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## Respect and Social Inclusion

### How this domain relates to active ageing

Social inclusion and respect are important predictors of overall health and well-being for older people (WHO, 2003). In particular, social inclusion is essential for 'participation' - a key determinant of active ageing (WHO, 2007).

#### The impact of social inclusion/exclusion:

Social *inclusion* is characterized by societal elements that would include active participation by citizens, equality of opportunities, and basic levels of well-being (Sen, 1999). People who are socially included have greater access to resources – economic as well as those which come from living within a society such as social networks and supports (Shaw, Dorling, & Smith, 1999, p.223). Social *exclusion* overlaps with 'poverty' and 'deprivation', and refers not only to the economic hardship of relative economic poverty, but also incorporates the notion of the process of marginalization – how individuals come, through their lives, to be excluded and marginalized from various aspects of social and community life (Shaw, Dorling & Smith, 1999).

There are many negative health outcomes associated with social exclusion. According to the World Health Organisation, social exclusion is socially and psychologically damaging, materially costly, and harmful to health including premature death (World Health Organisation, 2003, p.16). The mechanisms through which social exclusion impacts health have been articulated by the World Health Organization in its 2008 report *Understanding and Tackling Social Exclusion*:

Constitutively exclusionary processes restrict participation in economic, social, political and cultural relationships which negatively impact on health and wellbeing. Instrumentally, these restrictions result in other deprivations, e.g. poor labour conditions or absence of paid work, leading to low income, poor nutrition, etc., which contribute to ill-health (p. 8).

Studies examining the consequences of social exclusion for older populations demonstrate social isolation predicts numerous health problems such as morbidity and mortality from cancer and cardiovascular disease (Hawkey, Burleson, Berntson, & Cacioppo, 2003; Hawkey & Cacioppo, 2003), re-hospitalization (Mistry, Rosansky, McGuire, McDermott, & Jarvik, 2001), as well as a myriad of mental health consequences such as depression (Cacioppo, Hughes, Waite, Hawkey, & Thisted, 2006).

### The processes of social inclusion/exclusion:

Factors that impede social inclusion include poverty, gender, disability and racism (Viswanathan, Shakir, Tang, & Ramos, 2003). In the case of older populations, social exclusion is often a result of structural inequalities experienced in early life such as education, employment and healthcare, all of which are exacerbated by social determinants such as gender and ethnicity (Wilkinson, 1996).

Stigmatization and marginalization including ageism, also contribute to the social exclusion of older people. Ageism – the prejudice or discrimination against or in favor of any age group (Angus & Reeve, 2006, p.139; Butler, 1975) – is a form of discrimination that, unlike others such as racism and sexism, is widespread, overlooked and accepted in western cultures (Cuddy, Norton, & Fiske, 2005; Nelson, 2005; E Palmore, 1999). Indeed, as Butler and the Anti-Ageism Task Force at the International Longevity Center highlight, ageism is “strikingly evident” in many arena's within the United States including the workplace, healthcare and media (ILC-USA Anti-Ageism Task Force, 2006, p. 4-13). Ageism obscures understanding of aging processes, reinforces structural inequalities, and shapes patterns of behavior in both older people and other members of society (Holstein & Minkler, 2003; Thornton, 2002; Tornstam, 1992). Indeed, gerontologists argue negative ageist attitudes may be at the root of some of the worst problems that can affect older people (Angus & Reeve, 2006) including elder abuse (ILC-USA Anti-Ageism Task Force, 2006; K. Quinn & Zielke, 2005; M. J. Quinn & Tomita, 1986).

Ageism and in particular institutional ageism (see ILC-USA Report, 2006 for a description of the various types of ageism), also manifests itself in exclusionary practices such as age segregation. For example, age is often used to organize community-based recreational activities such as youth recreation leagues and senior centers. Although indeed, some older adults prefer inter-cohort leisure experiences, it has been suggested that organizing activities according to age can interfere with social inclusion by “blocking essential opportunities for individuals to meet, interact, and move beyond “us versus them” distinctions (Hagestad & Uhlenberg, 2005, p.349).

### The impact of negative age stereotypes:

Societal goals of respect and social inclusion are challenged by negative stereotypes and media images of aging that persist within mainstream culture; instead of reflecting the contribution, strength and resourcefulness of older people they are often depicted as weak, useless and dependent. This is particularly true for older women (United Nations, 2002, p.38). The literature highlights two key ways in which negative age stereotypes impact the well-being of older people – as individuals and as a specific social group.

*Individual impact.* Negative stereotypes are capable of adversely affecting cognitive and physical outcomes of older persons (Donlon, Ashman, & Levy, 2005, p.307). Scholars working in the area of identity and aging argue the negative stereotypes to which older

people are commonly exposed create significant challenges for their sense of self (Sneed & Whitbourne, 2005, p.386). Research studies additionally demonstrate negative age stereotypes increase cardiovascular stress in older persons as well as impacting the ability of older people to respond to stressors in their environment (Levy, 2003, p.207).

*Specific social group impact.* At a broader level, ageist attitudes and stereotypes can negatively influence government policy and programming for older populations. There is some research to suggest age discrimination plays a substantial and negative role in generational equity debates and can impact government decisions related to resource allocation for older populations (Garstka, Hummert, & Branscombe, 2005; Robertson, 1997).

Social inclusion is one of the most robust predictors of health among older people and a key determinant of active ageing. Social inclusion is imperative both as a rights issue, in terms of changing patterns of social and economic exclusion, as well as a health issue, in terms of promoting, maintaining and improving the health and well-being and active ageing of older people. The current literature in this area makes it clear that age-friendly cities are socially inclusive cities where all citizens, regardless of age, are respected and have opportunities to participate and contribute.

#### Respect:

There is very little empirical research dedicated to exploring 'respect' and the related health impact of this kind of social behavior. One study was located in which survey research was used to examine "rudeness" in America (Farkas, Johnson, Duffet, & Collins, 2002). Eighty eight percent of survey respondents indicated they "often or sometimes come across people who are rude and disrespectful" (p.11). Findings also describe older Americans as having better experiences than younger people when it comes to civility; 59% of people over 65 (compared to 39% of people under 30) give people excellent or good grades when it comes to treating elderly with respect and courtesy (p.12). In other research, 84 older adults (60+) were asked to indicate on a list of 20 examples of ageism (e.g., denied medical treatment, ignored by waiter) if, and how often, they have experienced that event. Thirty percent of respondents indicated they had been "treated with less dignity and respect" (E Palmore, 2001).

### **Social inclusion and respect from a NYC perspective**

The way in which a city is perceived and experienced by its inhabitants, including whether it is considered a socially inclusive or exclusive environment in which to live, depends on individual circumstances (e.g., SES, personality) as well the social and material conditions of the environment. Certain characteristics of New York City play a role in the processes of social inclusion including diversity, segregation, and the cost of living.

New York City is one of the most racially and ethnically diverse cities in the world (Taylor & Lang, 2005). Included within this diversity is a large immigrant population; 44% of adult New Yorkers are foreign born (New York City Department of Health and Mental Hygiene, 2006). The ethnic diversity of New York creates an enormous challenge to those interested in promoting a socially inclusive society. In particular, social inclusion in a multicultural city such as New York requires extensive translation services to ensure residents have meaningful access to City programs, services and activities.

Social inclusion can also be compromised by segregation – a phenomenon that can be reflected spatially as well as along racial/ethnic and socioeconomic lines (Wallace (R Wallace, Wallace, Ahern, & Galea, 2007). New York City is one of the most segregated places to live in the United States (Charles, 2003; Massey & Denton, 1993).

Finally, as mentioned previously, poverty and social inclusion are interconnected such that people with lower socioeconomic status (SES) tend to be more socially excluded than those with a higher SES. New York is ranked the fifth most expensive city in the world in which to live (Employment Cities Abroad (ECA) International, June 2008). The high cost of living in New York City is a financial burden for many residents and can increase their risk of living in poverty. For example, researchers studying the rent affordability problem in New York City report falling real incomes and rising rents have created housing costs that are a significant burden to residents (Been et al., 2005, p.1).

### **Social inclusion and respect for older New Yorkers specifically**

Certain groups of older New Yorkers are at an increased risk for social exclusion – those who are immigrants, poor, and/or disabled.

There are a substantial and growing number of minority elders in NYC. According to the 2000 Census 12% of foreign born New Yorkers are over the age of 65 and nearly one in every two elderly New Yorkers is part of the city's ethnic minority population (New York City Department of Health and Mental Hygiene, 2006; US Census 2000). Materials, products and programs that are culturally as well as linguistically appropriate are necessary to ensure these elderly New Yorkers have the opportunity to participate.

Other social and demographic factors such as gender, disability, and poverty combine with age to increase the possibility of stigmatization and challenge social inclusion and individual feelings of respect. Disability, described as activity limitation, increases with age. In New York State, 34% of residents aged 65-74 and 46.4% of residents aged 75+ report an activity limitation (New York State Department of Health, 2003). This is similar to New York City where 46% of residents over the age of 65 live with disability (J. Walker & Herbitter, 2005, p.9). Negotiating the physical environment associated with fast-paced large urban centers such as New York City can be incredibly challenging particularly for individuals with limited mobility and may create additional barriers to

social inclusion for older residents. Poverty represents another potential barrier to social inclusion. New measures of poverty that take into consideration the high cost of living in New York City indicate 32% of older New Yorkers live in poverty; more older women than older men live in poverty (New York City Center for Economic Opportunity, 2008).

One of the potential consequences of social exclusion and age discrimination for older people is elder abuse. There have been two ways in which this relationship has been explained. First, it has been suggested that ageism in the media is a causation factor for elder abuse (e.g., ads which objectify seniors as disposable or expendable perpetuate abuse of the elderly) (Ward-Hall, 2004). Secondly, ageism has been linked to the way in which denial and rationalization has been used by those who perpetuate elder abuse (Laws, 1995b; Tomita, 1990). It is difficult to determine the prevalence rates of elder abuse as it is understood to be underreported due to issues of fear and stigma. Taking these issues into consideration, however, it has been estimated that one to three million older Americans are victims of abuse (Lachs & Pillemer, 2004).

**Objective for Action:** To promote respect and social inclusion for older New Yorkers  
A socially inclusive city, in which older residents are respected, is a place where they feel a sense of ownership and belonging. When elderly citizens are out in the city, actively engaging with its people and places, they demonstrate a sense of entitlement that is only possible when they are *included* and *respected* members.

## References

- Angus, J., & Reeve, P. (2006). Ageism: A threat to "Aging well" in the 21st century. *Journal of Applied Gerontology, 25*(2), 137-152.
- Been, V., Bhalla, C., Ellen, I., Greene, S., Schinzel, A., & Voicu, I. (2005). *State of New York City's Housing and Neighbourhoods*: Furman Center for Real Estate and Urban Policy.
- Butler, R. (1975). *Why survive?: Being old in America*. New York: Harper & Row.
- Cacioppo, J. T., Hughes, M. E., Waite, L. J., Hawkley, L. C., & Thisted, R. A. (2006). Loneliness as a specific risk factor for depressive symptoms: Cross-sectional and longitudinal analyses. *Psychology and Aging, 21*(1), 140-151.
- Charles, C. (2003). The dynamics of racial residential segregation. *Annual Reviews in Sociology, 29*(1), 167-207.
- Cuddy, A. J. C., Norton, M. I., & Fiske, S. T. (2005). This old stereotype: The pervasiveness and persistence of the elderly stereotype. *Journal of Social Issues, 61*(2), 267-285.
- Donlon, M. M., Ashman, O., & Levy, B. R. (2005). Re-vision of older television characters: A stereotype-awareness intervention. *Journal of Social Issues, 61*(2), 307-319.
- Employment Cities Abroad (ECA) International. (June 2008). *The most expensive cities in the world, 2008*, from <http://www.citymayors.com/statistics/expensive-cities-world.html>
- Farkas, S., Johnson, J., Duffet, A., & Collins, K. (2002). *Aggravating circumstances: A status report on rudeness in America*. New York: Public Agenda.
- Garstka, T. A., Hummert, M. L., & Branscombe, N. R. (2005). Perceiving age discrimination in response to intergenerational inequity. *Journal of Social Issues, 61*(2), 321-342.
- Hagestad, G. O., & Uhlenberg, P. (2005). The social separation of old and young: A root of ageism. *Journal of Social Issues, 61*(2), 343-360.
- Hausdorff, J. M., Levy, B. R., & Wei, J. Y. (1999). The power of ageism on physical function of older persons: Reversibility of age-related gait changes. *Journal of the American Geriatrics Society, 47*(11), 1346-1349.
- Hawkley, L. C., Burleson, M. H., Berntson, G. G., & Cacioppo, J. T. (2003). Loneliness in everyday life: Cardiovascular activity, psychosocial context, and health behaviors. *Journal of Personality and Social Psychology, 85*(1), 105-120.
- Hawkley, L. C., & Cacioppo, J. T. (2003). Loneliness and pathways to disease. *Brain Behavior and Immunity, 17*, S98-S105.
- Holstein, M. B., & Minkler, M. (2003). Self, society, and the "new gerontology". *Gerontologist, 43*(6), 787-796.
- ILC-USA Anti-Ageism Task Force. (2006). *Ageism in America*. New York: International Longevity Center-USA.
- Lachs, M., & Pillemer, K. (2004). Elder abuse. *The Lancet, 364*, 1263-1272.
- Laws, G. (1995). Understanding Ageism - Lessons from Feminism and Postmodernism. *Gerontologist, 35*(1), 112-118.
- Levy, B. R. (2003). Mind matters: Cognitive and physical effects of aging self-stereotypes. *Journals of Gerontology Series B-Psychological Sciences and Social Sciences, 58*(4), P203-P211.
- Levy, B. R., Hausdorff, J. M., Hencke, R., & Wei, J. Y. (2000). Reducing cardiovascular stress with positive self-stereotypes of aging. *Journals of Gerontology Series B-Psychological Sciences and Social Sciences, 55*(4), P205-P213.
- Massey, D., & Denton, N. (1993). *American apartheid: Segregation and the making of the American underclass*. Cambridge, MA: Harvard University Press.
- Mistry, R., Rosansky, J., McGuire, J., McDermott, C., & Jarvik, L. (2001). Social isolation predicts re-hospitalization in a group of older American veterans enrolled in the UPBEAT Program. *International Journal of Geriatric Psychiatry, 16*(10), 950-959.
- Nelson, T. D. (2005). Ageism: Prejudice against our feared future self. *Journal of Social Issues, 61*(2), 207-221.
- New York State Department of Health. (2003). *Disability in New York State, 2008*, from <http://www.health.state.ny.us/nysdoh/prevent/prevalence.htm>

- New York City Center for Economic Opportunity. (2008). *The CEO Poverty Measure*. New York, NY: New York City Center for Economic Opportunity.
- New York City Department of Health and Mental Hygiene. (2006). *The health of immigrants in New York City*. New York.
- Palmore, E. (1999). *Ageism: Negative and Positive* (2nd ed.). New York: Springer Publishing Company.
- Palmore, E. (2001). The Ageism Survey First Findings, *The Gerontologist* (Vol. 41, pp. 572-575): Geron Soc America.
- Quinn, K., & Zielke, H. (2005). Elder abuse, neglect, and exploitation: Policy issues. *Clinics in Geriatric Medicine*, 21(2), 449-+.
- Quinn, M. J., & Tomita, S. K. (1986). *Elder abuse and neglect: causes, diagnosis, and intervention strategies*. New York: Springer Publishing Company.
- Robertson, A. (1997). Beyond apocalyptic demography: Towards a moral economy of interdependence. *Ageing and Society*, 17, 425-446.
- Sen, A. (1999). *Development as freedom*. New York: Anchor Books.
- Shaw, M., Dorling, D., & Smith, G. D. (1999). Poverty, social exclusion, and minorities. In M. Marmot & R. Wilkinson (Eds.), *Social determinants of health* (pp. 211-239). New York, NY: Oxford University Press.
- Sneed, J. R., & Whitbourne, S. K. (2005). Models of the aging self. *Journal of Social Issues*, 61(2), 375-388.
- Taylor, P., & Lang, R. (2005). *US cities in the 'World City Network'*: Brookings Institution Metropolitan Policy Program.
- Thornton, J. E. (2002). Myths of aging or ageist stereotypes. *Educational Gerontology*, 28(4), 301-312.
- Tomita, S. (1990). The denial of elder mistreatment by victims and abusers: the application of neutralization theory. *Violence Vict*, 5(3), 171-184.
- Tornstam, L. (1992). The Quo-Vadis of Gerontology - on the Scientific Paradigm of Gerontology. *Gerontologist*, 32(3), 318-326.
- United Nations. (2002). *Report of the Second World Assembly on Ageing Madrid, 8-12, April 2002*. New York, NY: United Nations.
- Viswanathan, L., Shakir, U., Tang, C., & Ramos, D. (2003). *Social inclusion and the city: Considerations for social planning*. Toronto, ON: Alternative Planning Group (APG).
- Walker, J., & Herbitter, C. (2005). *Aging in the shadows: Social isolation among seniors in New York City*. New York: United Neighborhood Houses of New York.
- Wallace, R., Wallace, D., Ahern, J., & Galea, S. (2007). A failure of resilience: Estimating response of New York City's public health ecosystem to sudden disaster. *Health and Place*, 13(2), 545-550.
- Ward-Hall, C. (2004). *Advertising and Abuse of Seniors*. Retrieved September, 2008, from [http://www.bceas.ca/newsletter\\_winter\\_04.pdf](http://www.bceas.ca/newsletter_winter_04.pdf)
- Wilkinson, R. (1996). *Unhealthy Societies: The Afflictions of Inequality*. London, UK: Routledge.
- World Health Organisation. (2003). *Social determinants of health: The solid facts*. Copenhagen, Denmark.