among those in older age cohorts occur because of both cultural and social differentiation in the social structure of a community or society. **Social stratification** is a process by which social attributes (age, gender, social class, religion, race, and ethnicity) are evaluated and acted upon differentially by a significant proportion of societal members. In North America, for example, individuals are generally evaluated more highly if they are young rather than elderly, and white rather than a member of a visible-minority group, heterosexual rather than a member of an LGBTQ community. These evaluations of social attributes influence our identity, life chances, and lifestyle throughout our lives and can foster social inequalities. To illustrate, we live in a "gendered" society. Gender distinctions are socially constructed so that women may have a lower position in everyday social and work life. Consequently, their situation and interpretation of growing old are different. Gender and aging are strongly connected across the life course, and as we will see in more detail in several later chapters, some consider aging to be primarily a "women's issue" (Arber and Ginn 2005; McDaniel 2004; Estes 2005; Muhlbauer et al. 2015).

In Canada, we live in a unique multicultural society. Approximately 19 per cent of Canadians are foreign-born (calculated using Statistics Canada CANSIM tables). A majority

Highlight 1.3 • Age-Friendly Rural and Remote Communities: A Guide

In September 2006, the Federal/Provincial/Territorial (F/P/T) Ministers Responsible for Seniors endorsed the Age-Friendly Rural/Remote Communities Initiative (AFRRCI). The initiative has two main objectives:

1. To increase awareness of what seniors need in order to maintain active, healthy, and productive lives within rural or remote communities.
2. To produce a practical guide that rural and remote communities across Canada can use to identify common barriers and to foster dialogue and action that supports the development of age-friendly communities.

In an age-friendly community, policies, services, settings, and structures support and enable people to age actively by

- recognizing the wide range of capacities and resources among older people;
- anticipating and responding flexibly to aging-related needs and preferences;
- respecting the decisions and lifestyle choices of older adults;
- protecting those older adults who are most vulnerable; and
- promoting the inclusion of older adults in, and contribution to, all areas of community life.

Source: Federal/Provincial/Territorial Ministers Responsible for Seniors 2009.

of these people belong to visible minorities who, in recent years, tend to originate from Asian, Caribbean, South American, Eastern European, and African countries rather than from northern Europe. Today, there are at least 200 language groups in the country. As these individuals age, there will be increasing diversity within our older population (see Chapter 2).

Place of residence, while not generally considered a stratification system, is an important factor when discussing diversity in aging. There is considerable diversity in the lifestyles, backgrounds, and aging-related services and support systems of residents in rural versus urban communities (Keating 2008; Davenport et al. 2009). For instance, there has been an initiative in Canada and other countries to develop age-friendly communities, with a focus on improving social services and programs for older adults living in disadvantaged rural and remote communities (see Highlight 1.3). Studies on the effectiveness of age-friendly interventions are being conducted, but are not definitive as yet.

The Social Construction of Old Age: Images, Labels, and Language

There are many myths and misconceptions about growing older and about being elderly. These are often institutionalized into images and labels. Such labelling creates and perpetuates **stereotypes**, which are exaggerations of particular attributes of a group of individuals,

and fosters **age discrimination** and prejudices toward members of specific age groups; in short, it constitutes **ageism** (also see labelling theory in Chapter 5). Such views may discourage older adults from participating in the labour force or in some social, leisure, or volunteer activities.

"Old" age, being "elderly," or becoming a "senior" does not happen overnight when a person turns 65. Rather, the meaning of being "old," "elderly," or a "senior" is socially constructed and reinforced when cultural values and misconceptions define those who are 65 or over as "elderly," "old," or a "senior." These labels[2] are not based on an individual's abilities or health status. Rather, they are assigned to everyone on the basis of stereotypes about those who reach a particular chronological age. This process of labelling is institutionalized in a society when social policies require all citizens to meet some requirement based on age, such as mandatory retirement at age 65. These age-related public policies can influence older persons' sense of self and how others regard them, especially if the policy fosters labelling (Hendricks 2004). In addition, cultural elements produce verbal and visual images about aging or elderly people through the television, the Internet, literature,[3] art, films,[4] song lyrics, photographs, jokes, and birthday cards. Often these images express the view, with or without humour, that later life is equated with illness, losses, loneliness, asexuality, and poverty. To illustrate, Ellis and Morrison (2005) found that 67 per cent of the birthday cards sold in retail stores in a small Canadian metropolitan area depicted aging in a negative light, although often humour was intended. Many images of older people presented on television, such as adult cartoons, are created to generate humour through references to asexuality, deafness, or forgetfulness, but in so doing they reinforce common (usually erroneous) stereotypes, albeit with a sense of irony that sometimes produces multiple meanings (Blakeborough 2008). Similarly, newspapers focus either on the horrors or tragedies of aging or on the marvels of truly unique but atypical long-lived people who have accomplished feats unusual for their age or have celebrated birthdays beyond 90 years of age. In an analysis of 30 articles published in *The Globe and Mail* in 2004, Rozanova et al. (2006) found that both positive and negative stereotypes and images appeared. Common themes included the diversity of the older population, successful aging, and conflict between generations.

Media images seem to be changing over time. Miller et al. (2004) analyzed historical portrayals of older persons in US television commercials. They concluded that elderly persons tended to be shown in comical roles in the 1970s, with more negative portrayals in the mid-1970s and early 1980s, shifting to neutral ones in the later 1980s and more positive ones since the early 1990s. Yet, other evidence suggests that these patterns are not uniform, and there are subgroups for which negative stereotypes prevail. For instance, older women are depicted in advertising less often than older men, and when they are, it is in more negative ways. For instance, Lee et al. (2007) find that older adults appear in 15 per cent of advertisements on television, with older women being under-represented. Indeed, Levy (2017) identifies an age-stereotype paradox, whereby patterns of positive and negative stereotypes appear to exist concurrently. She notes that improved health, growing numbers of older people, anti-ageist legislation, and more positive views of previously stigmatized groups (e.g., gay and lesbian seniors) can be seen as contributing to more positive views of older people over time, while at the same time there exist many studies of media outlets that suggest more negative stereotypes over time. It is likely that there are a number of types and layers of stereotype development and change that may not necessarily be consistent with one another. Regardless, studies indicate that ageist attitudes and behaviours continue to affect the public in several ways over the life course.

The effects of stereotyping can begin at early ages. Robinson et al. (2007), in a study of 34 Disney animated films, show that the media can serve as an important socializing function for children by supplying images that create or reinforce stereotypes. They found that while only 42 per cent of the older Disney characters were portrayed negatively (grumpy, mad, threatening, highly wrinkled), these portrayals might be influencing children to develop negative feelings about older people in general. Aging stereotypes also permeate new forms of social media targeting younger cohorts. Levy et al. (2014) analyzed 84 Facebook groups that concentrated on older individuals, which were created by younger persons (mean age 20–29) and discovered that the *Descriptions* of all but one of these groups focused on negative age stereotypes. Levy (2017) contends that stereotypes are assimilated from a variety of sources in culture and affect younger people's attitudes and behaviours toward older people—termed *embodiment theory*, a subset of labelling theory. He further argues that reversing negative stereotypes will require significant societal changes, including expanding aging-rights legislation and encouraging key anti-aging opinion leaders (persons who can lead the movement of aging positivity).

The fluid nature of aging-related stereotypes means that they can be altered by socio-political forces. The aging of the large baby boom generation will likely result in media portrayals of more healthy and wealthy older adults overall. However, closer examination of media portrayals of particular groups of elderly persons suggests variations in these patterns by gender, sexual orientation, disability, ethnicity, and race.

Negative or atypical images, when accepted as fact by the media, the public, or policy-makers, can shape public opinion about aging, influence which public programs are funded (should community recreational facilities be built for youth, older adults, or both?), and undermine the potential of adults as they move into the later years. For older adults, these socially constructed labels, images, and language foster a self-fulfilling prophecy whereby some older adults believe they should think and behave like the stereotypes perpetuated by the media. This in turn can lead to a loss of self-esteem, isolation, and the labelling of oneself as "old." To illustrate, research has shown that women at an advanced old age, who have internalized negative stereotypes, internalize self-perceptions of weakness and dependency that can create a barrier to seeking necessary health care (Chrisler et al. 2016) or result in accepting medical treatment without discussion. These are exacerbated when a women has had earlier experiences with discrimination, such as sexism, racism, or bias against sexual orientation. Another example of a socially constructed label applied to some older adults late in the life course is the term *frailty*. But, in fact, most older people do not experience frailty—a severe biomedical condition. Indeed, the conditions implied by this label may never appear or may only apply to those who, through a natural progression of aging, lose strength, endurance, weight, and perhaps some degree of cognitive functioning, especially in the last few months or years of life (see Chapter 3). The cultural construction of old age as a biological phenomenon is also propagated by anti-aging technologies and science, which often view aging as a negative medical problem (Vincent 2008). Yet, science can also counter ageist discourse. As one can see, language, images, and portrayals of older people perpetuate ageism in society. Highlight 1.4 is a plea to end ageism by Hazel McCallion, former long-time mayor of Mississauga, Ontario, and chancellor of Sheridan College in Oakville, Ontario.

We must be careful in the creation, selection, and use of labels and language about older people and later life. The language we use can affect the behaviour of older persons or influence the behaviour of others, who may avoid or ignore older persons or apply the stereotypes as they interact with older persons. Moreover, such labels, images, or language

Highlight 1.4 • Excerpts from: "Ageism is getting old. Let's end it"

Canadians need to confront the reality that, every day, its older citizens deal with the most widely tolerated form of social prejudice in the country: ageism.

Society has created stereotypes and sustained prejudices about older people—making assumptions about what senior citizens want and need, assuming that they can't think for themselves, or even feeling that they aren't valued. According to a new report released by senior-living company Revera and the Sheridan Centre for Elder Research—Revera Report on Ageism: Independence and Choice as We Age—one in four Canadians admit treating someone differently because of their age.

For a country such as Canada that is proud of its diversity, is known around the world for its kind, empathetic spirit, and is also facing a rapidly aging population, these findings are just unacceptable.

Most reasonable people would agree that depriving someone of their basic rights to independence and choice because of gender or race is wrong. Yet when it comes to our senior citizens, many of us do just that. The report found that half of all Canadians aged 77 and older say that younger people automatically assume that older people can't do things for themselves. And more than one-quarter of older seniors say that because of their age, younger people make choices for them without asking their preference.

As Canada's population ages, we grow more and more concerned about our health-care system's ability to pay for the escalating costs of caring for older citizens. But have we stopped to consider the cost of our ageist actions? When seniors are not allowed to exercise their independence because of ageist behaviour, they become reliant on our help. The more we prevent them from taking care of themselves, the more care they need. It creates a dependent mindset, and studies out of Yale University found that holding ageist views hinders a person's ability to recover from severe disability and shortens one's lifespan.

mask the considerable heterogeneity among older people. In short, there is no "typical" older person who can be depicted or defined by one image. Similarly, it is difficult to discuss or promote the idea of "successful" aging or to develop a model for "successful" aging that could be used for developing policies for the entire older population. In a critique and **deconstruction** of the construct of "successful aging," Bowling (2007) argues that there is little theoretical justification for the **concepts** or definitions included in this construct and that the definitions vary widely because they reflect the academic disciplines of the proponents—for example, the biomedical models of successful aging emphasize physical and mental functions, while the socio-psychological models emphasize social interaction/functioning, life satisfaction, and the availability and use of psychological resources. If an ideal and workable model of successful aging is to be developed, it must be multi-dimensional; it must involve a continuum of success; and it must be reflexive and include the views of older people on what constitutes successful aging, especially variations in values across gender, socio-economic status, disability and health conditions, cultures, and social structure.

But there's hope. Through simple actions that we can all take right now, all rooted in changing our attitudes, we can make very real changes in the lives of Canadian seniors.

For individuals, we need to change our thinking and change our language. We have to stop assuming we know what older people want, and quite simply ask them. We need to stop referring to aging in a negative way—"I'm having a senior's moment," or "Can't teach an old dog new tricks." It's demeaning to hear those kinds of statements. Changing ageist behaviours doesn't cost a dime, and the positive results are obvious.

Older people also have a role to play. As a busy 95-year-old who has always lived my life to the fullest, I believe it is important to stay engaged and active as you age. This means pursuing personal interests and finding ways to contribute and interact with others, especially younger people. It means living a life of purpose.

Businesses need to wake up and see the tremendous opportunities presented by the growing population of independent-minded seniors. Investing in new innovations and services that meet seniors' needs will give companies the win-win outcome of being both profitable and advancing the public good.

Finally, policy-makers have to ensure that older Canadians—not just 65 plus, but those 75 or 85 or older—are consulted just as any other major stakeholder group when discussing public policy. Seniors' voices matter and they must be part of the conversation, whether it is about housing, health care, safety, or finance.

Above all, society must recognize that older people are valued, contributing members of our communities. They want exactly what everyone else wants: independence, respect and the choice to live their lives as they please.

Source: "Hurricane" Hazel McCallion (born Feb. 14, 1921), published Monday, 6 June 2016, *The Globe and Mail*.

Stereotypes and Their Influence on Individuals and Society

Stereotypes: Shaped and Reshaped

Many stereotypical images are based on the changing appearance of the aging body (e.g., wrinkles, changing body shapes, baldness for men, greying hair) or on reported or observed changes in the social, physical, or cognitive behaviour of some older persons. In some cultures, wrinkles are a sign of high status and wisdom; in others, they are a sign of decay and symbolize being less attractive, less valued, and less useful. Similarly, paintings in some earlier eras indicate that short, plump women were admired, whereas today, photographs and paintings idealize women who are tall and very thin. This latter example illustrates how images are socially constructed and how they can change over time (de Beauvoir[5] 1970; Featherstone and Hepworth 2005; Davis and Friedrich 2010; Levy 2017).

Misleading stereotypes of older adults can also be found in elementary school texts, children's literature, and adult fiction in which older people are seldom, if ever, portrayed in illustrations. Older people are usually peripheral to the plot, have limited abilities, and play passive rather than active roles. Furthermore, they are usually under-represented in relation to their proportion in the real world. And older women are even more under-represented, even though they comprise a higher proportion of the older population than men. Not surprisingly, elderly members of **minority groups** are seldom included in books, except in literature written by or specifically about members of particular ethnic or racial groups. Thus, there is a constant need for education to eliminate false images and to eradicate stereotypes.

We must not assume that a misleading and stereotypical view of aging and older adults is acquired solely through literature or by watching television. There is no proof of a direct causal relationship between the reading of books in which older people are ignored, under-represented, or misrepresented and the adoption of negative attitudes toward older people. Furthermore, since school textbooks are interpreted by teachers, elementary school students could be more sensitive to the realities of aging issues, depending on the supplementary material presented by a particular teacher. Nevertheless, given the pervasiveness of negative **attitudes** about aging in our culture, these attitudes are often reflected in affective, cognitive, and behavioural responses of individuals and groups of all ages (Hess 2006; Davis and Friedrich 2010) and affect some older individuals in a negative way.

Stereotypes can, with time and research, be refuted. For example, in recent years, older people have been portrayed in a wider variety of occupations and social roles that more closely coincide with reality. Today, they are depicted as active, independent, influential citizens and family members and as having skills and experiences of value to society. The presentation of a more positive view of aging and older people is due, partly, to the mass media's recognition of the changing demographic profile of society in general and of television viewers in particular. The change is also due to entrepreneurs' recognition that a large, wealthy "senior market" is emerging. By some estimates, people over 50 control more than 80 per cent of the savings in Canada, making them the most economically advantaged age group. Negative stereotypes of older adults are being challenged and eliminated as well by increasingly politically active and age-conscious older people. This pressure can lead to a deconstruction and reconstruction of the images and discourse about aging and later life. Negative and inaccurate social images and words are being replaced by more accurate modern pictures and descriptions of active, vibrant, and independent older adults. By challenging the current discourse, such images help to refute the apocalyptic view of population aging and its hypothesized dreaded outcomes for a society.

Many realistic images of aging and of the meaning of being older are developed through interviews with and reflections by older adults. Much of the credit for the emergence of more accurate images belongs to anthropologists and sociologists, who employ a qualitative approach to understanding social behaviour, and to humanists, who employ biographical narratives to identify the meaning of later life (Randall and Kenyon 2004; Kenyon et al. 2011). These scholars present the voices of women and of people from diverse ethnic groups, social classes, or regional environments. Older adults, by telling their life stories and by sharing their thoughts and feelings, enable us to understand later life as it is experienced by those living that life. Highlight 1.5 describes aging in the words of older people.

Highlight 1.5 • Voices of Older Adults

People Living in the Community

I think it's quite normal to be anxious about aging. For all of us it means entering unknown territory, with its attendant fears. The reality for me is that growing older has meant a time of much greater freedom. My children are grown and increasingly independent. I am free to develop my own person, in a way that I never had the courage to do when I was younger. I am discovering strengths and recognizing weaknesses. I don't need to apologize and explain as much as I used to. I wish I'd known 10 years ago that getting older would be this interesting, because I have spent too much time in the past worrying about it.

(Rodriguez 1992, 26. Reprinted by permission.)

My life has been more happy than sad, much more good than bad. Still, for the past several years, I learned about the troubles of aging as my strong and vigorous husband gradually became weaker and more ill. When he was young, I thought he was like a great oak tree and that nothing could ever bring him down. Yet he is gone, and I, never particularly strong or robust, remain well and active and learning to manage on my own. . . . I drive my car, baby-sit grandchildren, and make plans to travel and visit around the country. I spend a great deal of time just being thankful for many things younger people take for granted. I am thankful to still have so many people to love and share my life—children, sisters and their families, many other relatives and good friends, and the many nice people around this city.

Source: Adapted from *Are You Listening? Essays by Ontario Senior Citizens on What It Means to Be a Senior* (1989) (Toronto: Office for Seniors' Issues, Ministry of Citizenship. Reprinted by permission).

Residents of Long-Term-Care Facilities

When my wife had her stroke, she spent almost a year in a hospital. I lived alone and was terribly depressed. When we both got accepted here I was really glad to be with her again. I have to admit that living like this with her is sometimes depressing for me. We only have one room and the children can't come very often. But I've adapted. At least I'm not lonely for her anymore.

They take care of me here but they don't do it the same as I would myself. I can't take care of myself because I'm all "crippled up." Sometimes I think this place is run more for the convenience of the staff than for the residents. I resent having to go to bed so early just to suit them. . . . I only have $90 a month to get by on. That is not very much. It is very hard for me to take a bus to go anywhere.

Source: *The NACA Position on Canada's Oldest Seniors: Maintaining the Quality of Their Lives* (Ottawa: National Advisory Council on Aging 1992), 54–5. Reproduced with the consent of the National Advisory Council on Aging (NACA), the Minister of Public Works, and Government Services Canada, 2004.

Age Identity: Not Just a Number

Age identity is the result of a subjective experience that represents the psychological and social meaning of aging rather than chronological age. This concept, sometimes referred to as "subjective age," illustrates how aging is socially constructed. Social and age-related identities are renegotiated in different social contexts or as an individual's health or visual appearance

changes (Lin et al. 2004). In this sense, the aging self is a managed identity (Biggs 2005). People of the same chronological age (e.g., 65) may report a wide range of age identities. Some may feel younger and report feeling like 55; others may feel older and identify with 75-year-olds, although this "age as older" identification seldom happens except on days or during periods when health and energy are low. Increasingly, the clothes we wear are central to expressing how older bodies are experienced, presented, and understood in our culture. Clothing can be used to express an age identity and to resist or define the dominant meanings of being older (Twigg 2007). Age identity is shaped by social experiences—how individuals view the self and how individuals think that others view and react to them. Kaufman and Elder (2002), in a study of grandparenting and age identity, found that those who become grandparents in their thirties and forties felt older than those who acquire this role "on time" (i.e., later in life). Older people who enjoyed being grandparents felt younger, believed that people become "old" at older ages, and hoped to live longer than those who reported that they did not enjoy being grandparents.

In reality, many older people do not think of themselves as old and often report feeling and acting younger than their chronological age. In an examination of five dimensions of age identity in later life, Kaufman and Elder (2002) found that as people age, their subjective and desired ages become further removed from their actual chronological age. That is, personal age identity changes as we age, but these personal perceptions and definitions lag behind our real age. The identification of the self as younger than our actual chronological age is more likely among those who are in good health and physically active, as well as among those who are employed. Individuals from lower socio-economic strata often experience an earlier onset of health limitations and a faster rate of decline in functional ability. Consequently, they tend to hold "older" identities (Barrett 2003). For some older people, negative societal attitudes about aging are a threat to self-esteem. For others, however, old-age stereotypes are functional in that the individuals may, in comparison with the stereotypes, see that they are better off than most elderly people.

Older people often define themselves as being different from others of the same age by presenting themselves as active and healthy. For example, a 91-year-old woman in Finland, in response to questions about how she interprets old age and how she views herself, talked about "dancing," "racing around," and "walking up stairs and around the yard." She concluded the interview by stating, "I haven't taken to a walking stick yet. And there are others here who go around with a stick and a walker" (Jolanki et al. 2000, 366). This respondent defines herself as being more active and more independent than those who are younger or of the same age in her retirement home. Similarly, Hurd (1999), in a study of older women who attended a senior centre in central Canada, found that older women distance themselves from those they consider old and that they actively work at presenting an alternative image of what it means to age. The demonstration of "active aging" is a form of identity management that is often related to higher levels of life satisfaction and subjective well-being (Westerof and Barrett 2005).

Ageism: A Form of Discrimination

In 1968, the public housing authority in Chevy Chase, Maryland, applied to convert a building in a white, middle-class suburb into housing for older citizens. The public hearings degenerated into a riot as residents of the area fought to keep "all those old people" out

of their community. As a result of this incident, Butler (1969) coined the term *ageism*. He considered ageism to be similar to racism and sexism in that inherent biological factors are used to define **personality** or character traits. Butler defined ageism as a process of systematic stereotyping of and discrimination against people because they are old. Ageism can be expressed, fostered, and perpetuated by the media, by public policies, in the workplace, and in casual daily interactions with older people. Indeed, even those who work with or study older people may employ unintentional, insensitive ageist language (Palmore 2000; 2001). A large body of literature has examined the attitudes and behaviours of various age groups toward aging and older people, as well as the effects of those attitudes on the older persons.[6]

Attitudes toward aging are influenced by a number of factors, including the age, ethnicity, education level, gender, sexual orientation, disability, and socio-economic status of the respondents. Those with more education consistently show more positive attitudes toward aging, perhaps because they have more knowledge about aging. Similarly, those who have frequent and meaningful interaction with older people, especially in a family, have more positive attitudes, primarily because the frequent contact provides factual, personal knowledge that refutes the myths and stereotypes about aging encountered elsewhere in society.

Ageism is a socially constructed way of thinking about and behaving toward older people. It is the one source of disadvantage, oppression, or discrimination that we all might face from others in later life. When negative attitudes and stereotypes become pervasive and institutionalized, they can be used to justify prejudicial and discriminatory legislation or regulations, such as increasing the age at which pensions are available to older adults. Or, on the basis of age, people may be excluded from social interaction or denied equal access to services in the public and private sectors, such as withholding potentially lifesaving treatment options when they are frail (Chrisler et al. 2016). Where ageism exists, older people are devalued, and their human rights are compromised. In short, there is both *individual* ageism, the acceptance of negative feelings and beliefs that influence our thinking and behaviour, and *institutionalized* (or structural) ageism, as expressed in legislation, advertisements, the mass media, and anti-aging products, all of which can lead to social and economic inequalities across society (Bytheway 2005b).

As with most forms of discrimination, it is difficult to obtain reliable research evidence to determine/identify the extent of ageism or why it exists (Cohen 2001; Nelson 2002; Palmore et al. 2005). It may be that the occurrence and degree of ageism is closely linked to demographic and economic factors in a society. For example, when a significant proportion of the aging baby boom cohort reaches retirement age in the years prior to 2031, the skills of older people may be needed to meet the demand for labour. In that case, structural ageism could ebb or disappear because of the need for more flexible work and retirement schemes (Longino 2005). In another 15 to 25 years, older people will be a near-majority group in the social structure, and ageism may be much less common, especially if older people are perceived as necessary and useful contributors to the labour force and the economy.

Regardless of the social changes the future may bring, "age" should not be employed as a convenient benchmark for behaviour or rights or as an explanation for processes or outcomes in later life. Chronological age should not be a criterion when framing legislation that affects older adults. In Belgium, strict anti-discrimination legislation requires that all legislation be reviewed with its use of 50 or more years as an age criterion (Breda and Schoenmaekers

2006). Indeed, Bodily (1991, 260) argues that the study of "age effects" should be abandoned and that "age differences" are not synonymous with "differences due to age":

> Gerontologists do not study the effects of age; rather, they study processes, the effects of which tend to surface among older populations, not because these people are older, but because the processes themselves take time or depend on other processes which take time. This distinction is crucial because it preempts the possibility of casting "age" as a cause, thereby making room not only for variations "between" different age groups, but variation "among" the same age group. People age differently both because they are subject to different events and processes and because the same events and processes affect them differently.

As members of a society become better informed about aging, chronological age as the defining marker of being old will be eroded. Increased research, a longer life expectancy, and visible, more active, and independent older people are revising the definition of later life.

The Field of Gerontology Matures

Gerontology, traditionally a multi-disciplinary field of study, is the study of aging processes and aging individuals, as well as of the practices and policies that are designed to assist older adults. Gerontology includes research conducted in the biological and health sciences, the behavioural and social sciences, and the humanities, as well as analyses of policies and practices developed at the global, federal, provincial, regional, or local level. Increasingly, the field is becoming even more interdisciplinary in terms of the questions asked and the perspectives and methods employed to answer the research questions about aging phenomena (Alkema and Alley 2006). The latest information in the field can be found in the proceedings of conferences; in articles in newspapers, magazines, and research journals; in government documents; and on the Internet.[7] **Geriatrics**, not to be confused with gerontology, is a sub-specialty of medicine that focuses on the physical and mental diseases of later life and on the clinical treatment and care of elderly patients by specialized physicians.

Social gerontology, a subset of gerontology, employs the social sciences to study the social processes, issues, practices, and policies associated with aging and older people (George and Ferraro 2016). It was not until the 1960s that scholars in Canada began to study aging processes and individuals in later life. This early research was concerned with two aspects of aging: first, with developing, evaluating, or critiquing welfare programs or social policies for older people; and, second, with describing and explaining aging processes and older adults' status and behaviour. The researchers in the second category were affiliated with a traditional discipline, such as sociology, psychology, political science, geography, history, demography, or economics. Since the 1980s, aging phenomena and issues have also been studied by practitioners and scholars in professions such as social work, nursing, dentistry, education, architecture, pharmacy, law, criminology, urban and regional planning, recreation and leisure, and kinesiology and physical education. More recently, scholars in disciplines such as philosophy, literature, fine arts, communication and film studies, women's studies, men's studies, and cultural studies have been offering critiques of the way that old age and older people are depicted in the arts, the media, and scholarly publications.

Gerontology has become a discipline in its own right, as reflected in the significant growth in the quantity and quality of educational programs about gerontology in Canada

and every other developed country, as well as in the discipline's recent expansion to developing countries. Ferraro (2006) published an editorial in *The Gerontologist* entitled "Gerontology's Future: An Integrative Model for Disciplinary Advancement." He argued that the field of gerontology has developed into a discipline, based on four elements critical to its evolution: theory, research methodology, formalized organizations supporting the field of study, and a common vernacular. He distinguished between a multi-disciplinary (pillar model) and an interdisciplinary (integrative model) approach to research and educational training. He speculated that "with greater emphasis on interdisciplinary work in educational programs, a paradigm shift may commence with academic and research institutions moving away from aging scholarship based on a single perspective toward valuing the unique contributions that gerontology offers as an integrative discipline" (Ferraro 2006, 580).

Gerontology can be further divided into two general components: the academic community, which produces research, theory, and critiques about the aging process and the situation of older people; and the professions, which apply research knowledge and theory to the development and implementation of policies, programs, and services to enhance the quality of life for older adults. The Canadian Association on Gerontology (www.cagacg.ca), which welcomes student members, includes researchers, graduate students, government policy-makers, and practitioners in the public or private sector who are employed in a variety of positions that serve older adults. This diverse group of members meets annually to share information that will advance knowledge and improve the lives of older Canadians.

The timeline displayed just before Part I of this textbook provides key advancements in the field of social gerontology in Canada in education, research, and policy.[8] While it is impossible to include all major events and publications, the timeline does identify significant milestones. During the early periods (prior to 1945), there was primarily isolated work related to aging, with little organization through formal organizations. Between 1945 and 1960, the first-generation scholars began to form "networked" organizations, conferences, and the first journals on aging in an attempt to develop a distinct area of research and training. A second generation of researchers was trained in the 1961 to 1975 era, some of whom received their education in gerontology programs and centres. This period experienced growth in key knowledge development in a number of sub-fields or clusters. Between 1975 and 2000, social gerontology became a recognized discipline, with a critical mass of researchers and practitioners. Since the turn of the millennium, we have witnessed an enormous growth in the field of social gerontology and the integration of knowledge across disciplinary boundaries.

In Canada, courses on the sociology of aging and social gerontology have been taught since the early 1970s. The first Canadian reader and textbook with a focus on social aging were published in the early 1980s by, respectively, Marshall (1980) and McPherson (1983). In 1971, the Canadian Association on Gerontology was founded, and in 1982 the association launched the *Canadian Journal on Aging*, a quarterly research journal. As well, a number of major research initiatives have contributed to our knowledge base in Canada. The Canadian Health and Aging Study focused on the epidemiology of dementia wherein 10,000 elderly Canadians were studied over a 10-year period from 1991 to 2001. In June 2000, the CIHR Institute on Aging (http://www.cihr-irsc.gc.ca/e/8671.html) was established as one of 13 institutes of health research in Canada. CIHR supports the development of the Canadian Longitudinal Study on Aging, which is collecting population health and social data, from the cellular to the societal level, on over 51,000 Canadians from 2010 to about 2030. Earlier, provincial longitudinal studies on aging were initiated in Ontario in 1959 under the leadership of Lawrence Crawford; and in Manitoba, in 1971, under the leadership of Betty

Havens. Other notable developments that have increased our knowledge and awareness of aging in Canada include the formation of centres on aging at universities or colleges; the development of diploma, undergraduate, or graduate programs in many universities and colleges since the 1980s; the creation of provincial gerontology associations; the funding of the Canadian Aging Research Network (CARNET) from 1990 to 1995; the National Initiative for the Care of the Elderly (NICE) since 2005; the Canadian Frailty Network since 2012; the Age-Well Technology and Aging Network since 2015; the creation of the National Advisory Council on Aging (NACA) (replaced by the National Seniors Council in the mid-2000s); the Division of Aging and Seniors, Public Health Agency of Canada, Ministry of Health, and various other departments or ministries concerned with aging issues at federal, provincial, regional, or local levels of government; and many research networks, grants, and contracts funded by provincial and federal agencies since the 1980s (see timeline before Part I).

The study of aging processes and older adults is thriving in Canada. Many government agencies produce regular reports about aging issues and older adults (Statistics Canada, Public Health Agency of Canada, Employment and Social Development Canada, the National Seniors Council, Veterans Affairs). Globally, more than 200 journals publish gerontological research, and most of them have the words *aging*, *gerontology*, or *elderly* in their titles (see Simon Fraser University Gerontology Research Centre [GRC]: www.sfu.ca/grc/). With the aging of the population expected to reach new heights over the next 30 years, jobs or careers in aging-related fields should present good opportunities for employment.[9]

Three Life-Course Conceptual Dimensions to Understanding Aging

Many theories and methods can be used to study aging phenomena (see Chapter 5). The overarching perspective that guides the structure and content of this book is the life-course perspective. At this juncture in the text, we introduce three conceptual dimensions upon which we can develop our questions and focus our analyses. The first dimension directs us to consider life histories and pathways of individuals as they age. The second and third dimensions entail dichotomies that represent a dimension with two extremes: agency and social structure; and the micro (individual) and macro (structural) elements of daily life. They refer to different aspects of social life that are interrelated and interdependent aspects of the life-course perspective. However, we separate them, conceptually, so that we can understand more completely an extremely complex social world.

Life-Course Histories and Pathways

To understand aging in our social world, we need to consider the historical period and events in which the aging occurs, the age of the individual(s) when experiencing these events, the age cohort or generation that can influence these experiences, and the connections among these. In particular, we must understand that earlier life experiences affect later ones and that life courses are shaped by opportunity structures and the social characteristics that influence them, such as our socio-economic status, gender, ethnicity, race, immigration status, social networks, and so on. Furthermore, the social forces that influence aging over the life course interact and interrelate with one another, and therefore require an understanding of their intersections. For instance, Syrian refugees entering Canada in recent years will experience

aging against a background that may include significant stress, poverty, discrimination, and other challenges. This dimension does not fully address how these individuals may, in turn, have an influence on Canadian society.

Agency and Social Structure

Another dimension of the life-course perspective is agency, which involves individual or group action, based on the ability and willingness to make decisions that affect social relationships and structures. We develop individual or group identities as we interact with others and form social relationships across the life course as a result of individual action within the constraints and opportunities of our social world. We have the potential, as individuals or groups, to construct and change our social world, at least within the boundaries of the social structures and social contexts in which we live. Social structures provide the social context or conditions under which people act and form social relationships. Most components of this structure—gender, race, ethnicity, and class—are present from birth and endure across the life course. To summarize, "the agency-structure issue focuses on the way in which human beings create social life at the same time as they are influenced and shaped by existing social arrangements" (Layder 1994, 5).

Micro and Macro Analyses

The third vector influencing our conceptualization of social life across the life course is the micro-macro distinction. This dialectic analyzes the interaction of those elements that focus on experiential, face-to-face social interactions in the daily life of individuals or small groups (a micro-analysis) and those that focus on the larger, impersonal structural components of a society—organizations, institutions, and culture, and their sub-elements of power, class, and resources (a macro-analysis).

All three of these conceptual dimensions should be kept in mind as you study aging phenomena, and they will be revisited in more detail in the theoretical section of Chapter 5.

Critical Issues and Challenges for an Aging Society

As you begin your journey toward increased understanding of and sensitivity to aging processes and older adults, a number of issues and challenges should be at the forefront of your critical thinking skills and your personal actions. They will be addressed in more detail throughout the book. At this point, you should note the following:

- Aging is not an illness or a disease state—avoid the **medicalization of aging** view and the view that aging can be decelerated, reversed, or "cured" through anti-aging medicines and modalities (Fisher and Morley 2002; Binstock 2003; Mehlman et al. 2004; Hudson 2004; Bayer 2005; Fishman et al. 2008; Flatt et al. 2013).
- Aging is primarily a women's issue—women live longer, often alone, and face more challenges in later life, such as poverty and discrimination, especially if they are divorced or widowed or have never married.
- We live in and are connected to an aging world. Much of the growth in population aging in the twenty-first century will occur in developing countries.

- Aging, as a social process, occurs in a changing social world with diverse structural opportunities and barriers; there is inequality in the aging process and in later life because of lifelong variations in life opportunities and choices.
- Individual and population aging are inevitably linked and constitute an evolving dialectic wherein aging issues and experiences manifest themselves in larger societal spheres, such as retirement, pensions, health care, and social support policies and programs.
- As birth cohorts grow older, and as immigration patterns change, there is increasing diversity among members of a cohort—in health status, lifestyles, income, attitudes, mobility, and independence, to name only a few dimensions. This diversity or heterogeneity must be considered in the development of tailored and targeted policies, programs, and services.
- As the large and diverse baby boom generation continues to move into later life, and as individuals live longer, the relationships among individual and population aging will become more complex and require the development of unique policies and practices, such as home care, long-term care, and palliative care.
- Social institutions, policies, and practices for an aging society must evolve to avoid perpetuating inequities or inadequate services. For example, the emphasis in public policy debates may shift from a concern about decreased availability of pension funds to a concern about labour shortages and the need to keep older workers in the labour force through delayed or partial retirement.
- Population aging will not weaken or destroy a society, as proponents of "apocalyptic demography" would have us believe. But population aging will present us with challenging policy, program, and political issues to resolve.

To meet the needs of an ever-changing, increasingly diverse older population, a balance of collective versus individual responsibility must evolve, especially with respect to economic security, health and health care, and social support and personal care. Population aging is a life-course, society-wide issue as much as it is an older person's issue. As the United Nations has argued with respect to global population aging, we need to build "a society for all ages." Two essential steps in this direction involve ensuring the ethical treatment of older people, especially those who are vulnerable, and ensuring that human rights in later life are protected.

Ethics in an Era of Population Aging

Ethics represents an objective and reflective way of thinking about how one should act in a specific situation by taking into account the best interests of everyone involved in the situation—the individual, family members, professional workers, society (e.g., advance directives for end of life care). For both individuals and the state, ethics involves the following:

- "should" questions (e.g., Should life-sustaining technology be used for those with a terminal illness?)
- ethical issues (how to prevent elder abuse by caregivers) and ethical dilemmas (e.g., Does a physician prevent or delay death or initiate death through physician-assisted suicide?)
- decisions about what is right, good, or appropriate for an individual or for society (e.g., Who should make decisions about ceasing treatment, extending life, or employing costly surgery, and when should those decisions be made?)

Ethics, as an area of study, does not provide a set of rules for decision-making or behaving, or a set of easy answers or solutions. Rather, a set of culturally induced principles and values (fairness, privacy, autonomy, freedom, honesty) is employed when debating and resolving moral, religious, or social issues. Ethics involves an *ideological* dimension (Should individualism or collectivism guide public policy and in what proportion?), a *practice* dimension (Should an 85-year-old receive a heart transplant, a hip replacement, or kidney dialysis?), and a *professionalism* dimension (adherence to the Hippocratic oath taken by physicians; the development of standards of care for home-care workers; a bill of rights for those living in a long-term-care facility).

The onset of population aging, along with biomedical technological developments that foster new ways of thinking and acting, raises legal, moral, philosophical, and ethical questions about aging and older adults.[10] Some questions and issues operate at the level of the individual; others, at the level of society. Discussions and debates concerning ethics should recognize that there will be individual differences of opinion. Debates might address some or all of the following topics, which would make for interesting discussions in class or with parents, grandparents, siblings, or friends:

- Should "age" or "need" be a criterion for entitlement to economic security or expensive elective surgery?
- Should economic and health resources be rationed and priority given to young people?
- Should we privatize the health-care system and, if so, to what degree and how?
- Should people pay a portion of their health-care costs if they smoke or engage in other unhealthy behaviours?
- Should families be responsible for the care of their dependent elders?
- Should older people have the right to die a "good death" with dignity and at a time of their choosing? If so, should they make the decision in advance or at the time, as autonomous individuals, or should a third party be involved? Will the medical professions assist and, if so, in what way?
- Who should make decisions about living wills, the use of protective restraints and drugs in nursing homes, and euthanasia?
- Should an older person's driver's licence be suspended or revoked and, if so, when and according to what criteria?
- Should an older person who cannot carry out the basic and necessary activities of daily living be removed from his or her home? How much home care should be provided in the home before an elderly person is moved into a long-term-care facility?
- Should genetic testing be employed to identify who is most at risk for certain illnesses, and should this information be used to treat individuals differentially within the health-care system or for personalized medicine?
- Should medical technology be used to extend a person's life if the quality of life deteriorates significantly or below an acceptable level because of a terminal illness or severe dementia?
- How should autonomy, privacy, and the rights of institutionalized and cognitively impaired older people be protected, and how do we enable them to have agency? Who should have access to information about dependent elderly persons?

In all debates and decision-making around ethical issues, we must ask whose best interest is being served by any decision or action—that of the older person, a caregiver, an organization, or society. And we must decide what is best at this time, in this situation, and

for a specific dependent person. As much as possible, the older person, a family member, or both should be a partner in decisions about personal matters and in public debates about ethical issues pertaining to later life, such as whether doctor-assisted death should be legalized. Many decisions about home or health care in later life involve competing or conflicting values, beliefs, or opinions. Often, laypeople and professionals disagree on issues with an ethics dimension. They may disagree about what treatment or outcomes would best serve a dependent older person, the family, or society. Yet many decisions are made, or influential advice given, about an elderly person by medical or social services personnel or by family or friends on behalf of the older adult, who is not consulted, even if he or she is able to make personal decisions (Holstein et al. 2011; Schermer and Pinxten 2013).

Ethical issues and dilemmas emerge and evolve over time; therefore, they need to be debated frequently and resolved because of the possible implications of an unethical decision or situation for an individual or for society. Throughout the book, you will find discussions of specific ethical issues, such as conducting research with older adults (Chapter 5); driving

Highlight 1.6 • United Nations Declaration of the Rights of Older Persons: Preamble

At the first United Nations World Assembly on Ageing in 1982, some consideration was given to human rights issues, and in 2000, Mary Robinson, United Nations Commissioner on Human Rights, emphasized the importance of protecting the human rights of older people. At the second United Nations World Assembly on Ageing in April 2002, the International Longevity Center–USA, in collaboration with its sister centers in Japan, France, the United Kingdom, and the Dominican Republic, proposed that the following Declaration of the Rights of Older Persons become the basis of action as well as discussion at the Assembly and beyond.

Declaration of the Rights of Older Persons

Whereas the recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice, and peace in the world,

Whereas human progress has increased longevity and enabled the human family to encompass several generations within one lifetime, and whereas the older generations have historically served as the creators, elders, guides, and mentors of the generations that followed,

Whereas the older members of society are subject to exploitation that takes the form of physical, sexual, emotional, and financial abuse, occurring in their homes as well as in institutions such as nursing homes, and are often treated in cruel and inaccurate ways in language, images, and actions,

Whereas the older members of society are not provided the same rich opportunities for social, cultural, and productive roles and are subject to selective discrimination in the delivery of services otherwise available to other members of the society,

Whereas the older members of society are subject to selective discrimination in the attainment of credit and insurance available to other members of the society and are subject to selective job discrimination in hiring, promotion, and discharge,

in later life and living in a long-term-care facility (Chapter 8); ensuring economic security for an aging population (Chapter 10); elder care and elder abuse (Chapter 12); and end-of-life decisions, such as assisted suicide, euthanasia, and the use of technology to sustain life (Chapter 12).

Protecting Human Rights in Later Life

Respect, autonomy, and dignity must be assured as rights for older adults, especially if they are likely to experience discrimination,[11] ageism, neglect, abuse, poverty, homelessness, or malnutrition. Increasingly, some "seniors" issues are being addressed as an integral component of a rights-based society that seeks to improve the standard of living and the quality of life for all older adults (Cox 2015). Human rights should be permanent, consistent, and universal across the life course—not devalued or lost as one ages and becomes more vulnerable or at risk.

To protect human rights in later life, a Declaration of the Rights of Older Persons (Highlight 1.6) was presented to the Second United Nations World Assembly on Ageing in

Whereas older women live longer than men and experience more poverty, abuse, chronic diseases, institutionalization, and isolation,

Whereas disregard for the basic human rights of any group results in prejudice, marginalization, and abuse, recourse must be sought from all appropriate venues, including the civil, government, and corporate worlds, as well as by advocacy of individuals, families, and older persons,

Whereas older people were once young and the young will one day be old and exist in the context of the unity and continuity of life,

Whereas the United Nations Universal Declaration of Human Rights and other United Nations documents attesting to the inalienable rights of all humankind do not identify and specify older persons as a protected group,

Therefore new laws must be created, and laws that are already in effect must be enforced to combat all forms of discrimination against older people,

Further, the cultural and economic roles of older persons must be expanded to utilize the experience and wisdom that come with age,

Further, to expand the cultural and economic roles of older persons, an official declaration of the rights of older persons must be established, in conjunction with the adoption by nongovernment organizations of a manifesto which advocates that the world's nations commit themselves to protecting the human rights and freedoms of older persons at home, in the workplace, and in institutions and offers affirmatively the rights to work, a decent retirement, protective services when vulnerable, and end-of-life care with dignity.

Source: Reprinted with permission from Butler 2002.

April 2002 (Butler 2002). This declaration, which pertains to societies as well as to individuals, concludes with a call for action to improve the quality of life of older adults throughout the world.

What Do Older Canadian Adults View as Important Issues?

In April 2009, the Special Senate Committee on Aging published its final report, entitled *Canada's Aging Population: Seizing the Opportunity*. Under the Hon. Sharon Carstairs, Privy Council Chair, and the Hon. Wilbert Joseph Keon, Deputy Chair, the committee travelled across Canada speaking to seniors and experts, and reviewing programs and services, with three major aims: (1) to identify priority areas for political leadership and multi-jurisdictional coordination; (2) to provide support for research, education, and the dissemination of knowledge and best practices; and (3) to provide direct services to certain population groups for which it has direct responsibility. From coast to coast, the committee discovered that many of the personal stories of older adults themselves provided the foundations of their report. Highlight 1.7 illustrates some of the major ideas that the committee learned concerning both positive messages and gaps in services and programs. These issues are critically examined in more detail throughout the book.

Highlight 1.7 • Special Senate Committee on Aging Final Report: Canada's Aging Population—Seizing the Opportunity

What the Committee Learned

- Seniors need to be recognized as active, engaged citizens in our society.
- Older adults should have the right to age in the place of their choice.
- All Canadians need to place as much importance on adding life to years as on adding years to life.
- The aging population should be viewed as an opportunity for Canada.
- Seniors are often unjustly stripped of their rights.
- Inappropriate care decisions are made because we do not provide the right service at the right time.
- The unequal rate of population aging across the country challenges the provinces to provide a necessary range of services.
- Some seniors live in isolation or in inappropriate homes because of inadequate transportation and housing.
- Current income-security measures for our poorest seniors are not meeting their basic needs.
- The current supports for caregivers are insufficient, and some Canadians, especially middle-aged women, are forced to choose between keeping their jobs and caring for the ones they love.
- The voluntary sector is suffering as volunteers themselves are aging.
- Canada faces challenges in health and social human resources, as doctors, nurses, and social workers are themselves aging.