Prioritizing Healthcare and Employment Resources during COVID-19: Roles of Benevolent and

Hostile Ageism

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Abstract

Background and Objectives: Benevolent and hostile ageism are subtypes of ageism that characterize older adults as incompetent. With benevolent ageism, older adults are also viewed as warm. The COVID-19 pandemic has strained resources and prompted debates about priority for older adults versus other groups.

Research Design and Methods: College students completed an online survey of how much priority should be given to older adults in three relevant healthcare-related scenarios and three relevant employment scenarios.

Results: Benevolent ageism significantly predicted higher priority for older adults to receive healthcare (triage, COVID-19 vaccine, COVID-19 testing) and employment resources (retention of job, working from home) while greater endorsement of hostile ageism significantly predicted lower priority ratings.

Discussion and Implications: These findings replicate and extend past work. As the COVID-19 pandemic continues to wreak havoc on healthcare and employment resources, this study sheds light on one factor -- benevolent and hostile ageism -- that contributes to a greater understanding of prioritization views toward a vulnerable segment of the population.

Keywords: Attitudes and perceptions toward aging/aged, Intergenerational tension, Stereotypes

Ageism is a significant and increasing problem that has been exacerbated by the COVID-19 pandemic (Monahan et al., 2020). During COVID-19, there has been widespread debate in regard to which groups should receive priority for limited healthcare and employment resources and accommodations. This paper considers the potential roles of benevolent and hostile ageism in the prioritization of older adults in these contexts. Drawing from the Stereotype Content Model (Fiske et al., 2002) and research on ambivalent sexism (Glick & Fiske, 1996), Cary and colleagues (2017) identified benevolent and hostile ageism as two forms of ageism. While both benevolent and hostile ageism grow from the stereotype that older adults are incompetent, the defining difference is that benevolent ageism also stereotypes older adults as warm (e.g., friendly, trustworthy) while hostile ageism does not (Cary et al., 2017; also see Fiske et al., 2002). As the benevolent and hostile ageism measure (Cary et al., 2017) is a novel, recently developed measure, we apply findings pre-dating the measure to inform our investigation and predictions.

Rooted in the view that older adults are "doddering but dear" (Cuddy & Fiske, 2002), benevolent ageism includes unrequested and unwanted helping directed toward older adults (Chasteen & Cary, 2015) as well as speaking loudly to older adults with short, simple sentences or "baby talk" (Caporael & Culbertson, 1986; Hummert et al., 1998). While perceivers may view their actions as "positive," even so called helping behaviors have harmful effects when insisted upon and unwanted, thereby reinforcing beliefs of older adults as incompetent (Lytle et al., under review) and reducing older adults' autonomy and self-efficacy (Cary et al., 2017; Hehman & Blunt, 2015). In the context of the COVID-19 pandemic, where older adults are seen as a particularly vulnerable population, benevolent ageism may lead to giving older adults greater priority to receive healthcare and employment resources.

By contrast, with hostile ageism, older adults are seen as incompetent without warmth, and therefore burdensome and a drain on resources (Horchata et al., 2019; North & Fiske, 2012). As such, Cary and colleagues (2017) characterize hostile ageism as a "contemptuous" prejudice linked

to long-standing findings of passive and active forms of discrimination toward older adults (Levy & Macdonald, 2016; North & Fiske, 2012). Hostile ageism has been documented in healthcare settings, such as passing over older adults for treatment and procedures for treatable illnesses and conditions because it is seen as a waste of resources (Chrisler et al., 2016) and even neglect and abuse (Pillemer et al., 2015). Examples of hostile ageism in the workplace include overlooking older workers when hiring, greater perceptions of older adults as inflexible and senile, and greater incidences of forced early retirement (Roscigno, 2010). Accordingly, hostile ageism may lead to giving older adults less priority during the COVID-19 pandemic.

Healthcare and Employment Resources during COVID-19

As context, the current investigation took place between April 16 and May 12, 2020. By May 12, 2020, there were over 77,500 COVID-19 related deaths in the U.S. (John Hopkins, 2020) with disproportionately high rates of complications and death among older adults (Monahan et al., 2020). Following reports from other countries and locally about hospitals being overwhelmed with COVID-19 cases in late March and early April 2020, doctors, healthcare workers, government officials, and the public were forced to discuss the possibility of having to ration lifesaving equipment such as ventilators (Maves et al., 2020; Monahan et al., 2020). Likewise, there were debates about who should be given priority for the limited COVID-19 testing available in April (Goodman & Rothfeld, 2020) and for a future vaccine (CDC, 2020). Accordingly, this investigation explores three healthcare situations (triage, COVID-19 vaccine, and COVID-19 testing) relevant to discussions of prioritization of groups, particularly older adults.

Furthermore, by the end of April 2020, tens of millions of Americans had lost their jobs with an unemployment rate of 14.7% (US BOLS, 2020) and 33% of households reported pay cuts (Parker et al., 2020). By late March 2020, only 30% of older workers (aged 65+) could work remotely compared to 40% of U.S. workers aged 25-34 (Brynjolfsson et al., 2020). Accordingly, this

investigation explores three employment situations (job retention, full salary retention, and working from home) relevant to discussions of prioritization of groups, particularly older adults.

Current Study

We explored whether benevolent and hostile ageism differentially predict how much priority is given to older adults in healthcare and employment contexts among undergraduates. This study sought to replicate past research (job retention, Chasteen & Cary, 2015) during the COVID-19 pandemic and examine novel healthcare (triaging, COVID-19 testing, COVID-19 vaccine) and employment scenarios (full salary retention, working from home). We studied college students consistent with past research on benevolent and hostile ageism (Cary et al., 2017; Chonody & Teater, 2016) and because the pandemic exacerbated intergenerational tension among college students who were seen as low risk for complications and mortality and older adults who were highest risk (Monahan et al., 2020). Across the scenarios, we hypothesized greater benevolent ageism would predict giving greater priority to older adults, whereas greater hostile ageism would predict less priority.

Method

Participants

A total of 500 (157 women; 337 men, 6 not listed) first-year undergraduate participants from a university in the Northeast with a mean age of 18.64 (*SD*=1.18) completed an online survey between April 16 - May 12, 2020. Participants were 69.8% White, 23% Asian, 2% Black, 12.4% Latinx, 0.2% American Indian or Alaskan Native, 0.6% Native Hawaiian or Pacific Islander, and 2.2% Other or Mixed (participants could choose more than one identity).

Procedure

Participants completed an online study via Qualtrics called "COVID-19 Beliefs" on "attitudes, perceptions, and behaviors as a result of the COVID-19 pandemic" (see Online Supplementary Material Appendix 1). The university's institutional review board approved this research.

Measures (presented in order received by participants)

Healthcare Scenarios. Participants reported how much priority on a 0 (*no priority at all*) to 10 (*highest priority*) groups{randomized}should be given for 1) life-saving support from a ventilator due to complications from COVID-19; 2) safe and FDA approved COVID-19 vaccine; and 3) COVID-19 testing (Table 1).

Employment Scenarios. Participants reported how much priority on a 0 (*no priority at all*) to 10 (*highest priority*) groups{randomized}should be given to 1) job retention; 2) full salary retention; and 3) work from home (Table 2).

Benevolent and Hostile Ageism. On a scale of 1 (*strongly disagree*) to 6 (*strongly agree*), participants rated 9 benevolent ageism items (e.g., "even if they want to, old people shouldn't be allowed to work because they are fragile and may get sick"; α=0.814) and 4 hostile ageism items (e.g.., "old people are a drain on the healthcare system and the economy"; α=0.829; Cary et al., 2017).

Demographics. Participants reported their age, gender, and race/ethnicity.

Results

We conducted linear regression for the six scenarios with benevolent and hostile ageism entered as predictors and gender as a covariate (consistent with past research on ageism; Lytle & Levy, 2019). To correct for family-wise alpha inflation, an alpha correction of .008 was used (alpha = .05 was divided by the number of regressions conducted.)

Benevolent and hostile ageism significantly predicted priority ratings for older adults in the triage, testing, full salary retention, and work from home scenarios, with benevolent ageism significantly predicting giving older adults greater priority while hostile ageism significantly predicted less priority (Table 3). The same pattern of results emerged in the vaccine scenario, but the difference did not meet the adjusted significance threshold (p=.026). Analyses for the job retention scenario were non-significant.

Discussion

This study examined two forms of ageism, showing greater endorsement of benevolent ageism significantly predicted higher priority for older adults while greater endorsement of hostile ageism significantly predicted lower priority ratings for older adults for key resource allocation in healthcare and employment. The employment scenario findings are broadly speaking consistent with past research, which found both benevolent and hostile ageism predicted perceptions of older workers keeping their jobs during non-pandemic times (Chasteen & Cary, 2015), extends those findings during COVID-19, and shows a similar pattern for two other situations (retention of full salary and working from home) during COVID-19. Our findings also extend an understanding of benevolent and hostile ageism in healthcare situations where examples of benevolent (Caporael & Culbertson, 1986; Hummert et al., 1998) and hostile ageism (Chrisler et al., 2016; Pillemer et al., 2015) have been noted in separate studies only. This is the first study to our knowledge to examine both subtypes together in the healthcare context. Future research should examine generalizability of our findings with other college and community samples, in workplace and healthcare settings, in other countries given the global nature of the pandemic, and over time as the pandemic unfolds.

While more research is needed, findings that both benevolent and hostile ageism significantly predicted how older adults are prioritized in both healthcare and employment scenarios is cause for concern. It is well-established that hostile ageism supports abuse and discrimination within and across settings (Chrisler et al., 2016; Pillemer et al., 2015). Despite relating to greater

prioritization of older adults in these scenarios, benevolent ageism can cause learned helplessness (Cary et al., 2017, Hehman & Blunt, 2015) and internalization and embodiment of age stereotypes (Chrisler et al., 2016; Levy, 2009), which can negatively impact the health and longevity of older adults (Stewart et al., 2012).

The COVID-19 pandemic may foster and strengthen perceptions of older adults as helpless and weak, making it even more pressing to combat these ageist stereotypes and foster positive intergenerational relations in interventions with the general public and in healthcare and other workplaces where older adults may be treated consistent with such stereotypes (Levy, 2018; Lytle & Levy, 2019). At the same time, this study brings greater awareness that these two types of ageism need to be directly addressed by interventions in ways that recognize that ageism can foster helping on the one hand while reinforcing stereotypes and their negative downstream effects.

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Table 1a.

Descriptive Statistics for Healthcare Scenarios

Priority Group	Triage		Vaccine		Testing	
	Mean	SE	Mean	SE	Mean	SE
Young adults	6.74	0.118	6.61	0.123	6.65	0.128
Older adults	7.67	0.117	8.37	0.105	8.54	0.108
First responders	8.76	0.1	9.25	0.102	9.42	0.101
People with health insurance	5.98	0.126	6.17	0.133	6.4	0.138
Parents with children under 18	7.89	0.103	7.84	0.104	7.79	0.114
People without pre-existing conditions	6.43	0.119	6.34	0.124	6.68	0.127
People with pre-existing conditions	8.22	0.118	8.82	0.104	8.89	0.108
Women	5.99	0.127	6.15	0.131	6.31	0.139
Men	5.9	0.126	6.1	0.132	6.23	0.139

Table 1b.

Descriptive Statistics for Employment Scenarios

Priority Group	Keep Job		Keep Salary		Work from Home	
	Mean	SE	Mean	SE	Mean	SE
Young adults	6.82	0.13	6.68	0.133	6.7	0.131
Older adults	6.69	0.131	6.94	0.131	8.71	0.117
Parents with children under 18	8.15	0.128	8.22	0.132	8.57	0.115
People without pre-existing conditions	7.04	0.13	6.63	0.132	6.8	0.13
People with pre-existing conditions	6.74	0.134	7.36	0.134	9.17	0.112
Women	6.3	0.138	6.32	0.142	6.55	0.142
Men	6.35	0.139	6.32	0.142	6.45	0.142

Table 2.

Linear Regression Analysis

Scenario	Benevolent Ageism β	Hostile Ageism β
Triage	0.165**	-0.155**
Vaccine	0.117*	-0.175***
Testing	0.153**	-0.175***
Full Salary Retention	0.165**	-0.154**
Work from Home	0.155**	-0.221***
*p < .05, **p < .01, ***p < .001		