

Chapter 22

Ageism and the Rights of Older People



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22.1 Introduction

Internationally, engagement in critical thinking on disability is still rare in official discussions on ageing policies as well as in gerontological research. Rather than focusing on environmental and societal failures to remove barriers to inclusion, activity restrictions and related problems encountered by people in later life are, in ageing discourse, even today, frequently viewed through the medical model lens. Ageing discourse largely continues to stress the incapacities and helplessness of older persons with care needs and impairments and tends to overlook the environmental and societal limitations that diminish a disabled person's opportunities to fully participate in society and enjoy life. Furthermore, attempts to counter ageism have tended to put healthy ageing and healthy seniors to the fore, and might therefore inadvertently contribute to further exclusion and discrimination of the less healthy and vital part of the older population. On the other hand, in actions against disability discrimination and in disability studies, there are few references to older people (Kennedy and Minkler 1998; Priestley 2003). Consequently, the scope for knowledge transfer from disability activism and research to the field of gerontology that could counter discrimination of older people with impairments and lead to changes and improvements in current systems of long-term care have so far largely been rendered invisible.

This chapter examines how, and if, the situation of older people in need of long-term care could be targeted by learning from disability policies. We base our

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elaboration on this issue on a number of works that we published between 2009 and 2016 (Jönson and Harnett 2016; Jönson and Taghizadeh Larsson 2009; Taghizadeh Larsson 2013, 2011), the most recent of which was co-authored with our colleague Tove Harnett. The chapter starts with a critical analysis of established attempts to counter ageism, highlighting how these attempts have failed to include the so-called fourth age, and might instead contribute to further stigmatization of older people with care needs. Drawing upon models from disability policies, we then introduce *an equal rights framework* and show how it could be used to combat discrimination and improve everyday conditions of older people in need of care. In the third section of the chapter, we use the equal rights framework to question existing cases of “institutional ageism” whereby older people with disabilities are excluded from government programs benefiting younger people. Cases where the support system of Sweden enables older people with impairments and need for support in tasks such as eating, dressing, and going to the toilet to participate in so-called third age activities (cf. Laslett 1989) are included to illustrate this possibility. We conclude with recommendations on how improvements in long-term care could be accomplished by learning from disability policies and critical thinking on disability.

In this chapter, we frequently refer to Sweden and, in particular, to Swedish disability policy. Given differences between welfare states, our argument is not that the Swedish model should be exported and used internationally. Instead, we consider Swedish policies and arguments presented in Swedish policy documents as useful in order to rethink and reframe long-term care.

22.2 Advantages and Disadvantages of Countering Ageism Through the Concept of “Healthy Ageing”

The most prevalent way to counter ageism so far can be summarized as dissociation between old age on the one hand and illness, impairment, and dependency on the other hand. As part of this approach, discourses and concepts of healthy ageing, third age, and successful ageing have helped to dispel myths about older people as a frail and dependent population. This approach has helped disseminate more accurate information about the fact that today most people over the age of 65 live healthy, active, and independent lives. This resonates with the tripartite model of attitudes that has been prominent in research on ageism, consisting of cognitive, emotional, and behavioural components, and draws upon theories on lagging images of old age that appear in the writings of scholars like Mathilda Riley and Erdman B. Palmore. In an article published in the *Journal of Ageing Studies* (Jönson and Taghizadeh Larsson 2009), we analysed this *upgrading approach* to ageism by referring to campaigns aimed at increasing participation in working life during the 1950s and 1960s, where activists claimed that older people had the same capacity to work as their younger workmates. What older workers lacked in speed and adaptability, they

gained in experience, patience, and thoroughness (Wohlin 1960). Older people should therefore be valued and encouraged to keep working. Upgrading of older people by bringing healthy ageing and healthy seniors to the fore is also embedded in current campaigns in Europe to promote intergenerational solidarity. While enhanced solidarity between different age groups is launched as a strategy in itself to counter age discrimination on the *AGE Platform Europe* (2016) website, it is also described as a way to “help achieve the EU’s goal of promoting active and healthy ageing.” Furthermore, a short movie that “encapsulates the achievements of the European Year 2012 for active ageing and solidarity between generations” that can be downloaded on the website is crowded with seniors dancing, singing, laughing, demonstrating, working, and golfing in groups or together with children of all ages. In the movie, there is no sign of wheelchairs, sticks, or walkers, and no sign of nursing homes or other forms of long-term care.

Though obviously excluding older people with impairments and illnesses, it is easy to understand the occurrence of this upgrading approach from a historical perspective. Every new generation of seniors has become increasingly more vital and healthy, and the development of welfare states has enabled a larger proportion of older people to keep a decent standard of living, but images have lagged behind. Laslett’s (1989) reference to a third age reflects these changes and was, unsurprisingly, introduced as an attempt to upgrade images of ageing on the basis of functional ability among third age seniors. For a long time, functional comparisons have been a trump card of anti-ageism, in the sense that “the truth” has proven that older people are more capable and similar to non-old people than is generally believed. For example, Wigdor (1995) wrote, “People confuse the 90% of older people who are able with the 10% that are not” (p. 103). Whereas the upgrading approach has great advantages, it is also “ableist” in its character as it communicates the message that societal status is gained through health and functional ability. This problem has been highlighted in critical gerontology, in relation to divisions between a third and fourth age and attempts to launch models of successful and healthy ageing by acknowledging that this might contribute to further stigmatization of older people with impairments and care needs.

Another, yet related, established attempt to counter ageism could be summarized as the *age irrelevance approach*. Critical gerontologists such as Bytheway (1995) have argued that the construction of old age as a distinct category acts to justify age discrimination. Using a similar argument, a Swedish government investigation of older people (SOU 2002:29, 2003:91) ten years ago suggested that “age” and “older” should become less relevant concepts. People would thus be freed from roles and limiting expectations that accompany the traditional division of the life course into separate stages, and working life could contain several careers and span well beyond the age of 65. However, because our present society is not only oriented toward age but also toward function, attempts to de-age policies could result in problematic consequences for people with illnesses and impairments. Even if such attempts aim at replacing age grading with individual needs among all equal

citizens, functional ability enters as a key factor when age becomes less important. This is what happened in Sweden during the 1950s and 1960s, when researchers hoped to arrange for a more flexible working life. The plan was to let company doctors decide when older workers were no longer fit to belong in the workforce rather than imposing a fixed retirement age (Jönson 2001). A suggestion made by Sweden's Committee on Older People also highlights the tendency to replace age with function: "Our claim is that political action must be directed towards the possibility of enabling new and more flexible patterns of the life course without further age divisions in society. Instead of dividing the life course further into chronologically defined blocks, possibilities must be increased to sandwich work, education, societal involvement, family life and free time from early youth until this is impossible due to illness or failing functional ability" (SOU 2003:91, p. 194). A chronologically graded life course with accompanying norms may be ageist, but it has the capacity to replace functional ability as a way of labelling citizens.

Upgrading and age irrelevance approaches have been developed as part of a laudable project to dissociate old age from a paradigm of decline and loss. However, the character or consequences of these prominent attempts to counter ageism tend to be ableist and to further stigmatize and marginalize older people with impairments and care needs by conveying and consolidating the message that high status and success in old age is related to health and functional ability. In both cases, and alongside the discrimination of older people, ableism is to some extent present in the very struggle against ageist norms. Thus, in order to combat discrimination and to improve everyday conditions of older people in long-term care there is a need for other approaches.

22.3 Lessons from Disability Policies and Disability Research

Already in 1980, Levin and Levin (1980) argued that a prominent feature of ageism is to regard problems of older people as caused by ageing. Following this line of thought, common strategies within anti-ageism have been to question age as an explanatory factor and organizing principle and to downplay physical, bodily consequences of the ageing process. This was also the logic followed by the Swedish Committee on Older People referred to above. Quite different approaches to function as well as to age have been launched by disability activists, policy makers, and researchers as part of an endeavour to improve the situation for (non-old) people with disabilities.

In Sweden, public care and support services for older people and people with disabilities are handled and discussed within two policy areas: policy for older people and disability policy. Although the objectives of these areas are in many ways similar, there are also obvious differences between the two (Erlandsson 2014), entailing government investigations and other documents within the realm of disability policy—an area with a strong connection to the disability movement—to

display more of a clear-cut citizenship perspective. Consequently, there is a stronger emphasis on equal value and equal rights and on the need to close the gap between people with and without disabilities. Within disability policies, researchers and official policy makers have frequently taken a protagonist stance and emphasized the need to make people with disabilities equal citizens. Prominent members of the disability movement have also been key players in the process—most notably, Bengt Lindqvist, who was the minister responsible for disability policies in the Social Democratic government from 1985–1991, had previously been president of the Swedish Association of the Visually Impaired (1975–1985), and was one of the founders of the socialist association, Disabled People’s International.

Below we present a model developed in disability policies that could be used to argue for improvements of long-term care for older people. The model refers to a recent paper published in *The Gerontologist* (Jönson and Harnett 2016). The strategy we suggest differs from both the upgrading and the age irrelevance approaches that have been adopted internationally within anti-ageism as well as within Swedish Policy for older people (SOU 2002:29, 2003:91). It aims to acknowledge age, while also looking past bodily shortcomings in later life, and focuses on the way society disables and discriminates older persons with care needs and impairments. In this model, we refer to the Scandinavian normalization principle that has been prominent in disability policies of the Nordic countries. In the *Gerontologist* paper, this principle is developed into an equal rights framework that may be used to identify discriminating practices and claim “equal rights” for older persons with long-term care needs.

The first outlines of the Scandinavian normalization principle appeared in Denmark and Sweden in the 1950s. A characteristic of the principle was that it used people in general—referred to as “ordinary citizens”—as the comparative reference group and identified persons with impairments as deprived relative to other members of society. The principle suggests that society should make available for persons with impairments living conditions that are the same as or similar to those of citizens in general. People with disabilities should be able to live like “others.”

In 1970, the originator of this principle, Bengt Nirje, suggested eight normalizing rights for young people with developmental impairments (Nirje 1970):

1. A normal rhythm of the day
2. A normal weekly rhythm
3. A normal rhythm of the year
4. A normal development experience of the life cycle
5. Have choices, wishes, and desires respected
6. Live in a bisexual world (not in unisexual groups)
7. Apply normal economic standards
8. Access to physical facilities such as (apartment-like) housing, schools, workplaces, and hospitals that are the same as or similar to those provided for ordinary citizens

Nirje (1970) formed his principle as a critique of contemporary disability policies at a time when large institutions were the dominant form of housing for persons with intellectual disabilities. Normality and justice for people with disabilities living in institutions was at the time based on comparisons to others living in institutions or having similar disabilities.

To question institutionalization and categorization according to medical models, Nirje (1970) used a number of references to comparative categories external to the institution and to the entire context of care and bodily and intellectual shortcomings. In accordance with the right to access physical facilities similar to those provided for ordinary citizens, Swedish disability policy has emphasized that housing for people with intellectual disabilities should be the same as or similar to ordinary housing. Daily activities should take place in arenas that are external to the context of care; that is, that schools and workplaces should be separate from housing (Tideman 2000).

In his original work, Nirje particularly commented on normal conditions in relation to life phases: childhood, youth (school age), adulthood, and old age. This construction of normality with reference to age has become central to Swedish disability policies and activism. Age-based activities have guided comparisons of lifestyles and rights, with the former being used to argue for the latter. For example, in the early 1990s, policy makers and disability activists argued with reference to age in a comprehensive government investigation (SOU 1990:19, 1991:46, 1992:52) preceding the introduction of a system of personal assistance that significantly improved conditions for younger people with disabilities. In the investigation, the Swedish Disability Committee (SOU 1991:46) explained how key concepts like accessibility, participation, influence, and equality should be measured: "We have seen it as important to present proposals which mean that people with significant impairments (children, youth and adults) have equal conditions as others of similar ages" (p. 143). In this perspective, it is in relation to their age peers that the conditions of people with disabilities should be compared. This is clearly expressed in writings about younger people with disabilities, where normalization is defined as a right to participate in activities typical of young people. A reference to the age norms of youth may be phrased like this: "He who is young should be able to live a life like other youngsters, to travel on an Interrail pass, take a language course, study abroad, party, and so on" (Peterson 2003, p. 217). The Disability Committee also mentioned specific roles, norms, and activities associated with childhood and youth, and discussed parenthood and participation in working life as roles for adults (SOU 1991:46). The possibility to compare ages may be regarded as the trump card of the disability movement, since such comparisons have the potential to identify welfare arrangements without focusing on diagnosis or characteristics associated with impairments.

22.4 The Equal Rights Framework and Institutional Ageism

Is it possible to transfer the ideas of the normalization principle adopted by disability activists to long-term care for older people? Can society make available for older persons with impairments and illnesses living conditions that are as close as possible to those of “others of the same age”? Who are those “others of the same age” who could serve as comparative reference groups in demands for justice? What kind of comparable living conditions should policies aim to achieve?

Building on the Scandinavian normalization principle, Jönson and Harnett (2016) have developed an equal rights framework (Fig. 22.1) that could be used to analyse and propose changes in care for older persons. A typical internal reference is to argue that justice is achieved when residents at a care facility are treated equally, for instance having the possibility to go for a walk or having a shower twice every week like others at the facility. An external reference group for comparison might include people in general: for example, other men or women; other Muslims; other vegetarians; or other couples. Should older couples be deprived of possibilities to live together like other couples, just because they have support needs? If not, society should provide solutions that allow them to keep living together. Following the disability movement, a general aim should be to increase external comparisons when discussing the rights of older people who receive long-term care.

In order to explain the strengths of the equal rights framework to improve long-term care and living conditions for older people in the fourth age, we use the framework to question existing cases of “institutional ageism” whereby older people with impairments are excluded from government programs benefiting younger people with disabilities. The strategy proposed could also be used in attempts to improve




Type of references	Internally oriented – care and impairment	Externally oriented – society in general
Context-centred	The contexts of care or impairment 	Other contexts invoked as comparison
Category-centred	Other care users or categories relating to care or impairment 	Other categories invoked as comparison
Personhood-centred	The unique person in relation to care or impairment 	Other aspects of the unique person invoked as comparison

Fig. 22.1 An equal rights framework for persons in need of support and care (First published in *The Gerontologist*, Jönson and Harnett 2016; Reproduced from Jönson and Harnett 2016)

long-term care in cases, and countries, where the situation in need of improvement is not as clearly and explicitly related to ageism.

Instead of acting as a normative reference group, as the ideal or individually correct standard that older persons may fail or manage to live up to, we suggest that it is possible, and relevant, to use the third age and older people without impairments and care needs as a comparative reference group. Furthermore, we argue that society should make available for older persons with impairments living conditions that are typical for members of this group of active, healthy seniors. Our point of departure is a qualitative interview study with people ageing *with* extensive physical disabilities that was conducted in Sweden some years ago. The study was previously published in English as an article in the *Journal of Human Development, Disability, and Social Change* (Taghizadeh Larsson 2011) and as a chapter in the book, *Ageing With Disability: A Life Course Perspective* (Taghizadeh Larsson 2013).

In disability policy, a prominent idea is that the right of people with extensive disabilities to live like others and to be self-determinant and autonomous can be realized through personal assistants that serve as the so-called assistance user's "arms and legs," while the user determines what should be done, and how. In Sweden, this idea was materialized in 1994 by the introduction of the system of personal assistance. This reform improved conditions for people below the age of 65 with lasting, long-term support requirements, in the sense that their opportunities to take control over their own lives were significantly improved (Szebehely and Trydegård 2007). In 2001, the right to keep assistance after 65 was introduced. However, the conditions still are that personal assistance has to have been granted before the age of 65, and the amount of assistance accorded may not be increased after the 65th birthday. This "institutional ageism" can be understood partly as the result of the above described and successful endeavour to provide disabled people of younger ages with rights that are typical of non-disabled citizens. In this struggle, what is just and equal has been defined in relation to citizens of similar ages: children, youth, and adults of "active ages". To some extent the exclusion of older people can then be understood as the inadvertent result of a struggle against other forms of prejudice; that is, as a struggle against ableism. It can also be seen as a struggle against the traditional inclusion of all people with needs into one group (Jönson and Taghizadeh Larsson 2009). For older people, there has been a lack of comparative reference groups and, as a result, comparisons in long-term care have tended to depart from the left-hand column of the framework: as internal to care and impairment.

How do we move comparisons to the right-hand column in the framework? We have already mentioned a number of categories that could be used creatively when claiming rights to live like "others". Our suggestion then is that the third age, associated with a number of activities and lifestyles—studies, travel, leisure, involvement in the family, and volunteer work—could be used as a comparative reference group for older persons in need of care. In other words, and building on lessons from disability policies and research, we suggest that it could be claimed that an older person who has aged into impairments should be able to live a life like others who are

older, visiting relatives, traveling, studying, and participating in volunteer work. These activities should not be regarded as normative—they should not be standards to live up to—but as typical, and thus possible to refer to when defining social rights.

Third Agers with Extensive Impairments The idea of using the third age as a comparative reference group for older persons with impairments does not depart from an imagined situation; it is empirically anchored in the life of some people who have *aged with* impairments. Based on qualitative interviews with 12 persons aged 65–72 with extensive physical disabilities belonging to the first, and small, cohort of Swedish citizens with the legal right to keep their personal assistance after 65 years of age, we illustrate the potential of the third age to become an important reference group for people with impairments and long-term care needs.

All 12 interviewees were dependent upon some form of mobility support (cane, walker, or wheelchair) more or less all the time; nine primarily used a wheelchair. The diagnoses reported were the following: polio (three); multiple sclerosis (MS) (five had at one time been diagnosed with MS, but two of these presented the diagnosis as uncertain or ambiguous); cerebral palsy (two); spinal injuries (one); stomach and intestinal diseases (one). What is of interest is that members of the population of older people who had impairments and extensive support needs before they turned 65 are provided with a type of help that other members of the category of older people are not entitled to have. Having had their impairments for a long time, they have to some extent also encountered and in some cases embraced the ideology and models that have been developed by the disability movement and as part of official policy.

When the 12 individuals talked about what they had been doing lately, what they were planning to do in the near future, and when they were asked to talk about an ordinary week and a normal day, an image of recreationally active, committed individuals emerged. The women and men in question described how they went to the theatre and concerts, were involved in artistic activities, took part in language studies, sports and gymnastics, and travelled both within and outside Sweden. Several took an active part in society through volunteer work at various levels (international, national, and municipal) and within various associations aimed at improving the living conditions of disabled people. Some were active in providing supervision for their personal assistants and in handling elements of the administration connected with their assistance. They appeared, in other words, as continually engaged in life in a way typical of a “third ager” (see Laslett 1989).

The current lifestyle of the participants largely seemed to be a matter of devoting their free time to activities that they to some extent had been previously engaged in, when they were still on early retirement pension or were working. As Margareta (aged 66), who left work when she was in her 50s, put it: “Much of what I thought was kind of hobby stuff before, I pursue in a somewhat different way now.” Some commented that the activities that they were engaged in today were the kind that they probably would have devoted their careers to if the possibility had existed. Among those was Inger (aged 67), who was diagnosed with polio as a child. Inger

had applied and been accepted to an art college when she was a young woman. At that time, however, the educational institution was located on the fourth floor of a building without a lift, which made it impossible for her, as a wheelchair user, to begin her studies. Today Inger, with the support of her personal assistants, devotes a good portion of her time to artistic activities of various forms. Likewise, other participants described how developments in technical aids had created an opportunity for them, despite increased impairment, to engage in sports in ways that were impossible when they were younger. Hence, the dimension of self-fulfilment that is characteristic of the third age (Laslett 1989) can also be part of being a senior with extensive impairments.

For those participants who had personal assistance, this support stood out as a critical element in effectively achieving an active, third-age-like lifestyle. They talked about personal assistance as “the best thing that ever happened” to them and as “heaven-sent”. When life with personal assistance was compared to previous experiences of eldercare in the form of municipal home help services, participants highlighted flexibility, the possibility to influence the choice of assistants, and greater control over one’s everyday life among the benefits. In line with arguments from disability scholars and activists that it is possible to be highly dependent on other people, yet perceive oneself as autonomous, some said that personal assistance makes it possible to “manage oneself.”

A striking example of this is the story of Ann-Marie, aged 65, and diagnosed with MS at the age of 20. Ann-Marie was an active member of an international art association. Through a monthly scholarship, a more established artist supported her in her artistic development for a few hours every Wednesday. As Ann-Marie had lost the ability to move her arms and legs, she used her mouth when she painted. Aside from being one of the participants engaged in artistic activities and in gymnastics, she was an experienced traveller. At the time of the interview, she had recently visited Denmark, Spain, and Iceland. During the interview, Ann-Marie described her future travel plans:

On the topic of travelling, I probably won’t travel abroad anymore. I’ve had enough of that. Although, sometimes I think I haven’t explored all of Iceland yet. I should go to the northern part, too. But, no, I probably won’t. I’ll keep myself to Sweden from now on. And you know what? Recently I had this idea to adjust Lennart’s car so we can adjust one of the seats to fit my wheelchair in there. That way we can go on shorter trips alone. So that’s our small project right now.

Lennart, who is referred to in the interview extract, is one of Ann-Marie’s personal assistants and has for many years assisted her with tasks from brushing away strands of hair from her face to personal hygiene, meals, and dressing. However, it is Ann-Marie herself, through a specially designed computer, who administers the assistance and plans the assistants’ schedules.

The participants in the study mentioned above managed to do something that both anti-ageists and disability activists so far have largely failed to do. Through their stories, they provided “updated” images of older people with extensive impairments living third-age-like lifestyles. By doing so, they also indicated that activity restrictions and problems that people encounter in later life could be countered in

similar ways as in younger ages; that is, they indicated that they should have the right to live like others in the same (third) age—like older people without impairments and long-term care or support needs.

Adding to our argument that the third age could be considered as a relevant reference group for older people with long-term care needs, two recent case studies exploring the phenomenon of living with dementia with support from personal assistants (Hellström and Taghizadeh Larsson 2017) showed that older people who have acquired cognitive impairments as older adults may also live active lives “like others in the third age.” The two persons who participated in the case studies both received their dementia diagnosis at a relatively young age and had extensive care needs when they reached the age of 65. One of the case studies involved a 72-year-old man, diagnosed with frontotemporal dementia 13 years previously, his wife, and personal assistants. The other involved a woman aged 66, diagnosed with Alzheimer’s disease 11 years previously, her husband, and personal assistants. Both the man and woman had lost their abilities to use spoken language and to walk. Their daily lives with dementia and personal assistance were studied by participant observations inside and outside the home of the participant, video recordings, and audio-recorded interviews with spouses and assistants. The study illustrates that an active and relatively independent life inside one’s own home and in the local community, including for example daily trips with an adapted car to various destinations, such as cafés and tourist sights, may be an option even for people with late stage dementia if access to flexible and personalized support, such as personal assistance, is provided.

22.5 Conclusions and Recommendations

How should we respond to ageism? This question is at the heart of the chapters in this book that deal with interventions to reduce ageism. Our conclusion, based on the Swedish case, is that older people in need of long-term care/support are victims of institutionalized ageism in the sense that they receive less help than people of younger ages. The justifying idea behind this discrimination is that because the *process* of ageing is generally linked to more diseases, impairments, and ultimately results in death, it can be considered appropriate to regard impairments among members of the category of older people as normal, and hence a matter to adjust to and cope with. This ageist rationale is internalized in the form of low expectations among older people themselves. Kane and Kane (2005) suggested that part of the discrepancy between long-term care for young and old can be traced to differences in the goals and expectations held by these age cohorts. Whereas younger people with disabilities see themselves as prevented by circumstances from participating fully in life’s activities and thus seek (or demand) services that will permit full participation, older people seem to be willing to settle for much less: “They seem to view decline as an inevitable consequence of aging that must be borne with equanimity. This propensity to accept less, and hence to demand less, is associated with

greater life satisfaction—interpreted as some form of coping, but the propensity really reflects ageism” (Kane and Kane 2005, p. 52). People are educated to expect that impairments after the age of 65 are the result of normal ageing and that shrinking possibilities are consequences of the normal ageing process.

In relation to the equal rights framework, attempts to fight institutionalization have been expressed in claims that the person in long-term care should be able to keep preferred habits and appearances. However, as shown by Harnett and Jönson (2017) in a recent study of Swedish nursing homes, external comparisons to personhood were found to be difficult to uphold when the ageing process was perceived to change the needs of the person. As a result, references to personhood are moved to the left in the framework; normality and justice are then defined as the possibility to live like one usually lives within the context of care. The persons who are cited in this chapter as members of a category that have aged with impairments and with the type of support that older persons are usually not entitled to, show us that these “truths” may be challenged.

Responding to ageism as a general phenomenon, anti-ageist campaigners have attempted to establish differences and divisions within the category of older people that are based on the presence and absence of disease and impairments. A major approach has been to claim that a majority of older people are healthy and able and, for this reason, ageist images of older people as frail should be replaced by updated descriptions. Our argument is that ableism has become embedded in and/or might be the consequence of some of the most prominent approaches that are used to counter ageism. Our recommendation is to shift focus from the performance and capability of ageing individuals to the performance and capability of society, and investigate how society enables or disables older persons with impairments. Our main argument is that policies relating to long-term care for older people could be improved by learning from disability policy and critical thinking on disability promoted by scholars aiming to improve the living conditions for, particularly, younger people with impairments. The approach that has been suggested in this chapter means that the third age, which so far has been a normative reference group for older people, could serve as a comparative reference group when older persons with impairments and care needs, as well as researchers and activists, argue for improvements in long-term care.

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