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Editors

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Editorial

Old-Age Exclusion: Active Ageing, Ageism and Agency

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Abstract
This editorial serves a double purpose. It introduces the articles and commentary comprising this thematic issue on old-age exclusion, and simultaneously aims to make a concise contribution to the discussion on the relation between agency of older people and old-age exclusion. While indeed it is clear that limitations of agency due to a lack of resources in old age or age discrimination lead to exclusion of older people, the relationship between reduced agency and exclusion is less clear in the case of internalized age norms. It ends with a plea for surveys studying older populations to pay more attention to older people's identities and life goals, opinions and reasons for action.

Keywords
active ageing; ageism; agency; old-age exclusion; well-being

Issue
This editorial is part of the issue "Old-Age Exclusion", edited by Wouter De Tavernier (KU Leuven, Belgium) and Marja Aartsen (OsloMet—Oslo Metropolitan University, Norway).

Over the last decades, the idea of active ageing spread around Europe (Foster & Walker, 2015). Faced by challenges posed by population ageing, international organizations such as the United Nations (2002), the World Health Organization (2002) and the European Commission (2018), promote active ageing as a way to keep older people healthy and utilize their productive capacity. Even though the concept is primarily used to promote older individuals as a productive factor, it also has a broader understanding, one in which older individuals are conceived of as full members of society (Boudiny, 2013; Foster & Walker, 2015; Walker, 2008). This conception reflects Marshall's (1950) understanding of citizenship in which full citizenship is only reached when individuals actively participate in economic, social and political life.

Many older people are excluded from participating in society due to various barriers. As Walsh, Scharf and Keating (2017) point out, exclusion can be conceptualized as a lack of agency, with structural barriers limiting options for participation for older individuals. When approaching exclusion as a lack of agency, the primary target of attempts to boost inclusion of older people should be the removal of any barriers in society that limit options for older people. Failure to do so may have negative consequences. The article by Precupetu, Aartsen and Vasile (2019) in this issue illustrates the detrimental effects of exclusion on the well-being of older individuals. Following the aspects of old-age exclusion identified by Walsh et al. (2017), Precupetu et al. (2019) examine associations between exclusion from financial resources, services, social relations and the community and well-being. The article indicates not only that well-being is severely negatively impacted by these forms of exclusion, but also that they are an important contributor to the lower levels of well-being of older individuals in Romania compared to younger generations. In particular, the lack of financial resources has a strong impact, illustrating the need for economic interventions to boost well-being of older Romanians.

It can moreover be argued that the individual's economic capital is a key determinant of other forms of ex-

clusion in later life. Jensen, Kongshøj and De Tavernier (2018), for instance, find that economic hardship reduces older individuals' active involvement in society, while De Tavernier and Draulans (2019) argue that it may hamper access to formal care even if this care is available at low cost. Given the tight link between pensions and the life course (Peeters & De Tavernier, 2015), planning ahead for retirement is essential to avoid a sudden drop in standard of living at retirement, particularly in countries with limited retirement provisions. In this issue, Preston (2019) presents a literature review of the factors inhibiting planning. The article illustrates how economic but also social exclusion in middle age bears the seeds for exclusion in later life by limiting individuals' capacities to plan for retirement.

Ageism (Butler, 1969) or age discrimination, still widespread in European societies (Ayalon & Tesch-Römer, 2017, 2018), also contributes to the exclusion of older individuals in society (Walsh et al., 2017). In their commentary, De Tavernier, Naegele and Hess (2019) critically assess the assumption that ageism is a product of modernization in the light of recent socio-economic developments. Whereas ageism is often analyzed from the perspective of individuals limiting others' possibilities and therefore their agency, the psychological literature has also shown that older individuals internalize ageist ideas (Swift, Abrams, Lamont, & Drury, 2017). Van der Horst (2019) analyses the relationship between ageism and retirement preferences in this issue. While several articles have identified formal and informal age norms as external drivers of retirement preferences (e.g., De Tavernier & Roots, 2015; Hess, 2016), this article analyses whether internalized ageism, conceptualized as age-related self-perceptions, leads to a preference for earlier retirement. This shows the limits of conceptualizing exclusion in terms of agency: structure goes well beyond external limitations to individuals' choice options, is being internalized and shapes individuals' very preferences (De Tavernier, 2016). The individual would not experience the internalized norms as limiting their options and would perceive following them as exercising their free will.

The role of goals and preferences is a central aspect of the ethical analysis of active ageing by Pfaller and Schweda (2019). In their article, they critically assess the active ageing discourse as a denial of agency because it assumes preferences for activity and denies older individuals to set their own goals. They explore the meaning of "the good life" in old age and advocate a paradigmatic shift in the politics surrounding ageing away from the productivity-centered interpretation of active ageing, towards one rooted in the capability approach. Only that way, they argue, politics can improve the situation of older people in society without at the same time enforcing norms about how older people should be living their lives. Inclusion, then, is to have the capacity to pursue one's own goals—that is, to have agency.

In the light of the articles published in this thematic issue, we should ask ourselves as a research community if we really have the tools necessary to assess exclusion of older individuals, particularly in quantitative research. For all their benefits, most surveys designed to understand the world older people live in include very little information on what older individuals actually want, how they see themselves and their role in society. While these surveys help to identify potential barriers to full participation in society, they reveal little information on the individual's needs and desires towards active ageing. Do they indeed desire a higher level of participation, or do they rather participate in different ways? Do they really experience the potential barriers identified in survey research as limiting their choice options, and how do they negotiate these barriers in order to overcome them? Given the centrality of agency for inclusion, we should not only have information on what we as researchers consider structural barriers, but also on whether older individuals perceive them as such: we can only really talk about exclusion if we can identify a loss of agency. Hence, this is a plea to go beyond describing older people's actions, bodies and environments in surveys for the older population, and to also include questions on identities and life goals, opinions and reasons for their actions. Until then, survey research is prone to picturing older individuals as passive victims of their circumstances, rather than as active agents pursuing their own goals and trying to overcome obstacles on the way. The qualitative literature in the field is leading the way.

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Conflict of Interests

The authors declare no conflict of interests.

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Article

Social Exclusion and Mental Wellbeing in Older Romanians

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Abstract
In Romania, inequalities in health and wellbeing between younger and older Romanians are substantial, and an important reason for inequalities may be the higher risk of social exclusion among older adults. After the fall of Communism in 1989, the many transformations in economic structures and welfare regimes contributed to enhanced levels of social exclusion, in particular among the older generations. Social exclusion is a multidimensional problem with substantial effects on the mental wellbeing of people. The present study examines age differences in mental wellbeing and evaluates to what extent differences can be explained by age and social exclusion, while controlling for a number of potential confounders. Data are from the fourth wave (2016) of the European Quality of Life Survey. Data for Romania include 1004 people aged between 18 and 85 years old, of which 726 are included in the analyses (only complete cases). In the study sample, 259 were 55 years or older. Mental wellbeing was measured with The World Health Organization Wellbeing Index (WHO-5 scale), and social exclusion was measured in four domains: social relations, material resources, services and the neighbourhood. The results show that older Romanians have a statistically significant lower mental wellbeing than younger generations in Romania. All domains of social exclusion were associated with lower levels of mental wellbeing. These effects remained statistically significant after controlling for partner status, chronic diseases, having children, and level of education. Improving mental wellbeing of older Romanians would greatly benefit from increasing social inclusion by means of social transfers provided by the government, improving the neighbourhood and access to services, and providing facilities to enhance the social network.

Keywords
ageing; mental wellbeing; post-Communist welfare; social exclusion; Romania

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1. Introduction

In Romania, there are large inequalities in health and wellbeing between younger and older generations. After the fall of the Communist regime, many transformations in the economic structures, labour markets, political institutions, and welfare regimes took place, which impacted heavily on the standards of living of all Romanians, but the older generations in particular. The accumulation of factors associated with age, such as poor health, loss of relatives and friends, and lower physical and social activities, may have contributed to a trend of increasing social and economic inequalities with strong effects on feelings of uncertainty, vulnerability, and deprivation.

Starting in 1990, Romania made a slow and painful dual transition to a market economy and democratic sys-

tem, characterised by high social costs (Sandu, 1999; World Bank, 2018; Zamfir, 2007). The poor Communist institutional legacies, coupled with a hesitant approach to economic and social reforms, led to an important economic decline and a large increase in poverty in the first phase of transition (Hellman, 1998; World Bank, 2008). This has affected the oldest cohorts in particular. The GINI coefficient[1]—reflecting income inequality—increased from 22.2 in 1990 to 33.7 in 2007. This placed Romania at the top of the EU countries with the highest levels of inequality (United Nations University, 2018). Even though income inequality lessened in the past decade to a certain extent, with a Gini value of 33.1, the country still ranks among the highest in the EU with regards to income inequality (Eurostat, 2017), and a wide range of deeply entrenched social disparities persist between young and old people (Precupetu & Precupetu, 2014).

Of all transitions that took place after the fall of Communism, the economic transition probably had the strongest consequences for older people, as it excluded them from mainstream society and turned them into "the losers of the transition" (Mărginean, 2006, p. 65). During the Communist regime, there was universal social protection through employment for all, but there was also a strong expectation that people should retire from their working lives and participate much less in society while benefiting from their hard-earned pensions. Remaining active in the labour market was only possible for a few categories, such as those working in agricultural cooperatives, in the social economy or, for those owning plots of land, in subsistence agriculture. Other forms of social participation were also severely limited after retirement as there was no civil society and the only forms of involvement were at the community level, in narrow family and neighbourhood networks. The Communist regime never prioritised the social protection and quality of life of retired people (Petrescu, 2019). Care responsibilities were considered a family duty as only a limited supply of public "elderly homes" would provide services to a small number of older people (Petrescu, 2019). Over the transition period, due to early retirement schemes, the older cohorts went into retirement at a younger age than the later born cohorts who reached retirement age. Employment rates of older people registered a significant drop, especially in the period of rapid privatisation in the economy. Employees in the older age groups have not been sufficiently able to adapt to the new challenges of the market economy (Zaman & Stănculescu, 2007). Many older people got involved in subsistence agriculture on small plots of land or went into the informal economy. The intricate context of transition thus impacted more heavily on older people than younger cohorts as their opportunities narrowed considerably.

Older Romanians are disadvantaged in many respects. They have a low standard of living, low access to health services, poor access to, and low quality of social services, low social participation, low quality of housing, and low quality of public services (Bodogai & Cutler, 2014; Eurofound, 2017; Petrescu, 2019). Probably as a consequence, older adults in Romania are among those with the lowest levels of mental wellbeing in Europe (Eurofound, 2016a; Mărginean, 2006; Sandu, 2009). When the disadvantage is severe and pertains to more domains, it will result in a number of negative consequences for the wellbeing of older adults (Levitas et al., 2007). However, empirical evidence supporting this claim for older Romanians is lacking, as gerontological research in Romania is sparse and mainly descriptive. Studies have so far looked at demographic changes (Bălaşa, 2005; Neményi, 2011), older people's needs and effective ways of intervention (Gîrleanu-Şoitu, 2006), social assistance, and pensions (Mărginean, 2015). A few qualitative studies have concentrated on Romania and highlighted the predominantly negative views of ageing (Craciun, 2011) or patterns of social capital of older persons (Craciun, 2012). The present study aims to narrow the knowledge gap by examining associations between various dimensions of social exclusion and mental wellbeing in older Romanians.

One concept that may be helpful to understand the multidimensional disadvantages of older Romanians is social exclusion. There are extended scientific and political debates about what social exclusion is. Whereas the European Union defines social exclusion primarily in terms of poverty, material deprivation, and exclusion from the labour market, social scientists argue that it is much more than that. Theories about social exclusion argue that it is a complex and multidimensional phenomenon with substantial disruptive health and wellbeing consequences for individuals and society (Walsh, Scharf, & Keating, 2017). Social exclusion involves many domains, among which exclusion from social relations, exclusion from economic resources, exclusion from health and social services, and exclusion from participation in civic society (Walsh et al., 2017). Exclusion from one domain often enhances exclusion from other domains. For example, a lack of financial resources reduces possibilities for (new) social relations, which in turn make people more dependent on public services, such as health services, social institutions, and public transportation. If access to these services is insufficient, it will reduce opportunities for civic participation and lead to substantial mental and physical health problems. If, in addition, the access to the domains is unequal for different social groups (i.e., men and women, older and younger people) the process of social exclusion will lead to large inequalities in health (O'Donnell, O'Donovan, & Elmusharaf, 2018). The process of social exclusion in older people occurs as they age, and older people have an increased risk of social exclusion due to the accumulation of factors associated with age, such as poor health,

[1] The TransMonEE data refer to the distribution of the population by per capita household net income and the Eurostat measure is the Gini coefficient of equivalised disposable income using the modified OECD scale.

loss of relatives and friends, and fewer physical and social activities.

In our study, we acknowledge the multidimensional nature of social exclusion by using the multiple domains in which exclusion may occur as defined in the study by Walsh et al. (2017), i.e., social relations, civic participation, health and social services, material and financial resources, socio-cultural aspects, and neighbourhood and community. In line with the theory, we assume that the domains of social exclusion are interrelated, and that exclusion from one domain enhances exclusion in other domains. Research that takes the multiple aspects of social exclusion into account, therefore, provides a more holistic and realistic picture of the relation between social exclusion and wellbeing.

Empirical evidence for associations between various domains of social exclusion and wellbeing comes from a number of studies. Exclusion from social relations may enhance feelings of loneliness and lead to a lack of social support, which are well-known risk factors for lowered levels of wellbeing (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015; Ong, Uchino, & Wethington, 2016; Prince, Harwood, Blizard, Thomas, & Mann, 1997). Loneliness is associated with a range of adverse health outcomes among which increased morbidity, more depressive symptomatology, reduced physical health, impaired daytime functioning, reduced physical activity, and lower subjective wellbeing (Ong et al., 2016). Lack of social support increases the risk of premature mortality in older men and women (Holt-Lunstad et al., 2015).

Exclusion from material and financial resources is strongly related to wellbeing in later life. Effects may be stronger when experienced over longer periods, despite some evidence that older adults can adapt to a lower level of financial resources (Clark, D'Ambrosio, & Ghislandi, 2015). Material disadvantage tends to accumulate over the life course through socio-economic correlates and life events (Price, 2006). There is also substantial evidence that lack of material and financial resources is associated with increased levels of frailty and poor health among older adults (Mackenbach et al., 2018; Stolz, Mayerl, Waxenegger, & Freidl, 2017). Exclusion from services involves areas such as health and social care, new technologies, transport, and mobility. This type of exclusion was found to explain variance in the wellbeing of older people living in both urban and rural areas, being more important in urban (Dahlberg & McKee, 2018). The neighbourhood and community are also relevant domains for social exclusion. Some even call it the most effective area in which to enhance links between people and re-engage individuals (Moulaert, Wanka, & Drilling, 2017). Research suggests that important aspects of the neighbourhood and community are the built environment, socio-political structures, and fear of crime (Walsh et al., 2017), and some studies found that neighbourhood exclusion was associated with the poor wellbeing of older people, especially in rural communities (Dahlberg & McKee, 2018). However, research on associations between neighbourhoods and social exclusion has only recently started in the UK, focusing mainly on how neighbourhoods influence social exclusion (Scharf, Phillipson, & Smith, 2005). When considered as a multidimensional phenomenon, social exclusion was found to be related to significant drops in quality of life in areas like optimism, life satisfaction, disposition, and energy (Barnes, Blom, Cox, Lessof, & Walker, 2006; Scharf et al., 2005). Two other domains (civic participation and socio-cultural aspects) could not be included because of a lack of information in the dataset (see section on methods).

This study seeks to examine associations between the distinguished domains of social exclusion and mental wellbeing. Mental wellbeing involves "good psychological functioning" (OECD, 2013, p. 10), "a state in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2004). The main research question that we seek to answer in this article is whether the lower level of mental wellbeing in older Romanians compared to younger Romanians can be understood in terms of a greater likelihood of being socially excluded. Disadvantages in the past may have accumulated over the years (Dannefer, 2003) such that the largest inequalities can be observed between younger and older age groups (Eurofound, 2016a; Mărginean, 2006; Sandu, 2009). Based on the theoretical perspectives and empirical evidence described above, we hypothesise that when compared to younger Romanians, older Romanians have lower levels of mental wellbeing (H1) which can be explained by their higher levels of social exclusion (H2).

2. Methods

2.1. Data

Data come from the European Quality of Life Survey (EQLS), a pan-European survey focused on the quality of life, carried out by the European Foundation for the Improvement of Living and Working Conditions (2018). EQLS includes indicators on employment, income, education, housing, family, health, work-life balance, as well as on the subjective wellbeing and quality of society. We make use of the fourth EQLS-wave conducted in 2016, including nationally representative samples in 28 member states and five candidate countries (Albania, FYR Macedonia, Montenegro, Serbia and Turkey). The original Romanian sample included 1004 people aged 18 to 85. After excluding cases with missing data, multiple linear regressions (method enter) were conducted for the 726 remaining complete cases of which 259 were 55 years or older. The data were weighted according to recommendations of the technical report of the EQLS (Eurofound, 2016b) by using the appropriate weight for analysis at the country level and below the country level.

2.2. Dependent Variable

The dependent variable "mental wellbeing" is assessed with the World Health Organization Wellbeing Index (WHO-5 scale). The scale consists of five items: 1. "I have felt cheerful and in good spirits", 2. "I have felt calm and relaxed", 3. "I have felt active and vigorous", 4. "I woke up feeling fresh and rested" and 5. "My daily life has been filled with things that interest me".

Each respondent is asked to rate how well each of the five statements applies to him or her when considering the last 14 days. Each item is scored from 1 (all of the time) to 6 (none of the time). The WHO-5 scale has adequate validity both as a screening tool for depression and as an outcome measure in clinical trials and can be used to assess wellbeing over time and to compare wellbeing between groups (Topp, Østergaard, Søndergaard, & Bech, 2015). In accord with Topp et al. (2015) and research reports by Eurofound (2017), we reversed the response scale for each item such that higher scores indicate better wellbeing. We computed factor scores for the recoded scale given their advantages over the summative score, despite the fact that this may have capitalised sampling variability (Treiman, 2009, p. 250). Factor scores were computed as regression scores in SPSS 23 using FACTOR command, PRINCIPAL AXIS FACTORING method, and VARIMAX rotation.

2.3. Independent Variables

Age was recorded in years and dichotomised into people aged 55 years and older (1), and people younger than 55 (0). The age threshold was set at 55 in order to attain a satisfactory sample size while maintaining a relevant age category. The rather low threshold for older people is appropriate for populations with lower life expectancy and poor health status. Romanian population has one of the lowest life expectancies in Europe at 75.1 years and a rather problematic health status (Precupetu & Pop, 2016). Figure 1 presents the age distribution in the sample. We included various indicators of social exclusion identified by Walsh et al. (2017) as the second set of independent variables: material and financial resources, social relations, neighbourhood and community, and services.

Two other domains that Walsh et al. (2017) distinguished could not be included as there was no information about it in the dataset (socio-cultural dimension), or there were only a small number of cases (social participation). Material and financial exclusion was measured using the question: "Thinking of your household's total monthly income, is your household able to make ends meet?" Answering categories were: 1. very easily, 2. easily, 3. fairly easily, 4. with some difficulty, 5. with difficulty, and 6. with great difficulty.

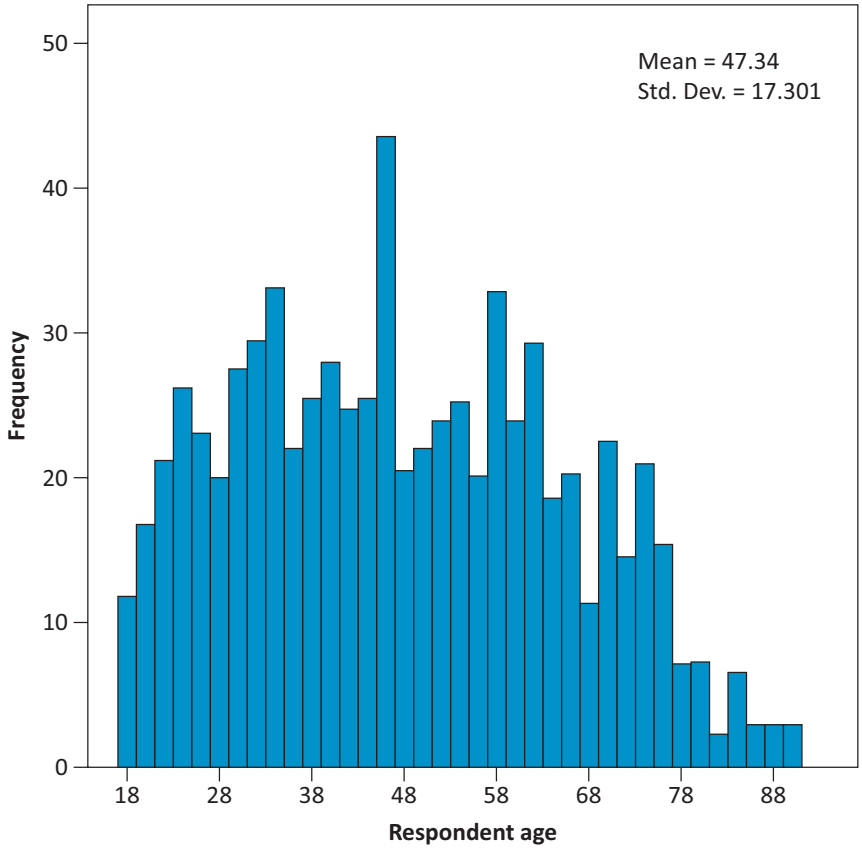

Figure 1. Age distribution.

Exclusion from social relations was assessed with a factors score based on the following four questions:

1. "On average, how often do you have direct face-to-face contact with any of your family members or relatives living outside the household?"
2. "On average, how often do you have direct face-to-face contact with any of your friends or neighbours?"
3. "On average, how often do you have contact with any of your family members or relatives living outside the household by phone, Internet or by post?"
4. "On average, how often do you have contact with any of your friends or neighbours by phone, Internet or by post?"

The response scale was similar for each of them: 1. every day or almost every day, 2. at least once a week, 3. one to three times a month, 4. less often, and 5. never. A higher score indicates more exclusion from social relations.

Exclusion from neighbourhood and community is also a factor score computed from six items: "Thinking of physical access, distance, opening hours and the like, how easy or difficult is your access to the following services: (a) banking facilities (e.g., bank branch, ATM), (b) public transport facilities (bus, metro, tram, train, etc.), (c) cinema, theatre, or cultural centre, (d) recreational or green areas, (e) grocery shop or supermarket, (f) recycling services including collection of recyclables". The answer categories were: 1. very easy, 2. rather easy, 3. rather difficult, and 4. very difficult. A higher score indicates more exclusion from neighbourhood and community.

Exclusion from services is also a factor score computed from five items. Thinking about the last time you needed to see or be treated by a general practitioner (GP), family doctor or health centre, to what extent did any of the following make it difficult to visit a doctor or health care centre? (a) distance to GP/doctor's office/health centre, (b) waiting list, (c) waiting time to see a doctor on the day of the appointment, (d) cost of seeing the doctor, (e) finding time because of work, care for children or for others.

The answer categories are: 1. not difficult at all, 2. a little difficult, and 3. very difficult. A higher score indicates more exclusion from services.

2.4. Confounders

Urbanity is based on the question "Would you consider the area in which you live to be…", with answering categories: 1. the open countryside, 2. a village/small town, 3. a medium to large town, and 4. a city or city suburb. Urbanity was dichotomised into rural (0), including the original categories 1 and 2, and urban (1) including the original categories 3 and 4. Gender is a dummy variable with 0 for females and 1 for males. For education, two dummy variables were constructed, one representing the International Standard Classification of Education (ISCED) 0–2 levels (lower education) and the other the ISCED 3–4 levels (medium level). The reference category is ISCED 5–8 levels (high education). Rural areas pose special challenges for access to services due to their lack of general service infrastructure, inadequate transport, and depletion of local service and social centres in comparison to urban areas (Walsh, O'Shea, & Scharf, 2012). Women run higher risks of being socially excluded because they are more often frail, more often widowed, have lower levels of education, have more often disrupted working careers, lower pensions, and less economic resources. Education is related to a number of social exclusion domains. Education and income go hand in hand, and the higher the financial resources the lower the levels of exclusion of most domains (even exclusion from social relations; Scharf et al., 2005).

2.5. Control Variables

The following control variables are included in the final analytical model: having children in or outside the respondent's household (1 = yes, 0 = no), if the respondent has a partner (1 = yes, 0 = no), and if the respondent has chronic diseases (1 = yes, 0 = no).

2.6. Analytical Approach

For descriptive reasons, we examine age differences in the study variables. We will conduct independent sample t-tests for the continuous variables (mental wellbeing and social exclusion), and chi-square and adjusted standardised residuals for dummy and categorical variables (all the other variables in the models). The tests will be carried out for both summative and factor scores, if applicable. For informative reasons, we calculate bivariate correlations between dimensions of social exclusion based on summative and factor scores. To examine whether variation in domains of social exclusion explains variation in wellbeing, we employ three linear regression models. With the first model, we examine age differences in mental wellbeing. We control for the potential confounding effect of urbanisation and gender as they correlate with both social exclusion and mental wellbeing. The second model adds the four dimensions of social exclusion to the aforementioned confounders and the age variable. These four dimensions are: material and financial, social relations, neighbourhood, and community and services. If social exclusion moderates the association between age and mental wellbeing, the estimated regression weight of age will become smaller. The third model additionally controls for a number of variables to exclude alternative explanations for an association between age and mental wellbeing, i.e., level of education, partner status, having children, and having chronic diseases. Finally, we will conduct a robustness test by introducing, in addition to the confounding factors, the interactions between social exclusion and age. In this way, we verify

whether there is a combined role of these factors influencing mental wellbeing. We will run five models, the first four testing one interaction effect at a time, and the final one testing all effects.

3. Results

Table 1 presents the basic characteristics of the study sample by age categories and total sample. For variables introduced in the analysis as factor scores, summative scores are included along with the factor scores in order to allow comparisons between age categories. Thirty-five per cent (N = 259) of the sample is 55 years or older, and there are slightly more women than men. Older people have lower mental wellbeing than younger individuals have, and they have higher levels of social exclusion in three dimensions: material and financial resources, social relations, and neighbourhood and community ($p < 0.05$). There is variation in the four dimensions of social exclusion, and 27% (N = 196) of the sample has a low level of education, 58% (N = 421) a medium level of education and 15% (N = 109) is highly educated. More than two-thirds of the sample has a partner and every one out of five has a chronic disease (one or more). Older individuals have a lower level of education in comparison to the younger, while the presence of the chronic disease is, at 48%, almost ten times higher than among the younger individuals (5%).

To test our hypotheses, we conducted multiple linear regression analysis. Model 1 (Table 2) evaluates the first hypothesis (H1) stating that older Romanians have lower levels of mental wellbeing than younger generations in Romania. The negative effect of age ($B = -0.57$) indicates that older Romanians score 0.57 points lower

Table 1. Descriptive statistics of the total study sample and by age group..

		18–54 (N = 467)		55+ (N = 259)		Total sample (N = 726)		Diff.
Variables		**M**	**SD**	**M**	**SD**	**M**	**SD**	**p**
Mental health (summative score/ factor score)		68/ 0.25	21/ 0.82	53/ −0.35	25/ 0.99	63/ 0.04	23/ 0.93	p < .001
Urbanisation % urban		47%		38%		44%		.018
Gender % male		50%		41%		47%		.024
Social exclusion dimensions	Material and financial resources*	3.65	1.22	4.30	1.36	3.88	1.31	p < .001
	Social relations (summative score/ factor score)	7.64/ −0.15	2.83/ 0.79	8.76/ 0.15	3.07/ 0.87	8.04/ −0.04	2.97/ 0.83	p < .001/ p < .001
	Neighbourhood and community (summative score/ factor score)	12.60/ −0.07	4.24/ 0.85	13.66/ 0.16	4.75/ 0.96	12.98/ 0.01	4.45/ 0.90	.002/ .001
	Services (summative score/ factor score)	8.13/ 0.11	2.62/ 0.92	7.51/ −0.10	2.46/ 0.86	7.91/ 0.04	2.58/ 0.90	.001/ .002
Has children		66%		76%		69%		.005
Education	ISCED 0–2 levels (low education)	18%		42%		27%		p < .001
	ISCED 3–4 levels (medium education)	62%		51%		58%		p < .001
Has partner		69%		68%		69%		.687
Has chronic disease		5%		48%		20%		p < .001

Notes: ISCED = International Standard Classification of Education; M = Mean; SD = Standard; *Ordinal variable measured on a scale from 1 to 6. Independent samples t-test show statistically significant differences between the two age categories, 18–54 and 55+, for mental health and the social exclusion dimensions; chi-square and adjusted standardised residuals show statistically significant associations for all the other variables with the exception of the variable *has a partner*.

Table 2. Summary of the hierarchical regression analysis for variables predicting mental wellbeing (N = 726).

		Model 1			Model 2			Model 3		
		B	*β*	*SE*	B	*β*	*SE*	B	*β*	SE
(Constant)		0.09		0.06	0.98		0.11	1.00		0.13
Age 55+ (0 ≤ 55, 1 = 55+)		−0.57	−0.29 **	0.07	−0.39	−0.20 **	0.07	−0.30	−0.16 **	0.08
Urbanisation (0 = rural, 1 = urban)		0.24	0.13 **	0.07	0.12	0.06 #	0.06	0.12	0.07 #	0.07
Gender (0 = female, 1 = male)		0.09	0.05	0.07	0.03	0.02	0.06	0.02	0.01	0.06
Social exclusion dimensions (factor scores)	Material and financial resources				−0.23	−0.32 **	0.03	−0.21	−0.30 **	0.03
	Social relations				−0.15	−0.13 **	0.04	−0.16	−0.14 **	0.04
	Neighbourhood and community				−0.11	−0.11 **	0.04	−0.11	−0.10 **	0.04
	Services				−0.09	−0.08 *	0.04	−0.10	−0.10 **	0.04
Has children (1 = yes, 0 = no)								−0.04	−0.02	0.07
Education (ref. group = high)	ISCED 0–2 levels (low education)							0.00	0.00	0.11
	ISCED 3–4 levels (medium education)							0.02	0.01	0.09
Has partner (1 = yes, 0 = no)								−0.07	−0.04	0.07
Has chronic diseases (1 = yes, 0 = no)								−0.20	−0.09 #	0.09

Notes: SE = Standard Errors; ISCED = International Standard Classification of Education; ** p < .01, * p < .05, # p < .10.

on the mental wellbeing factors score, controlled for the level of urbanisation and gender, which confirms H1.

Next, Model 2 indicates that all four domains of social exclusion are negatively associated with mental wellbeing (all p < .01). The lower regression weight for age in Model 2 compared to Model 1 indicates that the lower mental wellbeing of older Romanians can be partly explained by the higher levels of social exclusion. The statistically significant associations between the independent variables age and the four domains of social exclusion, on the one hand, and mental wellbeing on the other cannot be explained by differences with regards to having children or not, level of education, having a partner or not, or having chronic diseases or not (Model 3). Our second hypothesis is also confirmed (see Table 2). The robustness test did not alter our conclusion as none of the interactions between social exclusion and age reached the level of significance. The bivariate correlations between the domains of exclusion (Table 3) indicate that domains of exclusion are positively associated. However, associations are modest indicating that the domains cover both shared and unique aspects of social exclusion.

4. Discussion

This study has examined whether the level of wellbeing in older Romanians compared to younger Romanians can be understood in terms of a greater likelihood of being socially excluded. Based on a sample of 726 Romanians aged between 18 and 85, of which one-third was 55 years or older, we firstly confirmed that older Romanians have lower levels of mental wellbeing than younger Romanians. Furthermore, we observed that all four domains of social exclusion distinguished in our study were negatively associated with mental wellbeing, and these associations partly explain the lower level of mental wellbeing in older Romanians. Associations between social exclusion and mental wellbeing were independent of the effect of having children, level of education, having a partner, and chronic diseases.

The significant associations between the domains of social exclusion confirmed the multidimensional nature of social exclusion and suggest that people who are excluded from one domain have a higher likelihood to be excluded from another domain. Material and financial re-

Table 3. Correlation between dimensions of social exclusion (summative scores).

	Age categories	Material and financial resources	Social relations	Neighbourhood and community	Services
18–54 years (N = 469)	Material and financial resources	1	.24**	.19**	.25**
	Social relations	.24**	1	−.03	.04
	Neighbourhood and community	.19**	−.03	1	.31**
	Services	.25**	.04	.31**	1
55–89 years (N = 260)	Material and financial resources	1	.25**	.25**	.28**
	Social relations	.25**	1	−.08	.17**
	Neighbourhood and community	.25**	−.08	1	.23**
	Services	.28**	.17**	.23**	1

Note: ** Correlation is significant at the 0.01 level (2-tailed).

sources are correlated with all other dimensions showing they are key to all other domains. However, the strength of the associations is moderate, indicating that exclusion from one domain does not necessarily imply exclusion from other domains. Social exclusion can take many shapes, and there is no "out" or "in", but a dimension running from not excluded on any domain, to being excluded on all domains. Social exclusion is a complex process, and people may be excluded from a range of different societal institutions and groups, at different levels, and to different degrees (Burchardt, Le Grand, & Piachaud, 2002; Walker & Wigfield, 2004). The multidimensional nature of social exclusion requires a holistic and multidimensional approach that goes beyond a mere focus on material resources.

Our research has a number of limitations. One is that the data are cross-sectional, which means that we cannot draw any conclusions with respect to dynamics between social exclusion and mental wellbeing. Being socially excluded may be an antecedent, but it can also be concomitant, or even the outcome of diminished mental wellbeing (Kawachi & Berkman, 2001). Moreover, we cannot disentangle age from cohort effects. Although we reason that the age differences we found in our study are due to cohort effects, longitudinal data that follow people into old age would provide insight into the plausibility of this conclusion. It may well be that the disadvantaged position of older people is not only the consequence of different life history or growing up under different welfare regimes, it may also be that the difference between older and younger people is the consequence of an accumulation of disadvantages over the life course. Furthermore, we made use of an existing dataset with a limited number of indicators for our social exclusion definition, and with a limited number of older people, which reduced the power of the statistical tests to find significant results. Nevertheless, we observed statistically significant associations between the key variables, and all were in the expected direction. Future studies with a cross-national and longitudinal design are needed to examine the dynamics between social exclusion and mental wellbeing, as well as drawing conclusions with respect to the potential modifying effect of the macro social context.

5. Conclusions

This study is one of the first to examine the mechanisms behind the lower wellbeing of older Romanians. Much can be learned from examining the correlates of mental wellbeing, in particular the associations between social exclusion and mental wellbeing. We found that social exclusion is a crucial factor in the wellbeing of Romanians, not only older Romanians but also the younger generations, which is in line with the growing evidence. However, older Romanians are disadvantaged on all four domains of social exclusion examined in this study when compared to the younger generations. They are more often excluded from social relations, from material and economic resources, from services, and from facilities in the neighbourhood than younger Romanians. This partly explains why older Romanians have lower mental wellbeing than younger Romanians. Given the already low level of mental wellbeing compared to other European countries, interventions to improve the mental wellbeing of older Romanians are highly needed. One way to achieve this is to increase social inclusion by means of social transfers provided by the government, improving the neighbourhood and access to services, and providing facilities to enhance the social network. While the focus on improving material conditions should remain key, more efforts should be targeted at providing and integrating social and medical services, further developing long term care, while improving older people's access to these services. Policy targeting older people should be more carefully monitored and evaluated with the purpose of improving efficiency and equity as well as ensuring stability and sustainability. In general, policy should stimulate active ageing by changing the emphasis from deficit, decline, disability, and dependency to wellbeing, activity, and independence. More focus is probably also needed at the local level, especially in rural areas, with prominence on community resources, capacity building, healthy ageing, and empowerment in order to increase

capabilities and enable older people to participate in their communities.

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Conflict of Interests

The authors declare no conflict of interests.

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Annex

Table A1. Descriptive statistics of the total study sample and by age group.

Variables		18–54 (N = 467)		55+ (N = 259)		Total sample (N = 726)		Diff.
		M	SD	M	SD	M	SD	p
Mental health (summative score/factor score)		68/0.25	21/0.82	53/–0.35	25/0.99	63/0.04	23/0.93	$p < .001$
Urbanisation (0 = rural, 1 = urban)		47%		38%		44%		.018
Gender (0 = female, 1 = male)		50%		41%		47%		.024
Social exclusion dimensions	Material and financial resources*	3.65	1.22	4.30	1.36	3.88	1.31	$p < .001$
	Social relations (summative score/factor score)	7.64/–0.15	2.83/0.79	8.76/0.15	3.07/0.87	8.04/–0.04	2.97/0.83	$p < .001$/$p < .001$
	Neighbourhood and community (summative score/factor score)	12.60/–0.07	4.24/0.85	13.66/0.16	4.75/0.96	12.98/0.01	4.45/0.90	.002/.001
	Services (summative score/factor score)	8.13/0.11	2.62/0.92	7.51/–0.10	2.46/0.86	7.91/0.04	2.58/0.90	.001/.002
Has children (1 = yes, 0 = no)		66%		76%		69%		.005
Education	ISCED 0–2 levels (low education)	18%		42%		27%		$p < .001$
	ISCED 3–4 levels (medium education)	62%		51%		58%		$p < .001$
Has partner (1 = yes, 0 = no)		69%		68%		69%		.687
Has chronic disease (1 = yes, 0 = no)		5%		48%		20%		$p < .001$

Notes: ISCED = International Standard Classification of Education; M = Mean; SD = Standard; *Ordinal variable measured on a scale from 1 to 6. Independent samples t-test show statistically significant differences between the two age categories, 18–54 and 55+, for mental health and the social exclusion dimensions; chi-square and adjusted standardised residuals show statistically significant associations for all the other variables with the exception of the variable *has a partner*.

Table A2. Summary of the hierarchical regression analysis for variables predicting mental wellbeing (N = 726).

	Model 1				Model 2				Model 3			
	B	*β*		*SE*	*B*	*β*		*SE*	*B*	*β*		*SE*
(Constant)	0.09			0.06	0.98			0.11	1.00			0.13
Age 55+ (0 ≤ 55, 1 = 55+)	–0.57	–0.29	**	0.07	–0.39	–0.20	**	0.07	–0.30	–0.16	**	0.08
Urbanisation (0 = rural, 1 = urban)	0.24	0.13	**	0.07	0.12	0.06	#	0.06	0.12	0.07	#	0.07
Gender (0 = female, 1 = male)	0.09	0.05		0.07	0.03	0.02		0.06	0.02	0.01		0.06
Social exclusion dimensions (factor scores)												
Material and financial resources					–0.23	–0.32	**	0.03	–0.21	–0.30	**	0.03
Social relations					–0.15	–0.13	**	0.04	–0.16	–0.14	**	0.04
Neighbourhood and community					–0.11	–0.11	**	0.04	–0.11	–0.10	**	0.04
Services					–0.09	–0.08	*	0.04	–0.10	–0.10	**	0.04
Has children (1 = yes, 0 = no)									–0.04	–0.02		0.07
Education (ref. group = high)												
ISCED 0–2 levels (low education)									0.00	0.00		0.11
ISCED 3–4 levels (medium education)									0.02	0.01		0.09
Has partner (1 = yes, 0 = no)									–0.07	–0.04		0.07
Has chronic diseases (1 = yes, 0 = no)									–0.20	–0.09	#	0.09

Notes: SE = Standard Errors; ISCED = International Standard Classification of Education; ** p < .01, * p < .05, # p < .10.

Table A3. Correlation between dimensions of social exclusion (summative scores).

Age categories		Material and financial resources	Social relations	Neighbourhood and community	Services
18–54 years (N = 469)	Material and financial resources	1	.24**	.19**	.25**
	Social relations	.24**	1	–.03	.04
	Neighbourhood and community	.19**	–.03	1	.31**
	Services	.25**	.04	.31**	1
55–89 years (N = 260)	Material and financial resources	1	.25**	.25**	.28**
	Social relations	.25**	1	–.08	.17**
	Neighbourhood and community	.25**	–.08	1	.23**
	Services	.28**	.17**	.23**	1

Note: ** Correlation is significant at the 0.01 level (2-tailed).

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Article

What Are the Structural Barriers to Planning for Later Life? A Scoping Review of the Literature

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Abstract
The rollback of the welfare state in countries such as the UK, coupled with population ageing, have contributed to a situation in which responsibility for older people's wellbeing is placed more heavily on the individual. This is exemplified in the notion in popular and policy circles that individuals should plan for later life, particularly financially, and a corresponding concern that they are not doing so sufficiently. This scoping review aimed to identify the structural factors which inhibit people from engaging in planning for later life. For the purposes of this review, we characterised planning as the range of activities people deliberately pursue with the aim of achieving desired outcomes in later life. This entails a future, as opposed to shorter-term, goal orientation. In study selection, we focused on planning at mid-life (aged 40 to 60). Systematic and snowball searching identified 2,317 studies, of which 36 were included in the final qualitative synthesis. The review found that limited financial resources were a key barrier to planning. Related factors included: living in rented accommodation, informal caring, and working part-time. A lack of support from employers, industry, regulators and landlords was also found to inhibit planning. The findings suggest that certain sections of society are effectively excluded from planning. This is particularly problematic if popular and policy discourse comes to blame individuals for failing to plan. The review also provides a critical perspective on planning, highlighting a tendency in the literature towards individualistic and productivist interpretations of the concept.

Keywords
ageing; later life; mid-life; older people; planning; retirement; scoping review; structural barriers

Issue
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1. Introduction: Background

This review draws on Street and Desai (2011) to characterise planning as the range of activities people deliberately pursue with the aim of achieving desired outcomes in later life. Planning entails a future goal orientation and typically concerns issues such as finance, housing, and leaving work.

The austerity agenda, coupled with the ageing of the population have helped focus European and UK government policy on two areas related to planning: extending working lives and savings (Chartered Institute of Personnel and Development [CIPD], 2016; Department of Work and Pensions [DWP], 2013, 2017; Eurofound, 2007, 2016; Lifelong Learning Programme Grundtvig [LLPG], 2012). The rationale for encouraging planning is the understand-

ing that many people in mid-life are underprepared for and vulnerable to the challenges that later life can bring (e.g., European Commission, 2018; Financial Conduct Authority [FCA], 2017). Yet mid-life is seen as a pivotal life stage, during which change can have a positive impact on future trajectories (e.g., Hagger-Johnson et al., 2017; Lachman, 2015; LLPG, 2012). This focus on encouraging individuals to engage in greater levels of planning has also been accompanied by steps to oblige people to work longer and save more. For example, along with many other high-income countries, the UK is raising its state pension age. The first step was to raise the state pension age for women from 60 to 65 in 2018, to match that of men, and further rises for both sexes are planned for coming years (Cridland, 2017). The UK also introduced, in 2012, a policy of auto-enrolment in employer-sponsored occupational pensions, which are a form of private pension that supplements the state pension. The scheme requires employers to put qualifying staff into an occupational pension scheme and to make contributions towards their employee's pension. Staff can choose to 'opt out' subsequently. Both these developments should be considered in the context of the rollback of the welfare state in the UK and a corresponding shift in responsibility from the state to the individual for wellbeing in later life.

A focus on planning can serve the same purpose. Planning is frequently promoted from successful and productive ageing paradigms, which can imbue it with a normative assumption about the control that individuals have over their ageing. For example, Rowe and Kahn (1998) state that their "main message is that we can have a dramatic impact on our own success or failure in aging. Far more than is usually assumed, successful aging is in our own hands" (Rowe & Kahn, 1998, p. 18). Furthermore, "to succeed…means having desired it, planned it, worked for it" (Rowe & Kahn, 1998, p. 37). This perspective not only frames planning as a strategy for improving wellbeing, but it places responsibility at an individual level, in a manner criticised by others (e.g., Bauman, 2002; Rose, 1999). As a result, many argue that the successful ageing paradigm fails to take full account of the socio-economic structuring of planning (e.g., Holstein & Minkler, 2003; Katz & Calasanti, 2014; Moffatt & Heaven, 2017; Street & Desai, 2011). At its worst, therefore, a policy to promote planning can carry with it a level of blame directed at the very people least able to plan in practice.

Other reviews of the literature treat the subject slightly differently from this one. Street and Desai (2011) reviews a selection of sociological literature as a means to highlight theoretical and empirical shortcomings in the field. Others review the psychological literature on retirement (Wang & Shi, 2014) and on planning for retirement (Adams & Rau, 2011). A systematic review of factors promoting retirement adjustment (Barbosa, Monteiro, & Murta, 2016) considers planning as a candidate factor but does not tackle the central task of this study: to identify the structural barriers to planning. Interestingly, Barbosa et al. (2016) did not find that retirement preparation was among the strongest determinants of positive outcomes in retirement, which included physical health, finances and retirement voluntariness. Another feature which sets this review apart is its focus on later life rather than retirement. A focus on retirement is critiqued elsewhere for its gendered assumption that the end of paid work marks a key turning point in people's lives (Kornadt & Rothermund, 2014). Furthermore, retirement is becoming a gradual process, marked by periods of flexible or part-time work. There is also a contrast between studies which envisage retirement as a discrete decision versus those which see it as a lifecourse transition (see Wang & Shi, 2014).

2. Methodology

2.1. Capturing Planning Empirically

Literature on financial planning dominates the field, providing a number of reviews and large-scale quantitative studies. This reflects a productivist view of ageing (critiqued, for example, in Foster & Walker, 2015) and, by extension, a tendency towards research on measurable phenomena. As a result, other significant forms of planning that are harder to capture get relatively little attention (Street & Desai, 2011). These include planning that does not result in a change in activity, for example, deciding not to move into a new house, or that is harder to measure, for example planning to maintain friendships. Reactive planning resulting from unforeseen changes in circumstances, such as involuntary retirement, is also under recognised.

2.2. Review Design

The approach adopted in this scoping review broadly follows the methodological framework developed by Arksey and O'Malley (2005) and expanded by Levac, Colquhoun and O'Brien (2010). This article reports on analysis conducted as part of a larger review (Preston, Drydakis, Forwood, Hughes, & Burch, 2018). The aim of this analysis was to identify structural barriers to planning, where 'structures' refer to "constructed frameworks and patterns of organisation that serve to constrain or direct human behaviour" (Bilton et al., 2002, p. 15). This was operationalised to include socio-economic group, occupation, education, marital status, gender, religion and ethnicity.

The review search process comprised two stages: the first was a single systematic search of databases to identify studies related to planning in the following domains: financial, paid work, emotional/psychological, social, housing, care, physical activity, leisure, health. The second comprised snowball searching in domains where relatively little literature was found.

Several databases were used to identify suitable articles: Applied Social Sciences Index and Abstracts, Science and Social Science Citation Indices, PsycINFO,

PsycARTICLES, Psychology and Behavioural Sciences Collection, Education Resources Information Centre, Business Source Premier, Medline, Embase, Cochrane Database of Systematic Reviews, CENTRAL, Database of Reviews of Effects, Health Technology Assessment, IDEAS, and Scopus.

The search terms comprised combinations of variants on 'mid-life', 'pre-retirement', 'planning', 'preparing', 'older' and 'ageing'.

Inclusion criteria were research or review articles published in peer-reviewed journals, books and grey literature reports between 1 January 2000 and 31 April 2018, reported in any language but with an abstract in English; study participants or populations based in any high-income countries (as defined by the World Bank) applicable to the UK ageing and policy environment; a home and/or work setting; adults of any age but focusing on those at mid-life (defined as 40 to 60 years old).

Exclusion criteria were studies which focused exclusively on people with terminal illness, specific mental illness, specific health conditions or cognitive decline, and studies in a health-related or social care-related establishment.

A best-evidence hierarchy was applied to abstracts of all studies meeting the inclusion criteria. The hierarchy favoured good, recent systematic reviews or narrative reviews, followed by recent, good quality, published primary research from the UK that addressed the issue directly. We focused on UK evidence but where there was little good UK evidence on a specific topic, we then used evidence from other countries meeting the inclusion criteria, rather than not addressing the topic. Full text articles were subsequently assessed for eligibility on the basis of their relevance in identifying structural barriers to planning for later life and their quality in respect of this task. Quality was judged by applying the appropriate Critical Appraisal Skills Programme checklist (available at casp-uk.net/casp-tools-checklists) and only studies which at least two authors agreed were of medium or strong quality were included in the final selection. Any disagreements were resolved by discussion among members of the research team. This resulted in 36 unique studies which were then subjected to narrative synthesis. The synthesis involved a process of charting, similar to that described in Arksey and O'Malley (2005). Using a spreadsheet, the material was sorted according to key features of the studies (such as methodology and participant information). Extracts from study findings and conclusions which addressed the issue of structural barriers to planning were also copied into a spreadsheet. This enabled the team to identify similarities and differences among the included studies, as well as drawing attention to gaps in the literature.

3. Findings

The findings are arranged according to the domain of planning. Financial literature dominated the field, as other reviews have noted (e.g., Street & Desai, 2011). By contrast, there were surprisingly few studies on planning for health and an absence of eligible studies on planning for social connections, leisure activities, and emotional and psychological wellbeing. Of the included studies, 75% were of UK origin but the review also included studies originating in US, Canada, Japan, Australia and various European countries.

3.1. Planning in General

Various studies which looked at planning across domains identified socio-demographic characteristics of people who were more or less likely to have engaged in planning. A higher income, being from managerial and professional occupation, having higher educational qualifications and being aged 50 to 64 were associated with an increased likelihood of people saying they had "hopes and ambitions" for later life, as opposed to saying that they had not thought about it much or at all, in Humphrey, Lee and Green (2011). Men were found to be more likely to have engaged in any planning and to have engaged earlier than women in Moen, Sweet and Swisher (2005). Gender and income were also found to affect likelihood of planning in a qualitative study (Denton et al., 2004). It found that low income women, who were divorced or separated, accounted for the majority of people it identified as living "day-by-day", meaning they were more likely to plan reactively than proactively (Denton et al., 2004). The study concluded that gender, work history, and marital status combined to influence people's ability to plan in general and it suggested that socio-economic constraints make financial preparation, in particular, an "unaffordable luxury" for disadvantaged groups (Denton et al., 2004, p. 80). The notion of capability to plan was developed in a study looking at wellbeing through retirement transitions (Heaven et al., 2016). Drawing on the work of Amartya Sen (1985), the authors characterised affordability as the capability to meet particular objectives by having enough money to purchase services and goods. Although the study considered affordability to be an essential component of capability, it concluded that the capability to mobilise various resources to achieve particular goals and respond to changing circumstances was key to wellbeing through retirement transitions.

As to the conception of social actors in the literature on planning, this review found that most literature on planning uses individuals as its unit of analysis. There is some recognition that spouses and partners serve as important frames of reference: for example, a review of literature about factors that affect people's ability to extend their working life (Nilsson, 2016) cites various studies demonstrating that spouses and partners served as important frames of reference in planning decisions. Meanwhile primary research has shown that partners in dual-earner couples often perceive their two retirements as "tied" transitions (Moen et al., 2005), that women often retire from work to complement their husband's

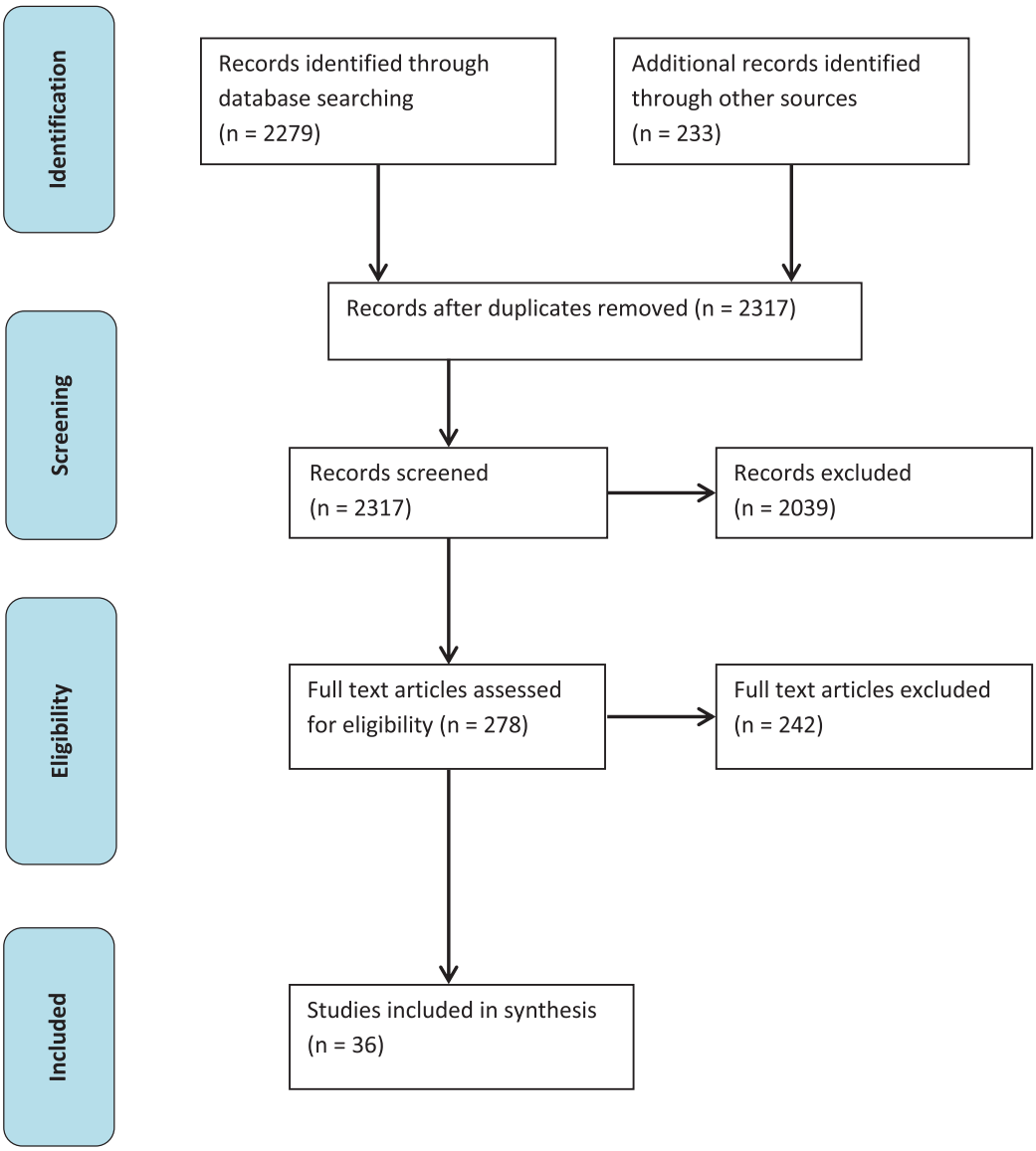

Figure 1. PRISMA flow diagram.

plans for retirement (Loretto & Vickerstaff, 2015) and that there is a tied aspect to couples' financial decision making (Heraty & McCarthy, 2015; Lloyd & Lord, 2015). However, a review of literature on retirement saving makes the point that social influences have been overlooked in many studies in that field (Gough & Niza, 2011).

3.2. Financial Planning

Two literature reviews identified financial resources as central among the determinants of financial planning and saving for retirement (Gough & Niza, 2011; Personal Finance Research Centre [PFRC], 2016). They also found that policy change and other uncertainties in the financial environment were likely contributors to people's reluctance to engage in financial planning (Gough & Niza, 2011; PFRC, 2016).

The PFRC (2016) study comprised a review of literature on financial capability. It defined financially capable behaviours as managing money well day-to-day; managing and preparing for life events; and dealing with financial difficulty. The model of financial capability it used linked these behaviours to financial wellbeing (current wellbeing and longer-term financial security). It found that analysis of large-scale survey data supported the idea that people who manage money well day-to-day are better placed to plan for retirement and that, to a large extent, this is facilitated or limited by people's financial situation and the financial resources available to them. A review of international literature on retirement saving found that salary, age, education and job tenure were key determinants of the decision to save via retirement plans (Gough & Niza, 2011). The review noted that older, white and more educated people tended to earn more, and higher job tenure was also associated with higher wages. Studies it reviewed also showed that older workers and high earners tended to contribute to the maximum plan or legal limit, whereas younger and lower-

income employees tended to contribute at the employer-matched level (this finding refers to the UK pension system, which combines a state pension with various forms of private pension, including employer-sponsored occupational pensions). The review found relatively little literature on the socio-demographic characteristics that influenced engagement in voluntary individual savings accounts. However, it cited one study that showed participants in these plans tended to be male, high earners, older, full-time workers and people from either white or non-black minorities.

Other studies based on primary research and secondary analysis of datasets provide further evidence in line with the findings of the reviews. One found that the challenges of living on a low income inhibited people from saving for retirement (Hall & Keohane, 2016). Moffatt and Heaven (2017) found that the notion of financial planning for retirement was embedded as a norm among participants but that the possibilities of doing so were structured by occupational social class and gender.

Heraty and McCarthy (2015) found that people employed on temporary contracts tended to have lower incomes and were therefore less likely to plan financially for retirement than those who were employed on a permanent basis. Low income was also identified as a barrier in regard to people in defined contribution pensions: low-income retirees demonstrated a reduced ability to save, compared to pre-retirees and retirees (Lloyd & Lord, 2015). Finney and Hayes (2015) looked at financial planning through the lens of financial capability. Planning ahead was seen as one of six dimensions of financial capability, the others being: making ends meet, organised money management, controlled spending, staying informed and choosing products. Planning ahead was defined as the extent to which someone makes provision for future expenditure from current income. The study offered strong evidence that people living in lower income households lacked planning capability compared to high earners. It also found that unemployed people lacked planning capability and suggested this was likely a reflection of their low incomes relative to employed people.

These findings are corroborated by studies investigating pensions saving in particular. Two of these investigated eligible non-savers, defined as those employees eligible for a workplace pension with employer contributions but who do not participate (Bryan & Lloyd, 2014; Bryan, Lloyd, Rabe, & Taylor, 2011). Bryan and Lloyd (2014) found that eligible non-savers were less educationally qualified than savers, earned less, and were more likely to rent rather than own their home. The study also found that they were disproportionately male, younger, single, and had fewer children than occupational pension savers. Eligible non-savers were also less likely to save into non-pension products, have lower levels of liquid savings, have more liquid debt and were more likely to be in arrears with household bills. Bryan et al. (2011) found that mortgage holders or tenants were less likely than outright home owners to save to a pension. It also found that the great majority of eligible non-savers, compared to occupational pension savers, were in the private sector, worked in smaller establishments, were disproportionately likely to work in retail and catering, and were more likely to be part-time employees (Bryan et al., 2011). However, it found that while exit rates from a pension were higher in the private sector, they did not appear to be higher in smaller establishments or in the retail sector.

Clark, Knox-Hayes and Strauss (2009) found that the younger the individual, the lower their income, and the lower the degree to which they recognised that pensions are designed to supplement retirement income, the less likely they were to believe pension planning to be important, to be prepared for planning, and to be knowledgeable about annuities. Moreover, women were less likely than men to believe pension planning to be important.

Two studies provide evidence on the relationship between financial planning and ethnicity. Vlachantoni, Feng, Evandrou and Falkingham (2017) examined the factors associated with the receipt of three different kinds of pension income among older men and women from separate Black and Minority Ethnic (BME) groups. The three kinds of pension were: State Pension, occupational/private and Pension Credit (a means tested top-up benefit). Of these, receipt of occupational/private income is the closest proxy for financial planning. The study found that belonging to certain BME groups reduced individuals' chances of receiving the State Pension or an occupational/private pension but increased their chance of receiving Pension Credit. The gender-specific analysis showed that these results held true for many BME groups of men, whereas among women, only Pakistani women were less likely than White British women to receive an occupational/private pension. An earlier study on savings behaviour of ethnic minorities in the UK found that income rather than ethnicity appeared to be the prime driver of savings levels (Gough & Adami, 2013).

Having caring responsibilities was found to affect saving in Ipsos Mori (2013). It found that 63% of dual carers (people who care for older and younger relatives/friends) reported that they had cut their savings rate and 25% their pension contributions and retirement plans since becoming carers.

Meanwhile, the association between sexual-orientation, occupational class and likelihood of financial planning was investigated in Guasp (2011). It found that lesbian, gay and bisexual (LGB) people were more likely than their heterosexual peers to have plans in place for their future financial needs but, in both categories, a higher occupational class was associated with more financial planning.

3.3. Will Making

Financial resources, age and marital status were found to be independently associated with the likelihood of hav-

ing made a will in Humphrey et al. (2011). The study found that 9% of those with assets worth up to £10,000 had made a will, compared to 80% of those with assets valued at more than £500,000. Those who had themselves received something on another's death were more likely to have made a will than those who had not (Humphrey et al., 2011).

3.4. Health and Care

This review found just one study (Humphrey et al., 2011) that quantified planning at mid-life with a view to improving later-life health, rather than current health. More often, literature measuring adoption of healthy behaviours is oriented to current benefits of that behaviour. This perhaps reflects the understanding from the behaviour change literature that a present benefit is likely to be a more effective incentive to adopt behaviour than a future one (Bashir, Wilson, Lockwood, Chasteen, & Alisat, 2014). Humphrey et al. (2011) asked respondents which, if any, from a list of possible activities they were doing to maintain their long-term health. Among all age groups (16 and over), respondents who said they did nothing to maintain their long-term health tended to be of lower socio-economic status.

The review also found evidence that a structurally-related fatalistic attitude about health was a barrier to planning for the future. In a qualitative study looking at health and retirement, various participants expressed the feeling that there was little point planning for later life because they did not know how long they would live (Brown & Vickerstaff, 2011). The report describes such pessimism about morbidity and mortality as a form of bounded rationality, related to the disadvantaged circumstances that the people who expressed it were facing. Similarly, mid-life, female caregivers cited that a lack of resources, coupled with the unpredictable nature of health and illness were inhibiting them from planning for later life (Pope, 2012).

In regard to planning for care in later life, this review excluded the majority of literature identified because it focused on older rather than mid-age people. This reflects the finding that the closer people are to a particular stage of later of later life, the more likely they are to plan for it (Kornadt & Rothermund, 2014). For example, the likelihood of making a living will was found to increase with age (Moorman & Inoue, 2012) but also with higher education and marital status (Carr & Khodyakov, 2007). Separately, there was a suggestion that perceived inadequacy in health and social care services hinders planning for some sections of the population. One study showed 61% of LGB people said they were not confident that social care and support services, such as paid carers, would be able to understand and meet their needs; whereas 51% of heterosexual people felt the same way (Guasp, 2011). Similar concern about inadequate diversity of care homes was evident in a study of ethnic minority populations (Khan, 2012).

3.5. Retirement from Paid Work

The literature shows that the timing of retirement is often not a matter of choice for the retiree, presenting a major barrier to proactive planning for those affected. Involuntary retirement was associated with low incomes in Matthews and Nazroo (2016) and DWP (2016). For example, the DWP research found that just under a half of those in the highest income quartile retired because they wanted to, compared with just under a third of those in the lowest income quartile (DWP, 2016). People on low incomes were also found to be uncertain about their ability to realise plans to work beyond retirement age (ILC-UK & UF Research Consortium, 2017).

A number of studies identified affordability as a major determinant of retirement timing (Hofäcker, Schroeder, Li, & Flynn, 2016; ILC-UK & UF Research Consortium, 2017; Matthews & Nazroo, 2016). Furthermore, one review showed that affordability varied by employment sector (ILC-UK & UF Research Consortium, 2017) and another that lower education and skill level were associated with involuntary retirement (Hofäcker et al., 2016). The former also demonstrated that choice in retirement is gendered, finding that for many women, the need and ability to work longer was shaped by their work histories and family circumstances. By contrast, Hofäcker et al. (2016) found little difference in the incidence of involuntary retirement by gender, but it did find that men are more likely to exit via employer provided pre-retirement schemes, while women frequently retired for personal reasons. A similar point is made in a study that found women were more likely to take a domestically-driven pathway into retirement, mainly in response to issues of caring (Loretto & Vickerstaff, 2015). The study also evidenced differences in discourses about retirement among men and women. It found that a discourse of 'choice and control' was mainly articulated by men, while a discourse of 'fitting in', or shaping retirement expectations around others' needs, was almost exclusively expressed by women (Loretto & Vickerstaff, 2015). In addition, it found that women were less prone to ask about flexible working in case it upset their employer and were more likely to retire in order not to be a nuisance. The impact of informal caring, which is predominantly carried out by women, on subsequent unemployment was investigated in King and Pickard (2013). It found that caring for more than 10 hours per week significantly increased the likelihood of unemployment two years later among people in mid-life (King & Pickard, 2013).

There is also evidence that, in the UK, a lack of support from employers is hindering planning about retirement timing, despite national policy putting the onus on employers to recruit and retain older workers (ILC-UK & UF Research Consortium, 2017). The study suggested, for example, that age discrimination legislation was unintentionally making line managers worried about talking to people about their retirement plans for fear of being accused of ageism. Another study echoes this finding, sug-

gesting that employers were wary of conducting analyses of the age structure of their workforce for fear of contravening equal opportunities legislation (DWP, 2017). Organisations surveyed typically did not have processes in place for discussing retirement plans with older workers. Plans for retirement were discussed informally, if at all, and discussions were usually initiated by the older worker (DWP, 2017).

3.6. Housing

As with retirement, the literature on housing evidences structural barriers affecting the degree of choice people have regarding housing in later life and hence their ability to plan. Early post-retirement 'lifestyle migration' was found to be concentrated in more well-off households in Pennington (2013), which also found that those who moved to a new house in later life tended to be in a high or low income bracket, while those who stayed in the same home were in a middle income bracket. A suggestion of involuntary relocation was also evident in the finding that older people who rented their home were more likely to move to a new house than homeowners, who in the UK tend to have higher incomes (Hillcoat-Nalletamby & Ogg, 2014; Pennington, 2013).

Several UK studies also demonstrated that a lack of suitable housing discourages older people from planning to move house (Communities and Local Government Committee [CLGC], 2017; Pannell, Aldridge, & Kenway, 2012; Pennington, 2013) and that private renters face additional barriers to planning, particularly a lack of support from landlords in adapting housing for ageing (CLGC, 2017; Pannell et al., 2012).

4. Conclusion

This review builds on an earlier overview of sociological literature (Street & Desai, 2011) by providing evidence from quantitative and qualitative research of the socio-economic structuring of individuals' ability to plan at mid-life for their later life. Chief among factors that inhibit planning is low income. This is shown to hinder planning across various domains and activities. However, the impact of low income is accentuated by its co-occurrence with other factors, such as occupational and marital status, low education, few assets, living in rental accommodation, part-time work and informal caring. In combination, these factors result in people having little control over the trajectory of their lives. Not only is it evident that these barriers are intersectional but also that disadvantage regarding planning accumulates over the life-course. As a result, one of the groups least likely to engage in later life planning are divorced or separated, low-income women. This example also illuminates the gendered nature of planning. Planning is defined as deliberate and future-oriented but attempts to record it mean that concrete planning activities such as pension contributions prevail over less measurable activities such as keeping up friendships. Because women tend to have more disrupted work histories and lower pay than men, they may therefore register as poorer planners. Two main conclusions can be drawn: firstly, insofar as policy places responsibility for later life on individuals, policymakers should, as a minimum, ensure that 'responsible action' at an individual level is conceived and recorded in the most inclusive manner possible; secondly, insight gained from understanding that the ability to plan is socio-economically structured can be used to better target support as people age. The review also provides useful evidence in this regard, demonstrating that lack of support from employers and landlords hampers planning, as does inadequate housing provision and care services.

The changing legislative and regulatory environment is also found to further inhibit planning by contributing to uncertainty over the future. While uncertainty in later life is inherent, a lack of financial and other resources renders some people less able than others to respond to it. The situation regarding lack of financial resources appears to be particularly acute in the UK, which was the focus of this review. The relatively high rate of poverty among older people in the UK is evident in a report from the OECD, which attributes it mainly to the low level of the state pension (OECD, 2017). This puts in perspective policies such as auto-enrolment, which despite evidence of its positive effect on pensions contributions (Pensions Regulator, 2018), suffers from recognised drawbacks related to eligibility, coverage and adequacy (Silcock, Pike, & Adams, 2018). Another notable feature of auto-enrolment is that it circumvents the decision to plan, by changing the defaults, and therefore does not equate to 'planning' in the sense meant in this review.

Finally, this review lends further evidence to the claim that planning literature tends to conceive social actors in a very individualist manner (Street & Desai, 2011). It also expands the point by noting the absence in planning literature of the idea that planning can be carried out at a group or community level, despite evidence that this occurs in relation to age-friendly cities and co-housing (e.g., Brenton, 2013; Emlet & Moceri, 2012; Steels, 2015). Overall then, the evidence suggests that planning to improve the lives of older people should be seen not only as an individual endeavour but as one that requires coordinated action by national and local government, the private sector and civil society.

This in turn raises the question of what forms of planning and by whom are most likely to improve the wellbeing of older people. As discussed, evidence in this area is scarce but a recent systematic review (Barbosa et al., 2016) found that while retirement preparation by individuals was not among the strongest determinants of retirement adjustment (including wellbeing), physical and psychological health, and finances were. This implies that an emphasis on individual planning is perhaps misplaced. Health and wealth, it seems, make for better retirement. What is less clear is that individual, rather than governmental, planning is the best route to achieving

this. Certainly, the structural impediments to individual planning identified in this review suggest that there is great scope for governments, employers and landlords to do more to improve older people's wellbeing. But insofar as planning at the individual level has potential, one course of action this review suggests is to encourage individuals to identify existing aspects of their life at middle age which will serve them well as they age and take steps to develop or preserve these. This might include, for example, remaining in a convenient and friendly neighbourhood. Such an approach avoids what the literature suggests is the fatalism that arises from being aware of an issue but feeling powerless to do anything about it, and instead encourages people to set achievable goals.

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Conflict of Interests

The authors declare no conflict of interests.

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Article

Internalised Ageism and Self-Exclusion: Does Feeling Old and Health Pessimism Make Individuals Want to Retire Early?

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Abstract
An important current policy goal in many Western countries is for individuals to extend their working lives. Ageism has been identified as a possible threat to achieving this; furthermore, the ways in which ageism may affect this policy goal may have been underestimated. It has been claimed previously that ageism can be seen as discrimination against one's future self and that a lifetime of internalising age stereotypes makes older people themselves believe the age stereotypes. The current article uses the English Longitudinal Study of Ageing to assess the degree to which internalised ageism is related to one's preferred retirement age. For internalised ageism, assessments are made about the degree to which individuals consider themselves to be old; they agree that their age prevents them from undertaking activities; they are pessimistic about their own future health and that being old comes with deteriorating health more generally. Results show that health pessimism especially affects one's preferred retirement age negatively, even when controlling for current health and other factors, and mainly for middle-educated women. Implications are discussed.

Keywords
ageism; educational level; gender; health pessimism; internalised ageism; older worker; retirement; retirement age; stereotypes; UK

Issue
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1. Introduction

It has been claimed that workers need to extend their working lives, as increased population ageing will put pressure on the welfare state, lead to a larger dependency ratio (number of people considered to be dependent on employment-aged individuals), and therewith also (negatively) affect economic growth and productivity (cf. ILC-UK, 2017; Phillipson, 2018). Projections for the European Union have indicated that the percentage of people aged 65 and older will rise from 17% in 2010 to over 30% in 2060 (Walker & Maltby, 2012). Although assumptions behind this have been challenged (see, e.g., Phillipson, 2018), extending workers' working lives remains an important policy goal in many Western countries (see, e.g., Egdell, Maclean, Reaside, & Chen, 2018). Age discrimination has been identified as an important limitation to this policy goal, however (e.g., Loretto & White, 2006; Walker & Maltby, 2012; see also Posthuma & Campion, 2009). There are now several experimental studies suggesting that—at least for certain jobs—employers prefer younger workers (e.g., Ahmed, Andersson, & Hammarstedt, 2012; Riach & Rich, 2002).

Though it is important to understand how employers may block the extending working agenda, ageism may have a greater impact than (conscious or unconscious) age discrimination. According to the stereotype embodiment theory (Levy, 2009), individuals internalise stereotypes about older people, which may affect—among other things—their expectations and behaviour. Although Levy (2009) focuses on health consequences, it is likely that the effects will go beyond health expectations and behaviour. There are some early indications that it may also impact on an individual's retirement

expectations or preferences and behaviour, though research on this topic is scarce. For example, a recent qualitative study showed that some individuals appear to self-exclude from promotion opportunities, training, and paid work as a result of internalised ageism (Van der Horst, 2018). However, most research on internalised ageism of older workers and the possible consequences for retirement preferences, expectations or decisions are qualitative in nature, leading to questions about generalisability. Moreover, as will be explained, these relationships between internalised ageism and self-exclusion from the labour market will be different for subgroups of workers. This article will assess whether relationships are the same for men and women, and workers of various educational levels.

In the current article, I will quantitatively assess the relationship between internalised ageism and expected self-exclusion from the labour market in the English context. Age perception, health pessimism and the belief that (old) age limits activities are related to preferred retirement age using the English Longitudinal Study of Ageing (ELSA). A context-setting discussion of previous literature leads to an overview of the data and methods informing this study, followed by the results. These show that, when controlling for other factors such as actual health and finances, health pessimism appears to be (negatively) related to preferred retirement age, but mostly for middle-educated women. Finally, the article concludes by discussing the implications of these research findings.

2. Theoretical Background

2.1. Ageism

Ageism is defined as "a multi-dimensional concept, which incorporates ageist stereotypes (both positive and negative beliefs), prejudicial and stigmatising attitudes, and age-based discrimination" (Azulai, 2014, p. 3). Ageist stereotypes are in turn defined as a "simplified, undifferentiated portrayal of an age group that is often erroneous, unrepresentative of reality, and resistant to modification" (Schulz, Noelker, Rockwood, & Sprott, 2006, p. 43). Both employers and employees have a combination of positive and negative stereotypes about older workers. For example, employers perceive older workers as less adaptable to change, but at the same time as more loyal (Egdell et al., 2018; Loretto & White, 2006). Such stereotypes have been tested for accuracy and are usually found to not hold. For example, Ng and Feldman (2012, p. 821) assessed in a meta-analysis whether older workers are "(a) less motivated, (b) generally less willing to participate in training and career development, (c) more resistant and less willing to change, (d) less trusting, (e) less healthy, and (f) more vulnerable to work-family imbalance". They only found some evidence that older workers were less willing to participate in training and career development, though this may partly be due to the internalisation of ageism and self-exclusion based on stereotypes (see Sections 2.2 and 2.3). Even though a persistent stereotype about older workers is that they would be less healthy (see also Grendon, Inker, & Welleford, 2018), this was not supported by the meta-analysis.

2.2. Internalised Ageism

Individuals internalise stereotypes about older workers throughout their life course (Levy, 2009). When older, they actively distance themselves from being considered 'old' as they do not consider themselves to match the stereotypes (Minichiello, Browne, & Kendig, 2000). When individuals are not able 'to keep up', they may see this as an individual failure and a logical consequence of being older rather than a social issue. When individuals self-identify as being older, they may change their behaviour accordingly. As also recognised by at least some employers, individuals may not go for training because they feel they are 'too old' (Loretto & White, 2006). Internalised ageism has shown to have far-reaching consequences, such as worse health and well-being outcomes, and even an increased likelihood of (earlier) mortality (e.g., Levy, 2009; Swift, Abrams, Lamont, & Drury, 2017).

In this article, several statements are assessed. First, to what degree do individuals consider themselves to be old. This is considered a general evaluation of oneself against an internalisation of all (positive and negative) images of what it means to be 'old' (on subjective age for a similar argument that the degree to which one 'feels old' is internalised ageism see also Grendon et al., 2018). Second, to what degree do individuals agree that their age prevents them from undertaking activities. This statement is typically used in the self-enumerated scale of quality of life (CASP-19) for the life domain 'control' (see, e.g., Wiggins, Netuveli, Hyde, Higgs, & Blane, 2008). However, this statement can also be a manifestation of both age discrimination (individuals being blocked from certain activities due to their age) as well as considering oneself to be 'too old' for certain activities. Finally, an important age stereotype is that old age comes with reduced physical and mental health (see, e.g., Grendon et al., 2018). Therefore, the degree to which individuals are pessimistic about their own future health is assessed alongside whether they agree that being old comes with worse health more generally. This will be referred to more broadly as health pessimism (cf. Brown & Vickerstaff, 2011). Because I control for actual health (as well as other factors) this is considered health pessimism rather than a reflection of current health.

2.3. Self-Exclusion Based on Internalised Ageism

According to the 'socioeconomics' perspective, social norms are 'enforced' through internalisation. Where the 'rational choice' perspective indicates that individuals will be sanctioned for violating certain norms, the 'socioeconomics' perspective indicates that individuals in-

ternalise norms and use these to set their own goals (Radl, 2012; also see Etzioni, 2000). Hence, according to the 'rational choice' model, one may see individuals retire due to age discrimination while actually preferring to retire later, while according to the 'socioeconomics' perspective, individuals may *themselves* indicate that they want to retire earlier based on internalised norms (cf. Radl, 2012). When certain stereotypes (such as older people are in a reduced state of physical health) are considered a normal part of ageing, individuals will not challenge whether this is due to ageing and adapt their behaviour accordingly (see also the stereotype embodiment theory in Levy, 2009). For example, Minichiello et al. (2000) found in their (qualitative) paper that older people experiencing access issues considered this an individual problem that led individuals to disengage with certain activities, such as an individual who was having difficulty getting onto a bus stopped using it and considered this a logical consequence of getting older (Minichiello et al., 2000, pp. 262–263). In this article, I focus on retirement preferences. In relation to this, Maurer, Barbeite, Weiss and Lippstreu (2008) found that the (internalised) belief that older workers cannot and/or do not want to develop (anymore) was related to their retirement beliefs, that is, their belief that they "should retire due to a variety of reasons such as no longer being interested in changes, retirement just being most appropriate, no longer being interested in career", etc. (Maurer et al., 2008, p. 404).

The following hypotheses follow:

- H1a: Believing that age limits activities is negatively related to one's preferred retirement age.
- H1b: Perceiving oneself to be old is negatively related to one's preferred retirement age.

Van der Horst (2018) found in her qualitative UK study on internalised ageism and self-exclusion from the labour market that respondents had internalised the physical decline narrative of ageing. Pond, Stephens and Alpass (2010) speak in this respect about "maximisation of life": wanting to retire while still healthy in order to be able to fulfil other life goals "with the intention of maximising their enjoyment of their remaining years of good health" (Pond et al., 2010, p. 533). This seems to be at least partly based—according to their qualitative study in New Zealand—on the presumption of older age coming with worsened health (Pond et al., 2010). Brown and Vickerstaff (2011) refer to this as "health pessimism" and indicate that this may be an important factor as to why individuals exit paid work. Where Brown and Vickerstaff (2011) also discuss how the interplay between individual experiences and social structures affect health pessimism, the current article focuses on the consequences of health pessimism on retirement preferences:

- H2: Health pessimism is negatively related to one's preferred retirement age.

2.4. Gender, Education, and Self-Exclusion Based on Internalised Ageism

Social norms regarding what types of behaviours and attitudes are appropriate for older workers will not be uniform, instead differing between groups of workers. For example, research has demonstrated how gender and social class influence perceptions about when an individual should retire (Radl, 2012). Related to gender, Van der Horst, Lain, Vickerstaff, Clark and Geiger (2017) showed that gender roles affect older workers' employment patterns. The impact of gender roles, thus, is not limited to younger workers. O'Connor, Orloff and Shaver (1999) identified the UK as a "modified male breadwinner/female caregiver" society, with women working part-time while combining paid work with care responsibilities and men working full-time as main breadwinners. Loretto and Vickerstaff (2013) found that this affects the point at which women wanted to retire; gender roles had limited women to jobs with fewer opportunities, therefore retirement became an escape from a job they did not like. More directly related to the impact of internalised ageism on preferred retirement age: ageism is gendered (e.g., Jyrkinen & McKie, 2012), women in the workplace are considered 'old' at younger ages than men (Duncan & Loretto, 2004) and women are expected to retire at younger ages than men (Radl, 2012). This makes it likely that the way in which internalised ageism relates to self-exclusion from the labour market differs between men and women. Based on this, we would expect the relationships to be more pronounced among women than among men. However, it should be noted that not all studies found gender differences in experienced ageism (see, e.g., Palmore, 2001).

A second distinction made in this article is the educational level. It is known that individuals with a higher educational level are more likely to be employed at older ages (Bjursell, Nystedt, Björklund, & Sternäng, 2017). Social norms regarding when an individual should retire are, however, also dependent on social class (Radl, 2012). This suggests that the ageism that individuals will experience and internalise is likely to depend on social class and educational level, with age norms mattering less for individuals with higher levels of education. Palmore (2001) found that individuals with less education appeared to experience more ageism than individuals with more education. Based on this, we may expect that the consequences of ageism may be more pronounced for lesser educated individuals. However, people with lower levels of education may be more dependent on their state pension and may not have the financial option to stop working earlier regardless of whether or not they *want* to be in employment (Lain, Van der Horst, & Vickerstaff, in press). Hence, patterns may be clearest among middle-educational level respondents who may have more options available concerning when to retire and experience more ageism than higher educated individuals.

3. Data

This article considered wave 7 (2014/2015) and 8 (2016/2017) of ELSA (Marmot et al., 2018). Earlier waves are excluded as the (internalised) ageism variables are not frequently asked in ELSA. As the situation in 2004/2005 (wave 2; last time all used questions were included) may have been very different (e.g., before the recent economic crisis of 2009), I focussed on the last two waves only. I selected core members (also excluding proxy interviews) aged 50 to 70 in wave 7. I also only included employed individuals in wave 7. For employment status, respondents could indicate which of a list best described their current situation. Respondents were then asked which activities they performed. The options respondents could choose from included paid work and self-employment (individuals in self-employment were excluded). If they indicated they did neither, they were asked whether they were temporarily away from work, looking for work, or waiting for work that had already been accepted. If the respondent indicated they were temporarily away from work or waiting for work that had already been accepted, they are considered as being employed. Based on the selections made, and excluding missing data, 1,067 respondents were left, of whom 53% were female. The consequences of listwise deletion of missing data are assessed in a robustness check.

4. Variables

In this article, one's *preferred retirement age* was used as a dependent variable. In the self-completion questionnaire, respondents were asked: "At what age would you like to retire?"

Preferred retirement age is reasonably related to actual retirement and considered a better predictor of actual retirement ages than whether respondents are considering working after pension eligibility ages (Solem et al., 2016). Individuals could write in their desired retirement age or tick a box stating that they were already retired. For individuals writing in an age, individuals used ages anywhere between 0 and 120. However, less than 1% mentioned an age younger than 50 and less than 2% mentioned an age older than 90. I, therefore, recoded all ages mentioned younger than 50 to 50 and older than 90 as 90 and assessed the consequence of doing so in a robustness check.

The main independent variables are three types of age perceptions. For H1a, whether the respondent believes age limits activities is measured with the statement "My age prevents me from doing the things I would like to do", with answering options (1) often, (2) sometimes, (3) not often, and (4) never. This is reversed coded so that a higher score means more often perceiving that age prevents respondents from doing things they want to do. This variable is referred to as *age prevents*.

For H1b, whether the respondent considers him-/herself to be old is measured with the statement "I don't think of myself as old", with answering categories running from (1) strongly agree to (5) strongly disagree. Therefore, the higher the score, the more the respondents perceive themselves as being old. This variable is referred to as *thinks old*.

For H2, health pessimism is measured with two statements, "Old age is a time of ill health" and "I worry that my health will get worse as I grow older", both having the same answering categories as the previous variable. These variables were reverse coded so that a higher score meant more health pessimism. Although individuals may think about different ages when considering these health pessimism statements, this should not matter for the interpretation of the results if a relationship is found; the expectation that health will get worse (regardless of the age the respondent is thinking about) still affects current retirement preferences. "Old age is a time of ill health" is referred to as *old bad health* and "I worry that my health will get worse as I grow older" as *worry old health*.

The analyses are controlled for an individual's age (in years), self-reported health (5-point scale), whether the respondent has any long-standing illness, disability or infirmity (yes/no) and if so whether these limit activities (yes/no), which income quartile the respondent belongs to (based on the equivalised version of the total benefit unit income), whether the respondent works full-time (yes/no), and the respondent's educational level (no qualification/foreign/other = low; nvq 1–3 = middle; higher education below degree, or nvq 4–5 = high), and sex (female versus male).

Descriptive statistics are shown in Table 1. Here one can see that the preferred retirement age is about 65 years old in wave 8. Women prefer to retire about a year earlier than men and preferred retirement age is highest among lowest educated individuals, with smaller differences between middle and higher-educated individuals.

5. Method

OLS regression analyses are performed for the respondent's preferred retirement age in wave 8, given their age perceptions in wave 7, the benefit being that the independent variables are measured before the outcome variable. By using predictors from wave 7 and an outcome variable in wave 8 it is hoped that there is less of a case that causality may be reversed. In both cases, the analyses are done without control variables first, and then with control variables. Analyses are done on the full sample, men and women separately, and different educational levels separately. In the web appendix, one can find the analyses for preferred retirement age in wave 7. This is to check whether the time between the waves may be too long (2 years) to observe certain associations. All analyses make use of the bias-corrected and accelerated bootstrap confidence intervals that correct for bias and skewness in the data (Puth, Neuhäuser, & Ruxton, 2015). Analyses are performed on 5000 bootstrapped samples. All analyses are performed in Stata 15 (Statacorp, 2017).

Table 1. Descriptives.

	Total sample			Men only			Women only			Low education only			Middle education only			High education only		
Variables	*Mean*	*SD*	*Range*	*Mean*	*SD*	*Range*	*Mean*	*SD*	*Range*	*Mean*	*SD*	*Range*	*Mean*	*SD*	*Range*	*Mean*	*SD*	*Range*
Preferred retirement age w.7	63.94	4.74	50–90	64.59	4.83	50–90	63.38	4.59	50–90	64.64	5.32	50–90	63.67	4.27	50–90	63.71	5.80	50–90
Preferred retirement age w.8	65.07	5.75	50–90	65.71	5.75	50–90	64.48	5.69	50–90	66.07	6.75	50–90	64.45	4.79	55–90	64.98	5.80	50–90
Explanatory variables w.7																		
Thinks old	1.88	1.07	1–5	1.93	1.02	1–5	1.83	1.10	1–5	1.85	1.09	1–5	1.99	1.13	1–5	1.77	0.95	1–5
Old bad health	2.19	1.09	0–4	2.29	1.05	0–4	2.11	1.12	0–4	2.22	1.11	0–4	2.09	1.10	0–4	2.27	1.06	0–4
Worry old health	2.72	0.96	0–4	2.67	0.97	0–4	2.77	0.95	0–4	2.71	0.96	0–4	2.67	0.99	0–4	2.80	0.93	0–4
Age prevents	1.92	0.82	1–4	1.97	0.81	1–4	1.88	0.83	1–4	2.01	0.84	1–4	1.93	0.84	1–4	1.85	0.78	1–4
Control variables w.7																		
Self-rated health	3.54	0.98	1–5	3.55	0.97	1–5	3.53	0.98	1–5	3.36	0.93	1–5	3.49	1.00	1–5	3.73	0.94	1–5
Serious illness																		
No illness	0.44	—	Ref	0.48	—	Ref	0.41	—	Ref	0.39	—	Ref	0.39	—	Ref	0.52	—	Ref
Illness	0.39	—	0–1	0.38	—	0–1	0.40	—	0–1	0.43	—	0–1	0.41	—	0–1	0.35	—	0–1
Activity limiting illness	0.17	—	0–1	0.14	—	0–1	0.19	—	0–1	0.18	—	0–1	0.20	—	0–1	0.13	—	0–1
Income level																		
Income quartile 1 (lowest)	0.13	—	Ref	0.09	—	Ref	0.16	—	Ref	0.16	—	Ref	0.15	—	Ref	0.07	—	Ref
Income quartile 2	0.21	—	0–1	0.19	—	0–1	0.23	—	0–1	0.25	—	0–1	0.24	—	0–1	0.15	—	0–1
Income quartile 3	0.31	—	0–1	0.33	—	0–1	0.29	—	0–1	0.31	—	0–1	0.34	—	0–1	0.27	—	0–1
Income quartile 4 (highest)	0.36	—	0–1	0.39	—	0–1	0.32	—	0–1	0.28	—	0–1	0.27	—	0–1	0.51	—	0–1
Fulltime job (vs. part-time)	0.60	—	0–1	0.82	—	0–1	0.40	—	0–1	0.61	—	0–1	0.54	—	0–1	0.67	—	0–1
Age	59.18	4.53	50–70	59.55	4.54	50–70	58.86	4.50	50–70	60.14	4.49	50–70	58.51	4.61	50–69	59.19	4.34	51–70
Female (vs. male)	0.53	—	0–1	0	0	0	1	1	1	0.54	—	0–1	0.62	—	0–1	0.43	—	0–1
Educational level																		
Low education	0.27	—	Ref	0.27	—	Ref	0.27	—	Ref	1	1	1	0	0	0	0	0	0
Middle education	0.39	—	0–1	0.31	—	0–1	0.45	—	0–1	0	0	0	1	1	1	0	0	0
High education	0.34	—	0–1	0.42	—	0–1	0.28	—	0–1	0	0	0	0	0	0	1	1	1
$N_{\text{all variables wave 7}}$	1,067			497			570			284			415			368		
$N_{\text{expected retirement wave 8}}$	722			347			375			197			280			245		

6. Results

6.1. Without Controls

Table 2 shows the relationships between the main independent variables and preferred retirement age two years later. The most consistent relationship appears to be between health pessimism and preferred retirement age (in support for H2). When individuals believe that their health will be worse when they get older, they have a lower preferred retirement age. Looking at the point estimate for the total sample, individuals who strongly agree with this statement prefer to retire on average almost 6 years earlier than individuals who strongly disagree, holding the other variables constant. This relationship is also found when looking separately at men and women, and individuals with a low, middle, or high education.

For women only, the findings show that individuals who consider themselves old want to retire earlier (in support of H1b). Women who strongly disagree with the statement "I don't consider myself to be old" want to retire on average more than 4 years earlier than women who strongly agree with this statement, holding the other variables constant. Surprisingly, women who agree with the statement "My age prevents me from doing the things I would like to do" want to retire later than women who disagree with this statement (contradicting H1a).

Thus far, results from qualitative research indicating that health pessimism may negatively affect when individuals want to retire is confirmed. Also, it is found that more general age perceptions (such as perceiving oneself to be old) may be negatively related to when one wants to retire, but only for women. A large benefit of quantitative analyses is that one can see to what degree these relationships hold when controlling for other factors, such as one's actual current health.

6.2. With Controls

Worry that one's health will worsen with age remains negatively related to one's preferred retirement age, but only significantly for women (see Table 3). The effect has become less strong, but still, women who strongly agree with the statement prefer to retire on average about 3 years earlier than women who strongly disagree with the statement, holding all other variables constant. When separating it out by gender and educational level, this seems to be mainly driven by (low and) middle-educated women ($b_{women + low\ education} = -0.85$ [−2.85 ; 0.62], n = 99; $b_{women + mid\ education} = -0.88$ [−1.88 ; −0.33], n = 172; $b_{women + high\ education} = -0.17$ [−1.05 ; 0.57], n = 104). For men, this relationship was not significant and, if existent, most likely to exist among highly educated men ($b_{men + low\ education} = 0.04$ [−1.76 ; 1.22], n = 98; $b_{men + mid\ education} = -0.06$ [−0.80 ; 0.87], n = 108; $b_{men + high\ education} = -0.86$ [−2.42 ; 0.33], n = 141).

For middle-educated women, considering oneself to be old was also significantly and negatively related to preferred retirement age ($b_{women + low\ education} = -0.02$ [−1.25 ; 0.96], n = 99; $b_{women + mid\ education} = -0.43$ [−0.93 ; −0.03], n = 172; $b_{women + high\ education} = -0.04$ [−0.74 ; 0.67], n = 104). For men, the point estimate of the relationship is only negative for lowly educated men, not for middle and highly educated men ($b_{men + low\ education} = -0.18$ [−1.26 ; 1.02], n = 98; $b_{men + mid\ education} = 0.19$ [−0.61 ; 1.45], n = 108; $b_{men + high\ education} = 0.29$ [−0.65 ; 1.36], n = 141).

Thinking that "Old age is a time of ill health" (the more generalised form of health pessimism) and that "My age prevents me from doing the things I would like to do" were not significantly related to preferred retirement age in any of the models.

In sum, I have found no evidence for H1a: "Believing that (old) age limits activities is negatively related to one's preferred retirement age". In the analysis without controls, this relationship is, if existing, positive rather than negative, and this relationship disappears in the analysis with control variables. I have found some support for H1b: "Perceiving oneself to be old is negatively related to one's preferred retirement age". This relationship appears to exist for women only, and in the analysis with control variables, only for middle-educated women. This corresponds with my theoretical framework where it was argued that it is most likely to find the relationships for middle-educated individuals and women. Finally, most support is found for H2: "Health pessimism is negatively related to one's preferred retirement age". Specifically, the belief that one's own health will decrease when getting old is negatively related to one's preferred retirement age. This relationship appears to be (again) most pronounced for middle-educated women.

6.3. Robustness Checks

For the tables indicating the robustness checks, please see the Annex. First, I assessed the preferred retirement age in wave 7 instead of 8 to verify whether the two-year gap between the waves makes us miss relationships (i.e., is the two-year gap too long?). It could, for example, be that individuals have changed their opinion regarding the statement that old age is a time of ill health (e.g., because a friend or relative got seriously ill) within the two-year timeframe and that the respondent has also changed his or her preferred retirement age because of this. In general, it does not appear to be the case that important relationships are missed by the modelling strategy. Worrying that one's health will get worse when the respondent is older is still the statement most clearly related to one's preferred retirement age. In wave 7, I find one additional relationship for the full sample; *age prevents* is positively related to preferred retirement age. When splitting out by educational level, this appears to be driven by middle-educated individuals (see Table A1 in the Annex). When control variables are added, there are also some small differences in the findings. In wave 7, *thinks old* is negatively related to preferred retirement age for women

Table 2. Regression preferred retirement age wave 8, without controls.

	Total sample			Men only			Women only			Low education only			Middle education only			High education only		
Variables	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*
Thinks old	–0.32	–0.69	0.16	0.31	–0.31	1.11	**–0.84**	**–1.28**	**–0.43**	–0.40	–1.17	0.38	–0.48	–1.00	0.34	0.11	–0.64	0.89
Old bad health	0.14	–0.32	0.58	–0.00	–0.77	0.57	0.15	–0.41	0.77	0.31	–0.64	1.31	0.03	–0.70	0.59	–0.05	–0.90	0.60
Worry old health	**–1.15**	**–1.71**	**–0.67**	**–1.13**	**–1.96**	**–0.42**	**–1.01**	**–1.78**	**–0.39**	**–1.59**	**–2.90**	**–0.59**	**–0.90**	**–1.62**	**–0.34**	**–1.13**	**–2.36**	**–0.23**
Age prevents	0.44	–0.09	0.96	0.07	–0.77	0.86	**0.73**	**0.04**	**1.47**	0.00	–1.10	1.19	0.55	–0.14	1.26	0.63	–0.25	1.55
Constant	67.62	66.08	69.67	67.98	65.61	71.23	67.11	65.13	69.56	70.40	66.84	74.74	66.65	64.54	69.44	66.89	64.19	70.76
R^2	0.03			0.04			0.05			0.05			0.05			0.03		
N	722			347			375			197			280			245		

Notes: Confidence intervals are bias-corrected and accelerated confidence intervals, based on 5000 bootstrapped samples; LL = Lower Limit; UL = Upper Limit.

Table 3. Regression preferred retirement age wave 8, with controls.

	Total sample			Men only			Women only			Low education only			Middle education only			High education only		
Variables (wave 7)	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*
Thinks old	–0.10	–0.39	0.24	0.09	–0.42	0.68	–0.24	–0.61	0.11	–0.19	–0.90	0.51	–0.23	–0.62	0.32	0.10	–0.41	0.71
Old bad health	–0.00	–0.35	0.34	–0.18	–0.74	0.28	0.13	–0.31	0.61	0.37	–0.41	1.24	–0.09	–0.67	0.37	–0.31	–0.94	0.22
Worry old health	**–0.41**	**–0.86**	**–0.01**	–0.21	–0.95	0.38	**–0.60**	**–1.29**	**–0.14**	–0.33	–1.63	0.62	–0.47	–1.05	0.01	–0.47	–1.42	0.18
Age prevents	–0.10	–0.55	0.31	–0.24	–0.94	0.39	0.04	–0.54	0.66	**–0.94**	**–1.95**	**–0.05**	0.25	–0.33	0.87	0.37	–0.29	1.14
Self–rated health	0.17	–0.26	0.65	0.42	–0.23	1.19	0.00	–0.61	0.65	0.47	–0.52	1.77	–0.33	–0.94	0.34	0.40	–0.21	1.14
No illness (ref)																		
Illness	0.44	–0.30	1.34	–0.01	–1.08	1.07	0.87	–0.26	2.29	1.23	–0.23	3.27	0.42	–0.62	1.97	–0.22	–1.55	1.13
Activity limiting illness	–1.03	–2.08	0.15	0.13	–1.53	2.28	**–1.97**	**–3.36**	**–0.75**	–1.40	–3.94	1.80	**–1.40**	**–2.83**	**–0.10**	–1.49	–3.30	0.09
Income quartile 1 (lowest) (ref)																		
Income quartile 2	–0.06	–1.32	1.11	0.49	–1.29	2.41	–0.54	–2.43	0.92	1.08	–1.53	3.28	**–1.74**	**–3.68**	**–0.39**	1.25	–0.77	3.58
Income quartile 3	–0.09	–1.37	1.04	–0.10	–1.77	1.53	0.14	–1.73	1.66	0.56	–2.22	2.96	–1.17	–2.93	0.41	0.81	–1.15	2.43
Income quartile 4 (highest)	–0.77	–2.02	0.38	–0.41	–2.06	1.25	–1.11	–3.00	0.46	–0.50	–3.23	2.17	**–2.05**	**–3.93**	**–0.77**	0.56	–1.47	2.34
Fulltime job (vs. part–time)	–0.41	–1.34	0.39	–1.58	–3.92	0.14	0.12	–0.92	0.98	0.33	–1.95	2.44	–0.58	–1.86	0.36	–0.85	–2.98	0.49
Age	**0.79**	**0.69**	**0.89**	**0.75**	**0.63**	**0.89**	**0.79**	**0.65**	**0.92**	**0.92**	**0.71**	**1.16**	**0.61**	**0.51**	**0.75**	**0.88**	**0.69**	**1.05**
Female (vs. male)	–0.72	–1.49	0.02	—	—	—	—	—	—	–0.08	–1.81	1.90	**–1.29**	**–2.65**	**–0.32**	–0.77	–1.92	0.37
Low education (ref)																		
Middle education	–0.51	–1.47	0.32	–0.44	–1.82	0.79	–0.70	–2.04	0.45	—	—	—	—	—	—	—	—	—
High education	–0.59	–1.57	0.37	–0.59	–1.98	0.66	–0.67	–2.11	0.73	—	—	—	—	—	—	—	—	—
Constant	21.33	14.81	27.61	23.24	14.28	31.06	21.42	12.51	30.13	11.58	–5.34	25.17	34.19	26.60	41.14	13.76	2.72	25.52
R^2	0.40			0.40			0.41			0.38			0.41			0.48		
N	722			347			375			197			280			245		

Notes: Confidence intervals are bias-corrected and accelerated confidence intervals, based on 5000 bootstrapped samples; LL = Lower Limit; UL = Upper Limit.

while in wave 8 it is not, but the point estimate is −0.28 in wave 7 and −0,23 in wave 8, not suggesting a large difference. Similarly, in wave 7 the coefficient is significant for the middle-educated, while it is not in wave 8, but the point estimate is actually larger in wave 8 (wave 7: −0.43; wave 8: −0.47). In wave 8 it is only significant for middle-educated women. Surprisingly, the coefficient of *worry old health* is less strong and not significant in wave 7 for women, while it is for wave 8 in the total sample and for women only. In wave 7, this is only significant for middle-education women (see Table A2).

Second, I assessed what happened if the preferred retirement age was not truncated. Without control variables, results were the same in terms of which relationships were significant (see Table A3). With control variables, the impact of middle-educated women increased, making the overall relationship of considering oneself to be old for women significant as well (which was not the case when truncated). However, when splitting the sample by educational level, it is still only significant for middle-educated women (see Table A4).

Finally, the missing data were imputed to see to what degree missing data affected the results. These intervals were calculated on each individual imputed dataset because bias-corrected and accelerated confidence intervals cannot be combined with multiple imputations. The combined results, as well as the times the corrected confidence intervals did not include zero, can be found in Table A5 in the Annex. Without control variables, *worry old health* was not significantly related to *preferred retirement age* in any of the imputed datasets for higher-educated only. The positive relationship between *age prevents* and *preferred retirement age* for women only was smaller and no longer significant. With control variables, *worry old health* was only significantly and negatively related to *preferred retirement age* in all imputed datasets for middle-educated women.

To conclude, the robustness checks show some differences with the main analyses. However, the following conclusions remain: most evidence appears to be for the relationship *worry old health* and *preferred retirement age*. This relationship is mostly found for middle-educated women. For lower or middle-educated women (but not higher-educated women) there also appears to be a (negative) relationship between considering oneself to be old and preferred retirement age. For men, there is less evidence that age perceptions affect the preferred retirement age.

7. Conclusion

Age discrimination is mentioned as possibly hindering the extending working lives agenda (see e.g., Loretto & White, 2006; Walker & Maltby, 2012). The impact of ageism may be larger than actively blocking individuals from certain jobs, however. It has been suggested that internalised ageism affects individuals' expectations and behaviours (Levy, 2009). This article assessed the degree to which considering oneself to be old, health pessimism, and agreeing that age prevents the respondent from doing the things they would like to do is related to their preferred retirement age two years later. It found that health pessimism is indeed related to a lower preferred retirement age. This corresponds with qualitative research on health pessimism (see, e.g., Brown & Vickerstaff, 2011; Pond et al., 2010). This may be because individuals want to "maximise their enjoyment of their remaining years of good health" and expect to be in worse health later on, therefore they want to retire now (Pond et al., 2010, p. 533). However, it may also be that work is physically very demanding meaning they cannot see how one could continue to work in older age (Lain et al., in press).

For women only, it was also found that considering oneself to be old was negatively related to the preferred retirement age. This is controlled for health pessimism. This suggests that it is not only about health. Other old age beliefs may therefore also affect women's retirement planning. This corresponds with the qualitative study of Van der Horst (2018) which showed that individuals had internalised various (positive and negative) views on what it means to be old and that this affected their retirement planning.

I did not find that believing that age limits activities negatively affected the preferred retirement age. Without control variables, this relationship was even positive. It may be that some individuals want to stop working, but their age and financial situation does not allow them to retire yet, leading them to agree that age limits activities and mention high preferred retirement ages. When controlling for age and other factors, this relationship then disappears. It is also unclear how individuals interpreted this question as it may be a measure of the quality of life, experienced age discrimination, and/or internalised views on what is age-appropriate (also see Section 2.2 on internalised ageism).

These findings underline the importance of using an intersectionality lens in the field of work (cf. Crenshaw, 1989; McBride, Hebson, & Holgate, 2015). Ageism will not be uniformly experienced by everyone of the same or similar age, nor will the consequences be the same. It relates, among others, to gender and educational level. For example, specifically regarding ageism and sexism, it has been claimed that:

> Women's experiences with ageism are often gendered, that women's experiences with sexism are often intertwined with age, and that these intersections occur even when individuals categorize their mistreatment in terms of a single system of inequality. (Harnois, 2015, p. 102)

In this article, the focus is on (internalised) ageism, but it is acknowledged that this will be experienced differently and will have different effects for various groups of older workers. With ageism being gendered (e.g., Duncan &

Loretto, 2004; Radl, 2012) and classed (e.g., Palmore, 2001; Radl, 2012), it was suggested that women and lower educated individuals were more likely to experience ageism. With lower educated people being more likely to be in a situation where they are financially dependent on their work in older age, it was suggested that middle-educated people would be especially affected by (internalised) age stereotypes. At the same time, women are expected to retire at younger ages than men (Radl, 2012), perhaps making it more acceptable for women than for men to exclude themselves from the labour market at earlier ages. These processes may occur at the same time, and relationships indeed appear to be most clear for middle-educated women. Future research should unpack these relationships further.

It should be noted that the current article assessed preferred retirement age and even though this is considered a predictor of actual retirement age, it is by no means a perfect predictor (see, e.g., Solem et al., 2016). Preferred retirement age is relevant in its own right as it shows when individuals (say they) want to retire, but it should be kept in mind that this does not mean that individuals will actually retire at this age. They may retire earlier or later based on a variety of factors, such as being made redundant, financial feasibility, and/or health shocks. Future research may want to wait until there are more waves of ELSA to assess when individuals will actually retire and relate this to internalised ageism. The current time availability (2 years) is considered too short to properly assess these relationships using these data. Further, although preferred retirement age does not have to be 'self-exclusion' but instead could, for example, be setting oneself free for pursuits outside of the workforce, it is assumed in this article that the degree to which it relates to age perceptions is likely to be related to self-exclusion. This interpretation also fits the 'socioeconomics' perspective and the stereotype embodiment theory described in the theoretical background and with qualitative literature indicating that these perceptions may relate to excluding oneself from certain situations (see, e.g., Minichiello et al., 2000; Pond et al., 2010). Nevertheless, it is important to study this mechanism in greater detail in further research.

The sample studied in this article may be biased as it only contains 'survivors' in the labour market. To be included in the sample, they needed to be in paid labour. Individuals who already exited the labour market were not included. This could lead to an underestimation of the effect of internalised ageism on preferred retirement age as individuals most affected may have already left the labour market. Future research may want to assess this further.

Future research should also assess various pathways in which these relationships could work. For example, now, models are controlled for health. However, Levy (2009) shows that internalised ageism also affects health expectations and behaviour and may have health consequences. I may be underestimating the effect of internalised ageism on preferred retirement age in the controlled model if health is a mediator rather than a control variable. These relationships should be teased out further in future research.

It would be useful, based on the claim that age stereotypes differ for various groups of workers (cf. Radl, 2012), if future research assessed the specific stereotypes in various jobs, the retirement preferences associated with these stereotypes, and the relationship between internalised ageism and preferred retirement age as well as retirement behaviour within these jobs. This would give a more detailed view of how internalised ageism relates to self-exclusion from the labour market. This would also help assess to what degree the differences between men and women and educational levels are due to actual gendered and classed ageism, or due to vertical and horizontal segregation on the labour market. Moreover, other intersections with age should be theorised and explored as well, such as based on ethnicity and/or disability (cf. McBride et al., 2015).

Despite these limitations and suggestions for future research, it is important to realise that the impact of ageism on labour market behaviour may go beyond discrimination alone. Circumventing ageist stereotypes may, therefore, be important to stimulate older workers to extend their working lives. It would also help if companies are more inclusive for individuals with various (dis)abilities. This is not to say that individuals should always continue working (see also Lain et al., in press), but if individuals would see that working with disabilities is a genuine option, they may be more likely to want to continue working regardless of their (future) (possible) disabilities. However, this may also involve addressing (dis)ableism more generally, because if the main reason individuals are affected by health pessimism is that they want to enjoy the remaining years of good health and, thus, assume that having less good health means one cannot enjoy oneself, 'just' having more inclusive workplaces will not be enough.

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Conflict of Interests

The author declares no conflict of interests.

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Annex

Table A1. Preferred retirement age wave 7.

	Total sample			Men only			Women only			Low education only			Middle education only			High education only		
Variables	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*
Thinks old	–0.28	–0.56	0.03	0.12	–0.26	0.74	**–0.63**	**–0.97**	**–0.32**	–0.30	–0.91	0.20	–0.38	–0.77	0.26	–0.14	–0.61	0.32
Old bad health	0.15	–0.15	0.43	0.32	–0.19	0.75	–0.09	–0.44	0.27	0.29	–0.21	0.80	–0.06	–0.58	0.38	0.26	–0.21	0.80
Worry old health	**–0.70**	**–1.02**	**–0.39**	**–0.62**	**–1.10**	**–0.14**	**–0.67**	**–1.07**	**–0.25**	**–0.91**	**–1.54**	**–0.24**	**–0.56**	**–0.98**	**–0.17**	**–0.70**	**–1.34**	**–0.04**
Age prevents	**0.41**	**0.05**	**0.79**	0.03	–0.54	0.55	**0.71**	**0.21**	**1.23**	–0.16	–0.95	0.56	**0.76**	**0.25**	**1.26**	0.38	–0.37	1.03
Constant	65.27	64.26	66.28	65.20	63.56	66.69	65.23	63.96	66.54	67.35	65.49	69.73	64.58	63.18	65.91	64.60	62.67	66.53
R^2	0.02			0.01			0.05			0.03			0.04			0.02		
N	1,067			497			570			284			415			368		

Notes: Confidence intervals are bias-corrected and accelerated confidence intervals, based on 5000 bootstrapped samples; LL = Lower Limit; UL = Upper Limit; also separated by gender within education groups: Low education: for men (n = 132), *worry old health* is significant (b_{men} = −0.88 [−1.77 ; −0.06]) but for women (n = 152) it is not, and the confidence interval is also clearly larger for women than for men (b_{women} = −0.67 [−1.69 ; 0.52]). However, the point estimate is in same direction and less different; Middle education: for men (n = 156) none of the relationships are significant; for women (n = 259) *thinks old* (b_{women} = −0.86 [−1.27 ; −0.48]; b_{men} = 0.42 [−0.30 ; 2.01]) and worry old health (b_{women} = −0.75 [−1.24 ; −0.26]; b_{men} = −0.38 [−1.12 ; 0.33]) are significantly and negatively related to preferred retirement age. For *thinks old* there is a clear difference between men and women; for *worry old health* less so. Surprisingly, *age prevents* is significantly and positively related to preferred retirement age (b_{women} = 0.81 [0.23 ; 1.44] b_{men} = 0.76 [−0.21 ; 1.65]). The point estimate is quite similar for men, but not significant due to a larger BCa confidence interval; High education: For men (n = 209) and women (n = 159) none of the relationships are significant.

Table A2. Preferred retirement age wave 7.

	Total sample			Men only			Women only			Low education only			Middle education only			High education only		
Variables	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*
Thinks old	–0.13	–0.37	0.12	0.08	–0.25	0.54	**–0.28**	**–0.64**	**–0.00**	–0.10	–0.74	0.40	–0.17	–0.48	0.29	–0.15	–0.51	0.22
Old bad health	0.12	–0.12	0.35	0.21	–0.20	0.57	0.06	–0.24	0.35	0.38	–0.09	0.89	–0.07	–0.52	0.32	0.22	–0.15	0.61
Worry old health	**–0.26**	**–0.52**	**–0.00**	–0.16	–0.54	0.28	–0.32	–0.64	0.02	–0.00	–0.57	0.59	**–0.43**	**–0.78**	**–0.06**	–0.28	–0.72	0.21
Age prevents	–0.13	–0.44	0.18	–0.35	–0.82	0.10	–0.01	–0.41	0.39	**–0.88**	**–1.56**	**–0.28**	0.41	–0.05	0.85	–0.18	–0.81	0.39
Self-rated health	0.10	–0.20	0.43	0.12	–0.34	0.69	0.11	–0.24	0.50	**0.77**	**0.15**	**1.56**	–0.17	–0.63	0.43	–0.04	–0.51	0.38
No illness (ref)																		
Illness	0.45	–0.13	1.12	0.87	–0.05	1.71	0.15	–0.67	1.06	0.43	–0.62	1.44	**1.03**	**0.08**	**2.30**	0.01	–0.98	1.08
Activity limiting illness	–0.58	–1.30	0.13	–0.18	–1.22	0.90	–0.83	–1.86	0.09	–1.05	–2.53	0.45	–1.01	–2.25	0.05	–0.02	–1.16	1.04
Income quartile 1 (lowest) (ref)																		
Income quartile 2	–0.04	–0.90	0.80	0.42	–0.90	2.01	–0.36	–1.54	0.65	0.06	–1.52	1.41	–0.32	–1.89	0.96	0.57	–0.99	2.09
Income quartile 3	0.10	–0.79	0.89	0.17	–1.03	1.57	0.04	–1.13	1.08	0.78	–0.67	2.34	–0.58	–1.97	0.69	0.68	–0.57	1.92
Income quartile 4 (highest)	–0.42	–1.31	0.39	–0.36	–1.56	1.00	–0.53	–1.72	0.42	0.23	–1.13	1.68	–0.95	–2.45	0.30	0.13	–1.13	1.37
Fulltime job (vs part-time)	–0.36	–0.89	0.18	–0.28	–1.37	0.69	–0.36	–0.95	0.24	–0.56	–1.77	0.73	–0.54	–1.38	0.21	0.16	–0.66	1.01
Age	**0.59**	**0.53**	**0.66**	**0.57**	**0.48**	**0.68**	**0.60**	**0.52**	**0.68**	**0.69**	**0.56**	**0.84**	**0.46**	**0.39**	**0.56**	**0.69**	**0.58**	**0.82**
Female (vs male)	**–1.00**	**–1.52**	**–0.48**	—	—	—	—	—	—	–1.18	–2.34	0.09	–0.62	–1.51	0.23	**–1.16**	**–1.98**	**–0.39**
Low education (ref)																		
Middle education	0.06	–0.58	0.68	–0.47	–1.49	0.42	0.35	–0.47	1.27	—	—	—	—	—	—	—	—	—
High education	–0.40	–1.08	0.26	–0.24	–1.31	0.63	–0.60	–1.51	0.29	—	—	—	—	—	—	—	—	—
Constant	30.49	25.94	34.66	30.62	23.25	37.14	29.74	24.11	35.09	22.49	11.91	31.83	38.94	33.43	44.17	23.92	15.96	31.53
R^2	0.36			0.32			0.38			0.37			0.32			0.45		
N	1,067			497			570			284			415			368		

Notes: Confidence intervals are bias-corrected and accelerated confidence intervals, based on 5000 bootstrapped samples; LL = Lower Limit; UL = Upper Limit; also separated by gender within education groups: Low education: for men (n = 132, $n_{bootstrap}$ = 5,000) none of the relationships are significant; for women (n = 152, $n_{bootstrap}$ = 5,000), *age prevents* is significantly and negatively related to preferred retirement age (b_{women} = −1.13 [−2.18 ; −0.32]; b_{men} = −0.73 [−1.45 ; 0.09]). Relationship seems to be somewhat stronger for women than men, but for men also negative relationship and only just insignificant; Middle education: For men (n = 156; $n_{bootstrap}$ = 5,000) none of the relationships are significant; for women (n = 259, $n_{bootstrap}$ = 5,000), *thinks old* (b_{women} = −0.41 [−0.74 ; −0.10]; b_{men} = 0.32 [−0.38 ; 1.48]) and *worry old health* (b_{women} = −0.60 [−1.01 ; −0.18]; b_{men} = −0.19 [−0.86 ; 0.43]) are both negatively related to age retirement. *Thinks old* point estimate for men is positive, for *worry old health* it is negative, but less strong than for women; High education: For men (n = 209; $n_{bootstrap}$ = 5,000) *age prevents* is significantly and negatively related to preferred retirement age; for women (b = 159; $n_{bootstrap}$ = 5,000) it is not (b_{women} = 0.49 [−0.25 ; 1.22] ; b_{men} = −0.85 [−1.76 ; −0.14]). This relationship seems to only exist for men.

Table A3. Preferred retirement age wave 8 (not truncated/no control variables).

	Total sample			Men only			Women only			Low education only			Middle education only			High education only		
Variables	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*
Thinks old	–0.62	–1.29	0.05	0.24	–0.72	1.45	**–1.33**	**–2.38**	**–0.69**	–1.14	–2.96	0.12	–0.61	–1.37	0.54	0.10	–1.02	1.05
Old bad health	0.06	–0.69	0.79	–0.11	–1.27	0.72	0.06	–0.97	1.21	0.29	–1.38	2.41	–0.13	–1.16	0.60	–0.17	–1.68	0.85
Worry old health	**–1.59**	**–2.52**	**–0.88**	**–1.47**	**–2.80**	**–0.52**	**–1.54**	**–3.13**	**–0.55**	**–2.52**	**–4.86**	**–0.94**	**–1.16**	**–2.77**	**–0.45**	**–1.48**	**–3.64**	**–0.20**
Age prevents	0.58	–0.26	1.50	–0.19	–1.55	0.98	**1.20**	**0.15**	**2.64**	0.40	–1.68	2.75	0.55	–0.33	1.59	0.59	–0.89	1.70
Constant	69.94	69.46	73.60	70.39	66.68	77.03	69.39	66.37	74.59	74.46	68.52	83.04	68.26	65.28	74.30	68.91	64.95	77.14
R^2	0.03			0.03			0.04			0.04			0.04			0.02		
N	722			347			375			197			280			245		

Notes: Confidence intervals are bias-corrected and accelerated confidence intervals, based on 5000 bootstrapped samples; LL = Lower Limit; UL = Upper Limit; also separated by gender within education groups: Low education: For men (n = 98, $n_{bootstrap}$ = 5,000), none of the relationships are significant; for women, (n = 99, $n_{bootstrap}$ = 5,000) *thinks old* (women: b = –2.05 [–5.92 ; –0.28]; men: b = –0.06 [–1.68 ; 1.81]) and *worry old health* (women: b = –3.81 [–9.35 ; –0.91]; men: b = –1.46 [–4.26 ; 0.03]) are negatively related to preferred retirement age. For *thinks old* the relationship appears to exist only for women. *Worry old health* appears to be stronger for women than men, but is only just insignificant for men as well; Middle education: For men (n = 108, $n_{bootstrap}$ = 5,000) none of the relationships are significant; for women (n = 172, $n_{bootstrap}$ = 5,000) *thinks old* (women: b = –1.22 [–2.31 ; –0.62]; men: b = 0.53 [–0.94 ; 3.51]) and *worry old health* (women: b = –1.61 [–4.58 ; –0.52]; men: b = –0.39 [–1.30 ; 0.92]) are negatively related to preferred retirement age; High education: For men (n = 141, $n_{bootstrap}$ = 5,000) *worry old health* is negatively related to preferred retirement age; for women (n = 104, $n_{bootstrap}$ = 5,000) not (women: b = –0.35 [–1.48 ; 0.95]; men: b = –2.55 [–6.09 ; –0.29]). So this appears to be opposite compared to low and middle educ.

Table A4. Preferred retirement age wave 8 (not truncated).

	Total sample			Men only			Women only			Low education only			Middle education only			High education only		
Variables	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*	*b*	*LL*	*UL*
Thinks old	–0.32	–0.92	0.22	–0.04	–0.95	0.86	**–0.60**	**–1.66**	**–0.03**	–0.83	–2.68	0.39	–0.34	–1.02	0.45	0.08	–0.77	0.88
Old bad health	–0.09	–0.72	0.53	–0.29	–1.16	0.44	0.09	–0.74	1.08	0.45	–1.01	2.27	–0.25	–1.18	0.43	–0.48	–1.71	0.47
Worry old health	**–0.65**	**–1.49**	**–0.00**	–0.34	–1.60	0.54	**–1.02**	**–2.39**	**–0.16**	–0.87	–3.09	0.81	–0.60	–1.95	0.04	–0.69	–2.38	0.45
Age prevents	–0.01	–0.80	0.82	–0.57	–1.76	0.44	0.56	–0.60	2.02	–0.82	–2.89	1.02	0.31	–0.48	1.38	0.38	–0.82	1.47
Self-rated health	0.55	–0.22	1.39	0.59	–0.44	1.71	0.64	–0.54	2.02	0.86	–1.06	2.98	0.09	–0.83	1.40	0.66	–0.18	1.78
No illness (ref)																		
Illness	0.88	–0.49	2.74	–0.07	–1.68	1.97	1.79	–0.49	5.13	2.80	–0.34	7.42	0.80	–0.73	4.32	–0.49	–2.69	2.16
Activity limiting illness	–1.55	–3.46	0.18	0.05	–2.97	3.11	**–2.96**	**–6.13**	**–1.05**	–3.14	–8.32	1.47	–1.56	–4.13	0.12	**–2.30**	**–6.49**	**–0.12**
Income quartile 1 (lowest) (ref)																		
Income quartile 2	–0.27	–2.74	1.59	1.15	–1.23	4.29	–1.40	–5.07	1.06	0.59	–4.91	4.13	**–2.53**	**–6.49**	**–0.67**	2.25	–0.55	6.31
Income quartile 3	0.08	–2.30	1.98	0.66	–1.45	3.43	0.20	–3.37	3.07	0.05	–6.12	4.51	–0.90	–4.20	1.87	1.47	–0.78	4.38
Income quartile 4 (highest)	–0.90	–3.53	1.09	0.65	–1.54	3.44	–2.35	–6.65	0.45	–1.21	–7.67	3.91	**–2.69**	**–6.65**	**–0.83**	1.47	–0.89	4.76
Fulltime job (vs part-time)	–1.30	–3.32	0.35	**–4.17**	**–9.42**	**–0.57**	–0.00	–1.97	1.85	0.57	–4.30	5.22	–1.40	–4.04	0.01	**–2.90**	**–7.69**	**–0.32**
Age	**0.98**	**0.81**	**1.22**	**0.91**	**0.71**	**1.21**	**0.97**	**0.71**	**1.30**	**1.28**	**0.87**	**1.85**	**0.71**	**0.55**	**0.97**	**1.05**	**0.69**	**1.46**
Female (vs male)	–0.90	–2.45	0.50	—	—	—	—	—	—	0.59	–2.97	4.85	**–1.72**	**–4.41**	**–0.29**	–1.46	–3.81	0.66
Low education (ref)																		
Middle education	–0.93	–2.60	0.76	–0.72	–2.98	1.19	–1.36	–4.21	1.08	—	—	—	—	—	—	—	—	—
High education	–0.82	–2.62	1.07	–0.84	–3.22	1.06	–0.85	–3.96	2.33	—	—	—	—	—	—	—	—	—
Constant	11.04	–3.15	21.50	16.88	0.13	29.96	10.74	–9.43	26.82	–8.56	–46.18	18.40	29.26	15.35	38.33	5.26	–17.36	27.08
R^2	0.25			0.30			0.24			0.24			0.27			0.32		
N	722			347			375			197			280			245		

Notes: Confidence intervals are bias-corrected and accelerated confidence intervals, based on 5000 bootstrapped samples; LL = Lower Limit; UL = Upper Limit; also separated by gender within education groups: Low education: For men (n = 98, $n_{boostrap}$ = 4,999) and women (n = 99, $n_{bootstrap}$ = 5,000) none of the relationships are significant. Middle education: For men (n = 108, $n_{bootstrap}$ = 5,000) none of the relationships are significant; for women (n = 172, $n_{bootstrap}$ = 5,000) *thinks old* (women: b = –0.65 [–1.62 ; –0.13]; men: b = 0.18 [–0.98 ; 2.04]) and *worry old health* (women b = –1.21 [–3.71 ; –0.38]; men: b = 0.16 [–0.75 ; 1.67]) are negatively and significantly related to preferred retirement age. These negative associations only seem to exist for women (point estimate is positive for men). High education: For men (n = 141, $n_{bootstrap}$ = 5,000) and women (n = 104; $n_{bootstrap}$ = 4,988) none of the relationships are significant.

Table A5. Preferred retirement age wave 8 (multiple imputation).

	Total sample			Men only			Women only			Low education only			Middle education only			High education only		
Variables	*b*	*p*	*# sig*	*b*	*p*	*# sig*	*b*	*p*	*# sig*	*b*	*p*	*# sig*	*b*	*p*	*# sig*	*b*	*p*	*# sig*
Without controls																		
Thinks old	–0.21	.199	0	0.19	.496	0	**–0.52**	**.008**	**5**	–0.40	.166	0	–0.22	.346	0	–0.01	.965	0
Old bad health	0.03	.880	0	0.02	.936	0	–0.04	.871	0	0.16	.660	0	–0.04	.878	0	–0.07	.827	0
Worry old health	**–0.58**	**.005**	**5**	**–0.60**	**.047**	**4**	***–0.47***	***.065***	***3***	***–0.58***	***.187***	***2***	**–0.79**	**.012**	**5**	–0.38	.262	0
Age prevents	0.25	.239	0	0.10	.754	0	0.35	.214	0	–0.36	.375	0	***0.51***	***.119***	***1***	0.40	.286	0
With controls																		
Thinks old	–0.04	.769	0	0.19	.427	0	–0.19	.219	0	–0.30	.205	0	0.01	.978	0	0.09	.733	0
Old bad health	0.03	.829	0	–0.03	.888	0	0.10	.601	0	0.33	.265	0	–0.09	.661	0	–0.15	.558	0
Worry old health	–0.16	.353	0	–0.03	.900	0	***–0.28***	***.172***	***1***	–0.13	.716	0	**–0.36**	**.145**	**3**	–0.01	.972	0
Age prevents	–0.22	.212	0	–0.16	.548	0	–0.26	.252	0	**–0.84**	**.015**	**5**	0.04	.878	0	0.01	.966	0
N	1,149			530			619			323			441			385		

Notes: # Sig based on individual imputed datasets where confidence intervals are bias-corrected and accelerated confidence intervals, based on 5000 bootstrapped samples. Five imputed datasets in total. 62% of the cases did not have any missing data (after selections made). Constant and control variables not shown. Also separated by gender within education groups: NO CONTROLS: Low education: For men (n = 149), none of the relationships are significant in any of the imputed datasets; for women, (n = 174) *thinks old* (women: 5/5 imputed datasets significant) was negatively related to preferred retirement age; for men, the point estimate was positive in all models, suggesting that this relationship exists for women only. *Worry old health*—that was significant in 2/5 models when men and women were combined—was not significant in any of the models for men or women; Middle education: For men (n = 168), *worry old health* was negatively and significant related to preferred retirement age in 3/5 imputed datasets; for women (n = 273) this was the case in 4/5 imputed datasets. *Age prevents* was in none of the imputed datasets significant for either men or women; High education: For men (n = 213) and women (n = 172) none of the relationships are significant in any of the imputed datasets. WITH CONTROLS: Low education: For men (n = 149), *age prevents* was negatively related to preferred retirement age in 5/5 imputed datasets; for women, (n = 174) *age prevents* was only significantly negatively related to preferred retirement age in 1/5 imputed datasets; Middle education: For men (n = 168), none of the relationships are significant in any of the imputed datasets; for women (n = 273) *worry old health* was negatively related to preferred retirement age in 5/5 imputed datasets; High education: For men (n = 213) and women (n = 172) none of the relationships are significant in any of the imputed datasets.

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Article

Excluded from the Good Life? An Ethical Approach to Conceptions of Active Ageing

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Abstract
Contesting previous deficit-oriented models of ageing by focusing on the resources and potential of older people, concepts of 'successful', 'productive', and 'active ageing' permeate social policy discourses and agendas in ageing societies. They not only represent descriptive categories capturing the changing realities of later phases of life, but also involve positive visions and prescriptive claims regarding old age. However, the evaluative and normative content of these visions and claims is hardly ever explicitly acknowledged, let alone theoretically discussed and justified. Therefore, such conceptions of 'ageing well' have been criticised for promoting biased policies that privilege or simply impose particular practices and lifestyles. This appears problematic as it can obstruct or even effectively foreclose equal chances of leading a good life at old age. Against this backdrop, our contribution aims to discuss current conceptions of active ageing from an ethical point of view. Starting from an analysis of policy discourses and their critique, we first examine the moral implications of prominent conceptions of active ageing, focusing on evaluative and normative premises. By employing philosophical approaches, we analyse these premises in light of a eudemonistic ethics of good life at old age and detect fixations, shortcomings, and blind spots. Finally, we discuss consequences for ethically informed active ageing research and policies, highlighting the interrelations between one-sided ideals of ageing well and social discrimination and exclusion.

Keywords
active ageing; discourse; ethics; gerontology; good life; philosophy

Issue
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1. Introduction

On its website, the International Council on Active Aging ([ICAA], 2018) commits to "the conviction that people can significantly improve the quality of their later years by staying active and fully engaged in life". The network, with more than 10.000 members in 37 countries, has dedicated itself to the idea of active ageing and its public promotion and economic exploitation. Its mission statement declares that the ICAA aims "to dispel society's myths about aging" and "to empower aging Baby Boomers and older adults to improve their quality of life and maintain their dignity" (ICAA, 2018).

The example highlights central aspects of contemporary active ageing discourses. It first illustrates how the idea of active ageing permeates media, policy, and industry reasoning and communication in ageing societies. Furthermore, it shows that 'active ageing' not only represents a descriptive category capturing the changing realities of later phases of life. As the quotes make clear,

the concept challenges previous deficit-oriented models of ageing—"society's myths about aging"—and emphasises the resources and potential of older people. In doing so, positive visions and prescriptive claims regarding old age come into play, in this case, "quality of life" and "dignity".

However, the evaluative and normative content of such visions and claims is hardly ever acknowledged, let alone discussed and justified. They often simply seem to mirror the value system of the respective era, political agenda, or sociocultural context. Consequently, conceptions of active ageing have been criticised for promoting biased policies that privilege or impose particular practices and lifestyles (Timonen, 2016). In the context of modern pluralistic societies and liberal democracies, this appears problematic as it can obstruct or even foreclose equal chances of leading a good life at old age (e.g., for people with disabilities, chronic diseases, cognitive impairments, socio-cultural minorities, or socio-economically underprivileged groups).

Against this backdrop, our contribution aims to discuss conceptions of active ageing from an ethical point of view. We first provide an overview of contemporary policy discourses on active ageing. On this basis, we identify and examine the moral implications of prominent conceptions of active ageing and its critique, focusing on evaluative and normative premises regarding activity and lifestyle. In the next step, we employ philosophical approaches in order to analyse these premises in light of a eudemonistic ethics of good life at old age and detect fixations, shortcomings, and blind spots. Finally, we discuss consequences for ethically informed active ageing research and policies, highlighting the interrelations between one-sided ideals of ageing well and social discrimination and exclusion from the good life. As we will argue, introducing an ethical perspective can help strengthen the argumentative foundations of the debate by clarifying underlying values and norms.

2. Active Ageing and Its Discontents

Scientific discussions on active ageing started to boom at the beginning of the 2000s in response to the 2002 World Health Organization (WHO) strategy. The publication figures reached double-digits in 2004. While there were only 176 publications from 2000 to 2009, the number tripled to 481 from 2010 to 2018.[1] By now, the concept of active ageing has come into common usage not only in policy (Boudiny, 2013, p. 1078), but also in gerontology and social science (van Dyk, 2014, p. 94).

There are various views on the concept's origins. Boudiny (2013, p. 1077) traces it back to the activity theory of ageing in the 1960s. Contesting the contemporary disengagement theory, this approach assumed that staying active and keeping up social participation were preconditions of sustained health, quality of life, and social utility in old age. Moulaert and Biggs (2013) focus on the emergence of active ageing in international policy during the G7 and G8 Summits in the late 1990s but also acknowledge an "enduring presence" (Moulaert & Biggs, 2013, p. 26) in gerontology since the 1920s (see also Katz, 1996). Walker (2002) describes active ageing as a relatively new concept in politics, but sees its origins in the gerontological discourse on successful ageing (Rowe & Kahn, 1987), highlighting the idea of ageing successfully by maintaining values and activity patterns of middle adulthood (Havighurst, 1961; Havighurst & Albrecht, 1953).

There is also little agreement on the exact meaning of active ageing (Boudiny, 2013, p. 1078). The term does not stand for a discrete concept but is often intertwined with ideas of healthy, productive, or successful ageing (Boudiny, 2013, p. 1078; Katz, 2013; Walker, 2002, p. 122). In comparison to these related interpretations of ageing well, the discussion around active ageing is rather young and its popularity is fuelled by political rather than gerontological discourses (Walker, 2002, p. 122). Boudiny distinguishes three kinds of definitions: "unidimensional approaches" (Boudiny, 2013, p. 1079), "multidimensional approaches" (Boudiny, 2013, p. 1082), and approaches "transcending the behavioural level" (Boudiny, 2013, p. 1084). Unidimensional approaches focus on only one aspect, usually physical activity or employment. By contrast, multidimensional approaches also consider other dimensions of life such as social and leisure activities. Approaches transcending the behavioural level further widen the scope by including factors like autonomy, social support, economic circumstances, and especially health and independence.

The emergence of active ageing in international policy was widely welcomed by contemporary gerontology (Moulaert & Biggs, 2013, pp. 26–29). Thus, Walker (2002, p. 137) applauded the "beauty of this strategy [that is] good for everyone". However, active ageing and related concepts have also provoked criticism from critical gerontology and sociology of ageing. Besides objections regarding theoretical and empirical shortcomings, the most prominent line of critique focuses on moral and political concerns revolving around the problem of exclusion at the intersection of age and social inequality (Katz & Calasanti, 2015, p. 29). According to the critics, there are severe structural differences in the distribution of resources for successful and active ageing due to dimensions of social inequality (especially gender, race, ethnicity, class, and sexuality). The effects of this social inequality unfold over the entire course of a person's life and culminate in old age. Moreover, with advancing age, older people are also increasingly exposed to ageism and age discrimination. Thus, already existing discrimination is further aggravated (Katz & Calasanti, 2015, p. 296).

Against this backdrop, Ranzijn criticises active ageing as "another way to oppress marginalized and disadvantaged elders" (Ranzijn, 2010, p. 716) as the concept devalues their life experiences. He advocates alter-

[1] International Bibliography of the Social Sciences (IBSS), search: keyword in title or abstract.

native conceptions of ageing well that are more sensitive to the cultural diversity of ageing and promote social inclusion (Ranzijn, 2010, p. 716). In addition, Boudiny (2013, p. 1081) also addresses the levels of physical and socio-economic diversity. From this perspective, unidimensional approaches are often criticised for adhering to a reduced understanding of activity and neglecting non-economic contributions to society. Thus, they exclude those who no longer partake in paid work, who contribute to society in other ways, but also those who suffer from physical limitations as well as the old-old in the fourth age (Boudiny, 2013, pp. 1080–1081). Multidimensional approaches are also conceptualised without including the old-old as this group is associated with non-active leisure patterns and therefore stigmatised. Approaches transcending the behavioural level still exclude the oldest-old and have a tendency to hypostasise health. As a result, they are often not clearly distinguished from healthy ageing concepts which focus on maintaining and improving the health of older people (Boudiny, 2013, pp. 1084–1087).

3. Guiding Concepts: Productive Activity and Individual Lifestyle

Using a genealogical approach, Moulaert and Biggs (2013) reconstruct the trajectory of active ageing in international politics and address the various players (e.g., G7/G8, OECD, WHO, United Nations) and the shifts in the definition. According to them, two prominent narratives of contemporary ageing are engaged in the discourse, one focusing on productivity and one on health and well-being (Moulaert & Biggs, 2013, p. 29). These narratives are described as "economic instrumentalism" and "holistic self-development" (Moulaert & Biggs, 2013, p. 29) and mirror corresponding lines of conflict and their development over time. Accordingly, two evaluative and normative guiding concepts can be identified: one is being "able to lead a productive life" and the other being "free to make personal choices" (Moulaert & Biggs, 2013, p. 28).

A background paper entitled "Active Aging: A Shift in the Paradigm" and introduced in the 1997 G8 Summit by the US Department of Health and Human Services can be traced as the first text explicitly using the term 'active ageing' at an international policy level. From here, the term found its way into the communiqué of the Summit (Moulaert & Biggs, 2013, p. 27). Since this was the initiation for the idea of active ageing in international policy, a quote from this paper can serve as a starting point to illustrate how notions of active ageing involve evaluative and normative assumptions regarding activity as productive activity and lifestyle as a matter of individual choice:

> We discussed the idea of 'active aging'—the desire and ability of many older people to continue work or other socially productive activities well into their later years and agreed that old stereotypes of seniors as dependent should be abandoned. We considered new evidence suggesting that disability rates among seniors have declined in some countries while recognizing the wide variation in the health of older people. We discussed how our nations can promote active aging of our older citizens with due regard to their individual choices and circumstances, including removing disincentives to labor force participation and lowering barriers to flexible and part-time employment that exist in some countries. In addition, we discussed the transition from work to retirement, life-long learning and ways to encourage volunteerism and to support family care giving. (G8, 1997, para. 7)

The quote introduces active ageing in the context of the state's idea of a modern working biography. Consequently, the concept becomes related to "productive/work-based solutions" (Moulaert & Biggs, 2013, p. 25). Within this frame of economic instrumentalism, activity is defined through work and other "socially productive" activities. Thus, active ageing is ultimately equated with productive ageing. In this perception, retirement in ageing societies is considered a "waste of human resources" (G7, 1996, p. 7). However, it usually remains unclear why exactly productivity should be a good measure for activity or—vice versa—what exactly should be wrong with such a perspective.

In the following years, the discourse of active ageing was complemented by a "more holistic vision of participation" (Moulaert & Biggs, 2013, p. 28). The WHO and the United Nations adopted a comparatively sophisticated line of thought in connection to the concept of activity that focused on self-development. Also according to Moulaert and Biggs (2013, p. 28), this led to a more balanced and differentiated definition of active ageing in the WHO's 2002 Policy Framework:

> Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. Active ageing applies to both individuals and population groups. It allows people to realize their potential for physical, social, and mental well being throughout the life course and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance. The word 'active' refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force. (WHO, 2002, p. 12)

Although these more holistic interpretations circulate in international policy, the active ageing discourse still shows a strong inclination towards economic productivity (Boudiny, 2013; Moulaert & Biggs, 2013; van Dyk, 2014). Research on active ageing tends to focus on labour-market participation. In addition, national govern-

ments also often emphasise economic aspects in their active-ageing policies (Boudiny, 2013, p. 1079). As a result, pragmatic considerations quickly dominate the concrete implementation of holistic concepts; and holistic approaches are only accepted to the extent that they do not question the idea of productivity (Moulaert & Biggs, 2013, pp. 29–30). Thus, when presenting his seven principles of active ageing, Walker (2002, p. 124) dedicated the first principle to a definition of activity that should "consist of all meaningful pursuits which contribute to the well-being of the individual concerned, his or her family, the local community, or society at large". However, although he emphasises that activity should not be reduced to employment, the definition highlights a positive outcome or usefulness of actions and also immediately adds that the importance of work should not be questioned. Against this backdrop, the idea of a holistic version of active ageing is often dismissed as "empty rhetoric" (Boudiny, 2013).

Indeed, conceptions promoting holistic self-development also raise concerns about their evaluative and normative foundations. In particular, they are challenged as manifestations of a shift towards neoliberalism, a socio-economic paradigm focusing on individual choice, economic competition, and free markets that systematically neglects the relevance of personal ties and political communities in social life (Boa & Gans-Morse, 2009). From this perspective, 'active ageing' appears to be little more than a strategic catchphrase for the promotion of activating social policies and a fundamental re-negotiation of old age in times of social welfare cuts (van Dyk, 2014). Thus, while critical gerontology contests economic visions of activity for reducing old age to an exploitable resource, holistic approaches are also interpreted in light of an increasing responsibilization of old age (Cardona, 2008). Moulaert and Biggs, for example, argue that "international discourses on 'active ageing' may be considered as the meeting point of 'productive ageing' centred on economic priority and personal responsibilization analysed as a normalizing discourse for neoliberal subjects" (Moulaert & Biggs, 2013, p. 38). In this interpretation, the holistic appeal to identity and personal development is actually only aimed to claim and control subjects in an even more pervasive and comprehensive way by holding them personally responsible for the way they grow old. Indeed, Walker interprets the WHO definition as suggesting a "general lifestyle strategy for the preservation of physical and mental health as people age, rather than just trying to make them work longer" (Walker, 2002, p. 124). In this way, older or, more generally, ageing people are not only addressed in terms of their labour force. Instead, all areas of their everyday life are comprised and reconsidered under the paradigm of activity and personal lifestyle choice. According to critics, however, the assumption that individual lifestyle is ultimately decisive for ageing well ignores the influence of social inequalities and systematic disadvantages (Holstein & Minkler, 2003, p. 787; Katz, 2013). In addition, the whole suggestion of an all-encompassing, i.e., both individual and social benefit of active ageing connecting the utilisation of the productive potential of older people with their better civic participation and thus improved quality of life (Walker, 2002, p. 137) has provoked critique (Stückler, 2016, p. 29). In this context, framing active ageing as a "win-win-situation" (van Dyk, 2014, p. 94) with benefits for both individuals and society is debunked as a purely ideological move. According to critical gerontology, the emphasis on personal responsibility actually functions as a mere alibi for dismantling the welfare state and shifting risks and costs to the single individual. As a consequence, the attribution of responsibility is not accompanied by more agency (Emirbayer & Mische, 1998) and empowerment, but only by the burden of negative consequences.

4. Introducing Ethical Perspectives on the Good Life to the Active Ageing Debate

The active-ageing discourse is aimed at a positive vision of later life. Critical gerontology criticises the program as part of a neoliberal ideology and its biased notions of activity and lifestyle. Although both perspectives involve evaluative ideals and normative expectations regarding ageing and old age, these are hardly ever spelt out or discussed. In the following, we introduce an ethical perspective to take a closer look at these evaluative and normative implications of active ageing and its critique. To this purpose, we follow a eudemonistic approach to ethics focusing on conditions of a good life. This perspective has the advantage of acknowledging subjective ideas of and preferences for ageing expressed in terms of happiness and fulfilment while at the same time also comprising more objective aspects of accomplishment and human flourishing (Russell, 2010). We illustrate the approach's potential for the analysis of concepts of active ageing and the theoretical foundation of their discussion. In light of ethical considerations, the moral underpinnings regarding productive activity and self-determined individual lifestyle come to the fore, facilitating a more articulate critique of economic instrumentalism and holistic self-development.

From the eudemonistic perspective of an ethics of the good life, the most fundamental question regarding active ageing has to address an aspect that is hardly ever tackled in the debate: the central value ascribed to activity. What exactly is so good about being active in the first place? Why should activity as such be constitutive of a good life in general and a good life at old age in particular? After all, in light of the philosophical tradition, this emphasis on activity is far from self-evident. Major strands of classical and medieval philosophy, as well as spiritual thought, considered a life dedicated to intellectual insight, perception, or meditation as superior to any form of active life. Thus, Plato and Aristotle praised the theoretical life as divine because of its sublime sophistication and self-sufficiency (Cooper, 1987). And for promi-

nent lines of Christian theology, a life of contemplation and mystic immersion rose above everyday hustle and bustle and brought the believer closer to god (Butler, 2001). According to Buddhist thought, meditation elevates the spirit from the material world and frees it from the illusions and restlessness of practical life. Many modern spiritual teachings consider a life of mindfulness as a pathway to higher levels of awareness, authenticity, and self-fulfilment (Bodhi, 2011).

Interestingly, pertinent considerations frequently draw connections to ageing and old age and thus also provide important viewpoints for the debate on active ageing. In the idea of wisdom, the association of superior insight and old age had already been commonplace in ancient thought (Robinson, 1990). Building on this tradition, Plato taught that philosophy benefits from growing older since ageing liberates the mind from bodily drives, sensual affects and inclinations, as well as practical interests, thus opening it for true intellectual comprehension (McKee & Barber, 2001). The role of the philosopher typically included withdrawal from active public life and duties, a process that often came along with old age (McKee & Barber, 2001). In modern ageing research, similar ideas were incorporated in the disengagement theory of ageing and related gerontological approaches. Disengagement theory held that it is natural and appropriate for the ageing person to withdraw from relationships and professional obligations, look back onto her past life and contemplate finiteness and approaching death (Cumming & Henry, 1961). The accompanying decrease of social interaction was frequently associated with a release from social norms and thus with a vision of "late freedom" (Rosenmayr, 1987). Of course, the theory as such also mirrored a specific historical state of industrial society that only offered a limited scope of meaningful social roles and activities for older people (Estes, Binney, & Culbertson, 1992). Nevertheless, more recent gerontological theorising points in a similar direction. Thus, in a refinement of his stage model of personal development, psychologist Erik Erikson explained that one crucial adaptive challenge in the trajectory to later life is marked by generativity, that is, an increasing awareness of one's role in a larger context, be it the overarching chain of generations or an all-encompassing cosmic order (Erikson & Erikson, 1997). In a similar vein, the conception of gerotranscendence rehabilitates ideas of disengagement by emphasising the increasing relevance of self-decentralisation, integration into a larger whole and self-transcendence in old age, drawing attention to holistic dimensions of spirituality and historical as well as ecological awareness (Tornstam, 1989). Accordingly, current gerontological studies point out the important role of mindfulness, transcendence, and spirituality for older people's wellbeing and meaning in later life (Ardelt & Ferrari, 2018; Bester, Naidoo, & Botha, 2016; Thauvoye, Vanhooren, Vandenhoeck, & Dezutter, 2018).

But even if we are to accept that activity as such has some value for a good life at old age, the crucial question is: what activity in particular? From a philosophical perspective, the kind of activity in question, its specific character, context, and outcomes, is decisive for its ethical evaluation. This is also relevant for active ageing, for example, in view of the 'productivistic' conception of activity involved in the debate. In her seminal work *The Human Condition* (1958/1998), philosopher Hannah Arendt distinguishes three paradigmatic kinds of human activity and ways of life: labour, work, and action. The concept of labour comprises instrumental activities to fulfil basic human needs, ensure survival, and afford procreation. Arendt emphasises that these activities traditionally belonged into the private sphere and were considered subaltern and even slavish because they merely served the necessities of biological self-preservation and reproduction and did not reflect the mastery of craftsmanship or the dignity of free citizenship (Arendt, 1958/1998, pp. 79–135). The category of work comprises skilful technical activities that achieve a specific result or product, e.g., the professional activities practised in various arts and crafts. According to Arendt, they transcend the private life and have a specific value since they cultivate the individual's skills and contribute to building an enduring common world (Arendt, 1958/1998, pp. 136–174). The concept of action finally refers to public activities and interactions as citizens of a political community. For Arendt, these are of supreme and intrinsic value since they alone allow and promote the public manifestation of the self as well as collective self-government (Arendt, 1958/1998, pp. 176–247). However, according to Arendt's perspective, modern life is essentially constituted by technological progress and industrialisation and therefore preoccupied with industrial labour and technological manufacturing while the classical republican ideal of (superior) political (inter-)action, self-manifestation, and collective self-government has been forgotten and needs to be recovered (Arendt, 1958/1998, pp. 248–326).

These philosophical distinctions show important connections to the social gerontological debates on active ageing. First, many gerontological approaches confirm the modern obsession with labour Arendt diagnoses. Early sociological theories of ageing in the context of structural functionalism particularly seem to mirror the value system and priorities of modern industrial society (Estes et al., 1992). Thus, regardless of their diametrically opposed orientations, both disengagement theory and activity theory focus on the trajectory from labour life into retirement as the crucial process defining the phase of old age and its characteristic opportunities and challenges. While the former spells out the implications of consequential retirement, the latter promotes the "busy ethics" (Ekerdt, 1986) of upholding previous activity levels (Katz, 2000). However, both theories lack a view on the meaning of ageing that transcends the institutionalised life course of modern industrial society and welfare state administration. Even accounts emphasising the relevance of non-labour activities such as crafts and civic

engagement often seem to do so in terms of an instrumental usefulness for psychological adaptation or economic welfare (van Dyk, 2014). What is missing in this utilitarian perspective is the idea that these activities not only have a therapeutic or economic function, but also an inherent value for a good life at old age since they are constitutive of personal identity, meaningful practices, and human flourishing. Indeed, recent gerontological studies highlight the importance of manual leisure activities, volunteering, and political engagement for fulfilment and meaning in later life (Kenning, 2015; Kruse & Schmitt, 2015; Morrow-Howell, Hinterlong, Rozario, & Tang, 2003).

Furthermore, even if we were to accept the economic focus of active ageing on productivity, the philosophical distinctions introduced can help spell out the ethical problems of the underlying economic definition of productivity. Thus, for Arendt, the genuinely productive activity is work since it results in the production of durable artefacts and thus in the construction of a common world, a truly human institutional and cultural civilisation (Arendt, 1958/1998, pp. 136–139). By contrast, Arendt does not consider labour productive in this substantial sense since it is part of the process of mere biological self-preservation and satisfaction of needs and involves no real telos, no final aim and definite accomplishment. Occasionally, she even seems to join Camus in associating modern industrial labour with the futile and absurd activities Sisyphus and the other inhabitants of the mythological underworld are condemned to perform ad infinitum (Arendt, 1958/1998, pp. 96–101). From this perspective, many conceptions of active ageing not only suffer from a reduction of activity to productive activity, but also from a reduction of productivity to something ultimately unproductive and meaningless: man's participation in the endless metabolism of nature (Marx). This line of thought thus provides an important normative basis and differentiation for a gerontological critique of economic instrumentalism. To put it bluntly, what is problematic in this paradigm is that it ultimately levels the ethically crucial distinction between the necessities of mere survival and the intrinsic value of a good, desirable, and fulfilled life.

As we have seen, Hannah Arendt's philosophical typology and evaluation of different kinds of activities prove rather instructive for spelling out and substantiating prominent lines of critique of active ageing discourses and programs. In fact, with the appraisal of the concept of (political) action, her approach also already hints at a positive vision of activity in old age. At the same time, the distinction between labour, work, and action is located on a rather abstract and general theoretical level. A more differentiated account of the value of various human activities could provide even more concrete clues for gerontological debates on active ageing and especially for developing a more comprehensive positive conception of ageing well. Such an account has been developed by philosopher Martha C. Nussbaum in her capability approach (Nussbaum, 2011). Similar to Arendt's reflections on the vita activa, the capability approach also starts from an ethical appreciation of human activities. According to Nussbaum (2011, p. 18), one of the central questions of any political ethics is: "What is each person able to do and to be?" Consequently, she defines a set of activities and aspects of life that constitute core elements of human wellbeing and flourishing so that any decent political community has to secure and promote them (Nussbaum, 2011, p. 18). Concretely, Nussbaum identifies a number of fundamental areas of human experience and corresponding fields of activities human beings must be able to perform in order to have the opportunity to live a good life.

The resulting list represents an open compilation of central capabilities that are necessary preconditions of human flourishing and a dignified existence (for the following, see Nussbaum, 2011, pp. 33–34). It first includes elementary needs and requirements like the ability to live to the end of a human life of normal length without dying prematurely (life), the ability to have good health, adequate nourishment and shelter (bodily health), and the ability to move freely from place to place, be secure against violent assault, and have reproductive autonomy (bodily integrity). Further basic capabilities refer to sensual, emotional, and intellectual dimensions of human existence, including the ability to make use of one's senses and to imagine, think, and reason in a truly human way (senses, imagination, and thought); the ability to develop attachments to things and other people and to experience love, grief, longing, gratitude, as well as justified anger (emotions); and the ability to form a conception of the good and to engage in critical deliberations about the planning of one's own life. Eventually, a third group of basic capabilities comprises abilities to take up relations and partake in interactions that are constitutive of a meaningful human life, especially being able to live with and towards others and to recognise and show concern for them (affiliation), to experience relations to animals, plants, and the world of nature as a whole (other species), or to enjoy playful and recreational activities (play), as well as the ability to participate in political decisions that are relevant for one's own life (control over one's environment).

Although this list represents a widely recognised set of criteria for the good life, it still remains to be specified in view of ageing (Ehni, Kadi, Schermer, & Venkatapuram, 2018). Thus, not all capabilities are equally important for the discussion of old age. The criteria of life and bodily health appear too general to be informative in view of later life. It is not clear what exactly living through a normal lifespan and having good health mean in this context. Do healthcare measures that are considered life-sustaining or health-preserving in younger years also have to be provided for people at a very old age (Kaufman, 2015)? Furthermore, some of the aspects discussed seem to be targeted at middle adulthood. Thus, it is not clear whether reproduction should be consid-

ered a part of a good life in later years and therefore be supported by social systems, e.g., by coverage of reproductive technologies (Rimon-Zarfaty & Schweda, 2019). Nevertheless, other capabilities are obviously highly relevant for old age. This holds true for the aspect of bodily integrity including the ability to move freely, to be secure against violent assault, and to find sexual satisfaction, which are often compromised in the case of older people, especially those living in institutional settings like nursing homes (Tuominen, Leino-Kilpi, & Suhonen, 2016). Moreover, the use of the senses, the imagination, and intellectual capacities may rather pertain to the theoretical or contemplative dimension of human existence neglected in the active ageing discourse; still, according to a capability approach, being able to use the imagination and thought, for example in connection with experiencing and producing works of art, must be considered a central dimension of good life at old age. Indeed, recent gerontological studies underline the potential of creative activities for wellbeing in later life (Creech, Hallam, Varvarigou, McQueen, & Gaunt, 2013; Reynolds, 2010). The same holds true for capabilities related to emotions. Being able to have attachments to things and people, to love, grieve, experience longing, gratitude, and anger remains vital in later life. Gerontological research has long established that an emotionally rich and fulfilled life in relationships with others constitutes a central prerequisite for wellbeing at old age (Courtin & Knapp, 2017).

By contrast, the ability to form a conception of the good and to engage in critical reflection about the planning of one's life (practical reason) has only recently been acknowledged as a concern of old age where traditionally defeatist and nihilistic views prevailed and positive ideals or meaningful role models for older people are still often missing (Moody, 1992; Riley, Kahn, Foner, Mack, 1994). Aspects of social affiliation and interaction are particularly important at old age, not only as a therapeutic or economic requirement but also as an integral element of a good human life of older people. Being able to experience other species and nature and to play are particularly interesting points since they represent activities that clearly point beyond the economistic and productivistic focus of active ageing but must still be considered essential parts of a good life at old age. Accordingly, current gerontological research identifies activities such as gardening or playing as important factors for wellbeing in later life (Gerling, De Schutter, Brown, & Allaire, 2015; Scott, Masser, & Pachana, 2015). The same holds true for the capability to participate in political choices that govern one's life. This perspective transcends economically exploitable civic engagement and instead requires possibilities for substantial political participation at old age, regardless of their contribution to an overall win-win-calculation. Recent gerontological work actually shows an increasing awareness of the interdependencies between wellbeing and political participation at old age (Barnes, Gahagan, & Ward, 2018). Along these lines, a capability approach can contribute to a more comprehensive and ethically more articulate perspective on human flourishing at old age. It not only helps to detect biased and distorted conceptualisations of active ageing focusing on economic productivity and individual lifestyle, but also makes the idea of holistic self-development in old age more profound and differentiated.

5. Conclusions

Against the backdrop of previous deficit-oriented notions of ageing in terms of inevitable decline and disengagement, the active ageing discourse set out to promote a more positive vision of old age. However, the question of why exactly enduring activity should offer a promising and worthwhile perspective for later life remained largely undiscussed, let alone answered. The frequent references to health, social usefulness, and economic welfare are ultimately begging the question since it is not clear why and to what extent health, usefulness, and welfare themselves should be considered valuable. Hence, at the heart of the active ageing discourse, there is a largely unarticulated ideal of good life at old age.

This inarticulate ideal makes active ageing programs an easy target for criticism. Especially critical gerontologists object that these programs propagate biased models of ageing whose political implementation discriminates against and excludes whole groups of older people. However, unless the underlying eudemonistic question of the good life at old age is tackled, the whole debate takes place on shaky ground. The fact that the critics appeal to a different kind of moral philosophical standard, essentially comprising justice and equal rights, does not help to resolve the problem. After all, being excluded from a way of life that turns out to be ultimately worthless and undesirable would not necessarily constitute an injustice (maybe actually quite the opposite). Moreover, a system of moral norms and political regulations centred on a misguided ideal of human existence would ultimately impede each and everybody in the realisation of a good life.

As Walsh, Scharf and Keating (2016, p. 81) remind us, research in the field of social exclusion of old age is still under-developed. The existing empirical studies often concentrate on problems of labour market integration and consequently ignore multiple other forms of exclusion in different social spheres as well as the issue of their intersectional interaction. In this way, critical social research on old age exclusion runs the risk of reproducing the same shortcomings that are already inherent in the criticised conceptions of active ageing themselves. In addition, Walsh and colleagues deplore that the existing efforts and contributions to the debate usually remain trapped within the confines of their respective subdisciplines, thus not only losing useful empirical insights but also wasting potential for critical theory-building on social exclusion (Walsh et al., 2016, p. 82).

Our study underlines the potential of an interdisciplinary approach: an ethical analysis helps clarify evalu-

ative and normative assumptions and thus strengthens the argumentative foundations of the discussion. It first makes clear that the preference for activity is far from self-evident and neglects other valuable dimensions of human life that may be more relevant and accessible to many older people, e.g., intellectual, aesthetic, or spiritual experience. Furthermore, the ethical distinction of different kinds of human activity helps explain what is wrong with specific understandings of active ageing, especially those promoted under the paradigm of economic instrumentalism. An understanding of activity in terms of economic productivity privileges an impoverished labour-oriented model of meaningful action and neglects other more productive and valuable kinds of activity contributing to a good life at old age, especially self-care work, arts and crafts, and political participation. Finally, a capability approach can provide a starting point for formulating a truly holistic conception of self-development and a comprehensive matrix of aspects and dimensions relevant for leading a good life at old age. With its wide and inclusive anthropological scope, it can help detect shortcomings of current ideals of ageing and justify the relevance of different aspects of good life at old age. Of course, further empirical research has to explore older adults' actual subjective assessment of the various dimensions of good life at old age as well as the role of further individual factors, such as resilience (e.g., Kok, Aartsen, Deeg, & Huisman, 2015; Kok, van Nes, Deeg, Widdershoven, & Huisman, 2018). This way, gerontological research could at the same time also contribute to an expansion and elaboration of the capability approach in view of old age.

As we have argued, the introduction of an ethical perspective can help to make clear what exactly is morally wrong with biased, one-sided ideals of ageing well: by neglecting and effectively blocking relevant dimensions of human value experience and self-fulfilment, they degrade, discriminate, and ultimately exclude certain ways of life and growing old from public recognition and political support. At the same time, the critical analysis also opens up constructive perspectives for a layered model of inclusive ageing policies. Thus, a capability approach helps define minimal preconditions and fundamental criteria that must be met in order to be able to live a decent human life at old age. In particular, precarious living situations and social inequalities threatening life, bodily integrity, and personal freedom at old age have to be denounced and fought throughout the life course. At the same time, however, an inclusive notion of the good life at old age also has to acknowledge the increasing plurality of individual lifestyles and living situations, especially in later life. Hence, beyond the fundamental level of basic needs and capabilities, ageing policies in modern liberal democracies are well advised to allow for a range of legitimate diversity and thus leave room for individual interpretations and prioritisations of different aspects of the good life such as aesthetic experience and production, creative activities and crafts, or active political engagement. Only this way can the abundance of possibilities to experience value in later life be fully explored and savoured.

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Conflict of Interests

The authors declare no conflict of interests.

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Commentary

A Critical Perspective on Ageism and Modernization Theory

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Abstract
Modernization theory has often been used to explain country differences in levels of ageism. The commentary at hand questions its usefulness in the analysis of ageism today for two reasons. First, modernization theory was developed to discuss social status of older people, not ageism. Second, social policies and management practices that emerged with industrialization are being rolled back over the last decades. We therefore argue for the reconsideration of the relationship between modernization and ageism and to re-assess it in order to better explain country differences in ageism in the 21st century.

Keywords
age discrimination; ageism; older population; modernization theory; social status; stereotypes

Issue
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1. Introduction

Modernization theory is one of the main theories explaining ageism at the macro-level. The essence of the argument is that ageism increases as societies modernize. Although this theory would have made sense in times of industrialization, in this commentary we question its applicability to today's society. In doing so, we follow the line of argument developed by Vauclair et al. (2014), showing that increased modernization in fact leads to higher social status of older people, and aim to extend the argument beyond the availability of economic resources and employment.

The roots of modernization theory in ageism are traced back to Cowgill and Holmes' (1972, pp. 8–9) statement that "the status of the aged in the community is inversely proportional to the degree of modernization of the society" (e.g., Ayalon, 2013; Löckenhoff et al., 2009; Vauclair et al., 2014). The authors develop a series of arguments for why this might be the case. The status of older individuals would decrease as societies go through periods of social change, they argue; as mobility and urbanization increase; as agriculture becomes less important as an economic activity decreasing the status connected to owning land acquired throughout life; as the extended family gives way to the nuclear family as the bedrock of society; and as ceremonialism decreases and literacy increases, challenging the status of older people as the bearers of wisdom and knowledge on how things should be done. Moreover, they contend that with the introduction of retirement, the welfare state took away the productive and reproductive roles of older people in society making them essentially obsolete and therefore reducing their social status, particularly in Western society where individuals' status would mainly be dependent on their productive capacity.

2. A critique of Modernization Theory

One can certainly ask to what extend their argument applies equally to older men and women, sparking questions of intersectionality and gendered life courses. However, the main point of critique in this commentary is that Cowgill and Holmes (1972) did not address the issue of ageism: their argument was about the status of older individuals in society. Given that ageism can encompass both positive and negative views of older people, high status does not mean absence of ageism, just as much as losing high status does not necessarily mean increased ageism. Since positive and negative age stereotypes often coincide—for instance, older people are often described as warm but incompetent (Durante et al., 2013)—assigning higher status to older people in society may actually coincide with higher levels of ageist stereotypes. Indeed, some evidence suggests that people from East Asia, where older people traditionally have had a higher status in society, have shown to hold more negative stereotypes about older people (North & Fiske, 2015). Therefore, instead of increased ageism, the disappearance of the higher status of older people in society may in fact be a symptom of individualization and people being judged for who they are rather than for the age group they belong to. Using an explicit measure of ageism, Ayalon (2013) finds that older people are typically viewed more positively than younger people across Europe, though that this preferential view of older over younger people vanishes as the level of secularization increases. In addition, the finding by North and Fiske (2015) that there is less ageism in more individualized countries, points in that direction.

Moreover, macro-sociological theorists have been describing a transformation of the process of modernization since the 1970s. While some argue that we have transitioned to a new era of post-modernity, others rather see it as a continuation of modernity and describe the new situation as 'new', 'second' or 'liquid' modernity (e.g., Bauman, 2000). The characteristics on which Cowgill and Holmes (1972) built their modernization theory have been fundamentally changed. Particularly the structure of the labor market and welfare policies have radically altered since, suggesting that the modernization argument might not add up anymore nowadays. This holds true particularly for the interdependence of industrialization, institutionalization of the life course and ageism.

The relationship between industrialization and ageism has repeatedly been studied. There are two lines of argument regarding this relationship. Hushbeck (1989) and McDonald (2013) focus on management practices and type of work in their analyses of industrialization and ageism. In this account, the introduction of scientific management reduced the need for skills meaning that older workers lose their competitive advantage of experience, while at the same time it valued the speed at which one could perform repetitive actions. Wear and tear resulting from physical labor strenuous to the body due to constant repetition and over-burdening of specific parts of the body meant that older workers could not follow the pace, and therefore had to be gotten rid of. Not only did industry since give way to services as the main sector of employment and did the emergence of the knowledge economy lead to a re-valuation of knowledge and skills, management has changed substantially as well, with the top-down approach of scientific management being replaced with an integrated management at the level of the shop floor (Storey, 1992), and a stronger focus on employee autonomy and job control to reduce mental and physical strain of employees (Karasek & Theorell, 1990).

An alternative line of reasoning concerns age segregation due to the institutionalization of the life course in industrial society, as discussed by Dannefer and Feldman (2017). With the extension of the welfare state, the life course was divided in phases: some speak of the tri-partition of the life course in education, work, and pension (Kohli, 1978). Particularly the introduction of old age security has segregated old age from work, reducing intergenerational contact—contact being an important element in reducing ageism (e.g., Fasbender & Wang, 2017)—and confirming and consolidating stereotypes of older individuals as less productive (Hagestad & Uhlenberg, 2005). This process was exacerbated by the introduction of early retirement schemes meant to let older workers 'make space' in the labor market for younger people who were believed to be more productive. However, since the turn of the millennium there has been a policy shift towards delaying retirement and re-integration older people into the labor market (Hess, König, & Hofäcker, 2016). The shrinking population on active age, potential of skill shortages paired with widespread concerns regarding the sustainability of welfare systems have led to an increased share of older workers in the labor market (Naegele, De Tavernier, & Hess, 2018). Thus, the transition from work to retirement is becoming more fluid, amplified by the credo of Active Ageing in Europe that not only demands older workers to be active, but preferably also productive and engaged in the labor force (Walker, 2002). As a result, the border between the work and retirement phases of the life course fades, rolling back age segregation and improving intergenerational contact carrying the potential to reduce ageism. This argument is supported by the finding that a high labor market participation of older people is correlated with a high social status of older people (Vauclair et al., 2014). Since the shift towards active ageing in the discursive basis of ageing policy, the welfare state not only protects older people from ageism through the reduction of poverty among older generations (Durante et al., 2013; Vauclair et al., 2014), but also by making them (potential) active contributors to society.

3. Conclusion

In conclusion, there are a number of reasons to argue that the modernization hypothesis of ageism may not

be congruent with recent socio-economic developments. The argument developed by Cowgill and Holmes (1972) concerned social status of older individuals, not ageism. Being fundamentally different in nature, high social status of older people could well have coincided with high levels of ageism. Increased individualization has the potential to reduce both simultaneously, as both social status of an age group and stereotyping fundamentally rely on treating an individual as part of the social group he or she belongs to, rather than as an individual. Moreover, the exclusion of older individuals from paid work induced by industrialization has recently been counteracted by developments in the labor market and social policy. Based on these arguments, we call for a new research agenda evaluating the relationship between modernization and ageism since the 1970s. It is time for a critical re-assessment of the modernization hypothesis, and for the development of an alternative narrative on the relationship between modernization and how older individuals are perceived, valued and treated in the 21st Century.

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Conflict of Interests

The authors declare no conflict of interests.

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