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University of Kent

VU VRIJE UNIVERSITEIT AMSTERDAM

UKRI Economic and Social Research Council

Enabling age at work

How ageism and ableism overlap in the workplace

Advice
Inequalities
Life expectancy
Retirement
Immunisation
Housing Wealth
Employment

Summary

New research, by researchers at the Vrije Universiteit Amsterdam (VU Amsterdam) and the University of Kent, highlights the overlap between ageism and ableism, along with how older people themselves internalise ageist and ableist attitudes. This can have a significant impact in workplaces, creating additional barriers to achieving broader policy ambitions to foster equality and encourage longer working lives.

The research project included a webinar held during January 2021, which highlighted two key topics:

- Employers and older workers too often see training and professional development as more relevant for younger people, which leads to missed opportunities for enhancing skills and sharing experience
- As the risk of developing an impairment increases with age, occupational health support is key

To remain competitive when dealing with an ageing workforce, organisations must act to create inclusive work environments. They should educate managers and staff about the social model of disability, including what this means for their workplace, rather than use the individual/medical model.

Where a worker develops health issues, occupational health services should act as an advocate for the worker, ensuring that the job is made to fit the person. These efforts should focus on ongoing support to enable the worker to stay in work rather than just get back to work.

About this report

This report summarises research from a recent project conducted by researchers at the VU Amsterdam and the University of Kent, funded by the Economic and Social Research Council.[1] It's written by researchers from the project, and provides background on the UK government's equality policy as well as the concepts of ageism and ableism. It summarises the project's key findings, taken from a series of interviews with older workers and managers

[1]The project was funded under ESRC grant Ref. ES/S00551X/1. Part of this research has also been published elsewhere; please see Van der Horst, M. & Vickerstaff, S. (2021) "Is part of ageism actually ableism?" *Ageing and Society*, 1-12. https://www.doi.org/10.1017/S0144686X20001890

from four organisations, as well as roundtable discussions with selected stakeholders from occupational health and professional development, held online in January 2021 as a webinar. For readability, sometimes distinctions are made based on binaries (i.e. older versus younger workers, people with an impairment or not). It is important to note, however, that in reality these are not simple binaries.

Author: Dr Brian Beach, Dr Mariska van der Horst, and Prof Sarah Vickerstaff

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Introduction

Policymakers have developed increasing awareness of population ageing in recent years. They have focussed greater attention on encouraging longer working lives. In this context, ageism has come into clearer focus, stimulating work among both researchers and advocacy groups.

Ageism plays a critical role in shaping labour market opportunities and participation for older people (or the lack thereof); it can affect retention, recruitment, and retraining. This ageism is partly driven by myths and stereotypes about older workers, most significantly raising concerns around their health and capacity to work into later life.

Such questions around 'ability' raise the spectre of ableism as a confounding factor. Moreover, the impact of ageism and/or ableism may partly be shaped by older workers' own internalised prejudices around age and health.

Policy background on equality

The UK's primary piece of policy relating to equality in the workplace (and society more broadly) is the *Equality Act 2010*.[2] This legislation establishes guidance on protecting people from discrimination, consolidating multiple previously existing anti-discrimination laws into one, in an effort to make the law easier to understand. It also strengthens some elements of protection.

The Equality Act establishes the set of characteristics that should be protected from discrimination: age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, and sexual orientation. It prohibits both direct and indirect discrimination, as well as harassment or victimisation. It also underscores the principles behind the employer's duty to make reasonable adjustments for people with impairments, along with the regulations associated with this.

The legislation provides further details on the implications for workplaces (in addition to other areas of society like public services, education and transport). It gives disability a prominent place, to ensure that previous regulations are incorporated and to promote fairness and equality across society. The main piece of legislation on

[2]https://www.legislation.gov.uk/ukpga/2010/15/contents

this subject was previously the *Disability Discrimination Act 1995*. Age was introduced as a protected characteristic much more recently, in the *Employment Equality (Age) Regulations 2006*.

The Equality Act provides a solid foundation to create a fairer society and enable opportunities for all members of society. One critique of the law is that, while Section 14 addresses the concept of combined discrimination (i.e. related to more than one protected characteristic), the detail does not fully allow the raising of complaints or cases that recognise intersectionality. **Intersectionality** is the concept that there may be unique disadvantages to being at an 'intersection' of multiple sources of inequality.[3] For example, anti-age discrimination legislation may benefit certain subgroups of older workers (e.g. healthy and male) more than others.

We must not underestimate the significance of intersectionality for efforts to combat discrimination on the basis of age or disability. For example, older women may be disadvantaged in the workplace when compared to either older men or younger women: think about television presenters.[4] Similarly, employers are obliged to make reasonable adjustments for people with impairments, but the ongoing prevalence of age-based stereotypes may shape what they consider 'reasonable' for an ageing worker, if they expect that worker to experience a decline in functional capacity. Moreover, if that worker has internalised similar stereotypes, they may not feel empowered to exercise their rights under the Equality Act, accepting dismissal or an early transition into retirement.

These points underscore the importance of the research here. We must critically examine the potential overlap of ageism and ableism, as well as strengthen awareness of this intersection. We must also ensure that workers don't carry their own negative perceptions about age and/or impairment as it relates to themselves, allowing their internalised attitudes to restrict their own access to opportunity.

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[3]The concept of intersectionality was established by Kimberlé Crenshaw in 1989. Crenshaw, K. (1989) "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics." *University of Chicago Legal Forum*, 1989(1): Article 8.http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

[4]https://www.fawcettsociety.org.uk/blog/uk-equality-act-is-not-fit-for-purpose-its-time-for-the-law-to-recognise-multiple-discrimination

What are ageism and ableism?

There is legislative protection for characteristics like age and impairments. However, the existence of anti-discrimination laws doesn't eliminate attitudes, behaviours, or beliefs that cause people to be marginalised or receive unfair treatment. The theoretical underpinnings of ageism and ableism can clarify some of the concepts and mechanisms that generate inequality.

Ageism can be understood to affect any group where age is the basis of stereotyping or discrimination.[5] There are three fundamental aspects of ageism:

- Stereotypes: what we think about people with respect to age
- Prejudice: what we feel about people with respect to age
- Discrimination: how we behave towards people with respect to age

These aspects may also be: either self-directed or other-directed; either conscious or unconscious (explicit or implicit); and either positive or negative.[6]

The term ageism was first coined in academic literature by Robert Butler in 1969.[7] Butler linked ageism toward older people with an uneasiness among younger and middle-aged people toward growing older and developing disease or impairments, with such feelings fostering a sense of impending powerlessness or uselessness.

The negative sentiments associated with impairment create a direct link between ageism and **ableism**. Like ageism with respect to age, ableism emerges from considering certain abilities as being better or worse than others. In this context, having an impairment is seen as a personal tragedy or a condition to overcome; this is often referred to as the **individual/medical model** of disability.

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[5]http://www.who.int/ageing/ageism/campaign/en/

[6]See São José, J., & Amado, C. (2017) "On studying ageism in long-term care: A systematic review of the literature." *International Psychogeriatrics*, 29(3), 373-387. https://doi.org/10.1017/S1041610216001915; Buttigieg, S.C., Ilinca, S., São José, J.M.S., & Larsson, A.T. (2018) "Researching Ageism in Health-Care and Long Term Care." In: Ayalon L. & Tesch-Römer C. (eds) *Contemporary Perspectives on Ageism*. International Perspectives on Aging, vol 19. Springer, Cham. https://doi.org/10.1007/978-3-319-73820-8_29

[7]Butler, R. (1969) "Age-Ism: Another Form of Bigotry." *The Gerontologist*, 9(4, Part 1): 243–246. https://doi.org/10.1093/geront/9.4_Part_1.243

Advocates for people living with an impairment prefer to focus on the social model of disability, e.g. drawing on a **social relational approach**. This sees disability as one expression of an unequal social relationship between those who live with an impairment and those who don't. When people living with an impairment are contrasted with those seen as 'normal', it creates a form of social oppression.[8] In this way, **impairments become disabling because of how society reacts and responds** to them, rather than being inherently disabling.

Fears about potential decline in capacity as workers grow older may influence expectations about the fit between the person and the job. Seeing impairment as a hindrance in itself is a negative and potentially discriminatory attitude; employers are obliged to make reasonable adjustments for workers with impairments. However, when practices treat age in a similar way, due to the increased risk of physical or mental decline, **part of ageism becomes hidden ableism**.

The significance of these issues for an ageing workforce is clear. People are encouraged to work longer, and businesses will need to draw on older workers to remain competitive. Employers must adapt to evolving health and care needs if we are to enable older people to stay in the labour market, but ageism and ableism remain barriers to employment opportunities for older workers.

[8]Thomas, C. (1999) *Female Forms: Experiencing and understanding disability.* Buckingham: Open University Press.

Internalised ageism and ableism among older workers

The need for employers to address policies that may exclude older and impaired workers has been highlighted in previous work – and we've seen growing awareness of and engagement on these issues by employers in recent years. Less is known about how older workers apply ageist or ableist attitudes toward themselves, internalising these perspectives to their own disadvantage.

Our project sought to address this gap. Part of the project explored attitudes to older workers in two critical areas: training/professional development and occupational health. We drew on semi-structured interviews with workers aged 50+, line managers, human resource (HR) managers and occupational health managers, from four UK-based organisations.[9]

Despite formally embracing equality, managers commonly spoke in ageist terms about older workers being less motivated or less able to undertake training and professional development. While discouraging, this is not news. However, **age norms were also internalised by older workers**. They expressed ageist views about themselves, such as that they were now "too old" for training and/or promotion and that they should leave that "to the younger ones". Both managers and older employees also deployed stereotypes about the inevitable physical and cognitive decline that comes with age to explain why learning new things was more difficult.

> **Interviewer:** *So older workers don't request as much training?*
>
> **Line manager:** *Definitely not. […] There's probably two reasons. One, there's no training there that they think they need. Two, they don't think they need training."*

Access to training and career development is key to facilitating longer working lives. Older workers need appropriate opportunities to engage in such activities, but **making opportunities available does not guarantee take up if internalised attitudes discourage older workers**. Managers and HR teams must address the impact of internalised ageism and ableism to ensure that older workers are motivated to engage in development activities.

[9]The occupational health theme was only examined among three of the four organisations.

With respect to occupational health, **ageist and ableist assumptions about capacity to work were prevalent, as were narratives of decline in older age**. In the organisation with the most proactive and extensive policies around health and safety (i.e. regular medicals, health screening, and policies for adjustments and redeployments), the organisational culture was more supportive of older workers. However, all organisations experienced constant tensions between wellbeing initiatives and commercial pressures.

> **Older worker:** *"I think there's a level as you get older your ability to absorb, maybe… like slowing down of the learning process within us. Maybe that's self inflicting 'cause we put up a barrier, oh I'm 60 so I shouldn't be doing this now, so maybe… you say you can't but you actually can."*

The study suggested that, despite a sense of support for health and wellbeing from the employer, **internalised attitudes to ageism and ableism kept workers from being open about their health concerns**. Reluctance to raise issues early can mean that they deteriorate to a point where adjustments are difficult or impossible; indeed, we know that prevention and early intervention yield better outcomes. As we saw with training and development, employers can highlight openness and supportive policies, but if their workers' own beliefs lead to worries and fears, they'll be less likely to take advantage of such support.

Employers must continue to provide opportunities for their workers and to encourage their older workers to engage with these opportunities. But their efforts need to go beyond making things available; **employers must work to proactively promote policies that stimulate an inclusive work environment**.

> **Older worker:** *"Yeah. I don't think if I went and said to them, you know, 'Oh, I'm finding it really difficult,' they normally say, 'Well, obviously if you can't do the job, you need to leave then'….It's not, 'Well, let's see what we can do to help you,' it's not like that at all."*

Views from our stakeholders

As part of the project, we held a webinar in January 2021 to highlight the research findings and gather cross-sector perspectives from people with an interest in training and occupational health. The webinar included six separate stakeholder discussions: three concurrent discussions focused on training and professional development in one breakout session, followed by three on occupational health in the second breakout. Many general themes related to the research emerged.

A key point in the training breakout was how training itself can be boring (or perceived as boring), which can deter people from taking it up or actively engaging in it when they do. In addition, some forms of training can be seen as part of a box-ticking exercise, further reducing motivation to take it up. **Employers must clearly demonstrate the value of training** to help workers understand how it will enrich their experience and performance. Materials used to promote training should be considered in addition to those used in the training.

Employers should consider different training formats for different groups, as people have different learning styles. Intergenerational approaches could be valuable in this context, both to **stimulate knowledge exchange between workers** and to **break down stereotypes in both directions**. This is true for workers with impairments as well as older workers; younger people living with health conditions are sometimes seen as "too young" to have an impairment. Intergenerational communication and cooperation can disseminate lived experiences, raising awareness of age- and health-related issues.

This approach could help us all to recognise that the paths of our lives and careers are changing. People's lives do not follow a predictable, linear path, and we all face new challenges and transitions at different points; arguably, diversity in experience has increased. **Work culture matters** here – organisations differ in how they deal with diversity in their workforce. If we want to change workplace culture, workplaces will need better tools that can provide workers with the language to discuss their needs. This also requires buy-in from employers at the highest level to help break down structural barriers – engaging with workers will not generate change alone.

Training to recognise unconscious bias could help to generate cultural change in the workplace, although it shouldn't be considered a magic bullet. If promoted in the right way, this training can be a tool that brings the issues of ageism and ableism to the fore and exposes how these are often more accepted than other forms of discrimination.

At the same time, **expectations must be realistic** when it comes to making changes to workplace attitudes to ageism and ableism. Our bodies do change as we grow older, and we experience changes in energy and concentration levels. These can affect performance and experience and must be recognised as part of life. However, they're not specific to a certain age, and each age group sees variation in this regard. By engaging workers early and in an appropriate way, we can encourage conversations that lead to reinvention when needed.

In the occupational health breakout groups, participants noted that **most employers don't have a dedicated occupational health function**. They rely on GPs and the healthcare system to create strategies to address health concerns. In contrast, employers that do occupational health well take a holistic approach that looks at prevention and support. Consultation is key: we must ask people about the kinds of interventions they want.

Our stakeholders raised the question of whether workplaces were really the best place to deliver health-based interventions. Some people may be reluctant to disclose a health issue in a work context, for fear of reprisal or other negative consequences from the employer. Yet work is a significant part of many people's lives, and it would be reasonable to expect workplaces to respond to workers' health needs. After all, employers have a duty of care to protect the health, safety, and welfare of their workers. Moreover, **an employer's attitude to workforce health and wellbeing may become one of the criteria for identifying a good job**; for example, the COVID-19 pandemic has spotlighted such concerns.

One of the project's key findings was that occupational health should strengthen efforts to **make the job fit the worker rather than the other way around**; this perspective was confirmed by our discussion stakeholders. Occupational health services were described as often disconnected from organisations, cut off rather than embedded throughout operational concerns. Moreover, our

stakeholders raised questions about whom occupational health is designed to support – the employee or the employer. Efforts also need to ensure services **support people within their jobs**, not only in getting back to work after an issue has occurred.

Some stakeholders questioned whether the conversations around health and age at work were taking place too soon; the foundational principles and awareness within HR departments often seem to lag behind the latest thinking on such issues. This makes raising awareness of the social model of disability among managers and employees vital, as well as its implications for their organisation.

For example, the disability movement had a stronger voice in the 1990s. Advocates have been calling for remote working options for several years, but remote working only entered the mainstream when it was needed by people without impairments, due to the pandemic. Now some organisations already appear be getting rid of the option before the pandemic has even ended.

Workplaces must ensure that health isn't policed or used as a tool to pick people off. Employers must embrace diversity in age and health to enrich their workforce, demonstrating proactive efforts and strategies to support their workers and adapt to changes that arise. Fundamentally, workplaces will need to strengthen the tools at their disposal (for example, by learning about the social model of disability) to ensure they are inclusive, open environments.

What needs to happen

The potential economic impact of enabling more older people to work for longer is significant. Previous ILC work found that, if all G20 members employed the same proportion of older people as they do in Iceland, earnings would go up by 3.7 trillion USD - around 7% of GDP on average.[10]

Based on this research and our roundtable discussions, we've identified three priority themes for future policy and practice development, that will help employers to position themselves well during the post-pandemic recovery period and beyond.

1. **Educate managers and staff about the social model of disability** to combat ageist and ableist attitudes
2. Promote **realistic attitudes** that focus on **adapting the job to fit the person**
3. Foster **ongoing support** that helps workers to succeed in their current job and to explore new opportunities.

1) Given that workers who are older and/or have an impairment may have internalised ageist and ableist attitudes, there is a role for employers in helping to dispel myths that may discourage workers from pursing training opportunities or discussing health concerns. **Shifting perspectives from the individual/medical model to the social model** will help combat ageist and ableist attitudes, helping employers to deliver on equality, diversity, and inclusion. Making these efforts visible help workers to understand that there's a safe space to raise their concerns, encouraging them to raise issues early. Larger employers can go further by establishing employee networks to foster diversity and inclusion, and strengthen their visibility.

2) It's important that efforts avoid treating everyone in the same way or promoting a one-size-fits-all approach. Older people and those with impairments have real and diverse experiences and abilities. As employers work to ensure an open environment that includes age and impairments, success will come from promoting **realistic attitudes** that acknowledge our differences. The approach that best reflects these focuses on making the job fit the person rather expecting the person to fit the job.

[10]https://ilcuk.org.uk/wp-content/uploads/2021/04/ILC-Health-equals-wealth-The-global-longevity-dividend.pdf

3) Whether employers focus on training or supporting health in the workplace, they should work to foster ongoing support rather than sporadic or one-time interventions. Workers need **ongoing support**, not just help to get back to work following illness, for example. Coaching can be a crucial tool to stimulate knowledge exchange among employees and to facilitate succession planning and redeployment where health needs require job adaptation.

ILC's Work for tomorrow programme

The International Longevity Centre UK (ILC) continues to promote action to rethink the way we work, learn, and live in the context of an ageing workforce. We have launched an international programme of work, supported by the Innovation Resource Center for Human Resources (IRC4HR), to identify the challenges and innovations that will be involved in responding to an ageing workforce. This will be addressed through an international innovations competition across four key areas:

- Maintaining good health
- Building knowledge, skills, and competence
- Addressing discrimination and supporting diversity
- Adapting the workplace

We will be talking to policymakers, employers and HR experts around the world about adapting workplaces for an ageing workforce, culminating in our international innovations competition, which will be delivered in 2021.

For more information, visit https://ilcuk.org.uk/work-for-tomorrow/.

About the ILC

The International Longevity Centre UK (ILC) is the UK's specialist think tank on the impact of longevity on society. The ILC was established in 1997, as one of the founder members of the International Longevity Centre Global Alliance, an international network on longevity.

We have unrivalled expertise in demographic change, ageing and longevity. We use this expertise to highlight the impact of ageing on society, working with experts, policy makers and practitioners to provoke conversations and pioneer solutions for a society where everyone can thrive, regardless of age.

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International
Longevity Centre UK

Vintage House
36-37 Albert Embankment
London SE1 7TL
Tel : +44 (0) 203 242 0530
www.ilcuk.org.uk