CHAPTER 7

Ageing and its embodiment

Over the last century, social policy has contributed significantly to the social construction of old age. Underpinning much of that policy has been a view of old age characterized by the notion of progressive enfeeblement. The 'physiological neediness' of the ageing body has been seen as justifying many of the policies concerning retirement, social security, health and welfare that have evolved over the first half of the last century. Any 'marginalization' of older people by these policies, it can be argued, largely reflects the debilitating impact of physical ageing. In the following chapters, we shall explore some of the underlying assumptions about the ageing body and its status as the 'bottom line' that not only determines the agenda of social policy but also limits the cultural expression of ageing.

While social gerontologists have been critical of the 'biomedicalization' of ageing, they have made relatively little attempt to challenge the foundations from which studies of bio-ageing come. Within sociology and social theory, however, there has been a growing interest in the reciprocal relationship between our existence as bodies and as social agents. In order to better discuss the relationships between social and physical ageing, it is helpful, first, to consider in a little more detail what lies behind this new interest in 'theorizing the body'.

Embodiment and social theory

The Cartesian tradition in Western intellectual thought has fostered a persistent division between the body and the mind. Until relatively recently, in the social sciences, the focal interest has been on relationships between individuals as rational actors. Their physicality – their bodily identity – had remained the legitimate subject principally and largely unquestioningly of the natural sciences.

One of the first sociologists to question this division of intellectual labour, Bryan Turner, has written:

> sociological theory has effectively neglected the importance of the human body in understanding social action and social interaction. The nature of human embodiment has . . . not been important in either social research or social theory.[1]

There has since been an outpouring of academic writing on the 'sociology of the body'. Over the last decade numerous books have appeared, conferences have been held and a new journal has been published – all concerned with the theme of the 'social' body.[2] Amongst the various reasons put forward for this interest is the privileged position the body has acquired within contemporary consumer culture. Sulkunen makes the point:

> The issue of the social constitution of the body is important in consumer society not only because everything we consume is taken in enjoyed and processed by the body, whether through the tactile senses of touch taste and smell, or through the distant senses of the eye and the ear. The body is important also because in its social and historical constitution the nature of the social bond is at issue.
>
> Consumer society is individualistic by definition. Consumption reflects and embodies our relationships not only to objects but also to others as choice and pleasure through the exploitation of goods and services usually produced by others but also through our own judgements as free decision makers. This has brought the body into focus for it is as embodied beings that we experience our separateness from others.[3]

The growing importance given to ageing has been a factor too. As we have already noted in Chapter 4, fear of bodily ageing permeates much of contemporary culture, boosting the sales of a wide variety of products ranging from anti-ageing cosmetics to vitamin supplements.[4] But the significance of ageing is not confined to its expression in the commodification of individual fears and desires. Within the press and broadcasting media there are endless reports and ruminations over the 'greying' of the population and the threats posed by increasing numbers of people in their sixth, seventh, eighth and ninth decades. Age-related bodily impairments are highlighted in public debates not principally because of their 'anti-aesthetic qualities' but because they are thought to present a

growing demand upon the state that, if unchecked, will overtax the public purse. These were noted in the previous chapter. However, these two issues are not unconnected. Health and the prevention of morbidity have become central elements in people's lives – as well as becoming central to the renegotiation of public and private responsibilities in contemporary society. Looking after one's body and preventing or putting off a costly old age are increasingly interwoven 'postmodern' virtues – in what Bauman has referred to as the aestheticization of everyday life.

A third factor contributing to the rise of sociological interest in the body is the contemporary uncertainty that renders problematic both our understanding of the body and its place in human/social life. Shilling describes the contradictions that emerge out of the modernist attempt to control/make safe our bodies thus:

> while rationalisation may have provided us with the potential to control our bodies more than ever before and have them controlled by others, its double edged nature has also reduced our certainty over what constitutes a body and where one body finishes and another starts.[5]

This uncertainty is expressed in various ways. On the one hand developments in medical technology enable far more to be done to the body – grafting skin, transplanting organs, unblocking arteries, introducing biomechanical prostheses, re-designing sexuality and so on. The 'cyborg' phenomenon has become a common theme for science fiction novelists and now for some postmodern social commentators. It 'embodies' the idea that biotechnology will gradually undermine many of the foundational properties of human nature, including characteristics such as age and sexuality.[6] Fashion itself plays an increasing role in determining bodily physique. The body has taken on a more plastic quality. Physical appearance is now manufactured out of individual consumer choice rather than fashioned by the necessary labour that a worker performs. The body has become the site for a new transgressive aesthetic.[7] Challenging 'wholesome tastes', the physical stereotypes of masculinity and femininity, and foundationalist ideas of beauty, a growing range of bodily types compete as aesthetic models for the human form. Despite the postmodern crisis in the visual arts, there is a burgeoning interest in the aesthetic possibilities of the human body. This is sustained by – and no doubt sustains – developments in 'creative' marketing where the

human figure is endlessly deconstructed and reconstructed in the expanding interests of retail capital.

The potentially significant progress in molecular genetics also raises the serious possibility of turning ourselves inside out. This 'new technology' offers tantalizing prospects of reconstructing human natures through cloning, gene splicing, organ synthesis and cell repair nanotechnology systems.[8] The idea of the body as a vehicle that – aside from a few patches – must carry us through life in a largely predestined fashion is challenged on several fronts. Just as the social boundaries of the lifecourse have become blurred, so too have the physical determinants of our bodily identity. While many of the possibilities for reconstructing biological structures remain largely unrealized – and most probably are unrealizable – the existence of this science suggests that it is within its capabilities to rewrite the story that our bodies express. It is this potential for reconstruction that so much echoes the mood of our postmodern times.

For these reasons – the rise of consumerism, the growing salience of age and the increased uncertainty surrounding the nature of bodies – the topic of embodiment has become an important part of (post)modern sociology. The physicality of ageing has always been a central issue in gerontology. Rendered problematic by the shifts of postmodern culture, the body continues to play a critical but now increasingly confusing role in the various approaches to understanding and making sense of ageing expressed at the end of the twentieth century.

The body as the 'true' foundation of ageing: confronting physicality

While public policies contribute much to the social construction of old age, there is a strong perception in people's minds that ageing is really a bodily affair. This viewpoint is evident in gerontology where the body has been a central reference point from which to study and understand 'the ageing process'. Perhaps the bulk of gerontologists would argue that ageing is, in the end, a matter of biology, best defined by an increasing risk of irremediable physical disability and death.[9] Most gerontologists – indeed most social gerontologists – accept ageing as an immutable fact, one that is fundamentally unaffected by how the productive processes are organized and how goods, services and capital are distributed. The

only arena for human agency is in equalizing the quality of life for each age group and for each category of physical and mental frailty.

It seems incontestable that there are limits to every lifespan. The more social environments support and enable everyone to reach old age, the more evident are these limits.[10] In the process of constructing a more equitable old age, what becomes evident is that age itself is unfair; that, in the end, age impoverishes more than poverty ages. Removing the skeins of social disadvantage exposes the greater disadvantage that is woven into our own imperfect DNA.

This kind of foundationalist position raises several questions for social gerontologists particularly when they adopt a 'social constructionist' account of old age as a product of social policy. The biological finitude of ageing is taken as setting the limits to the social construction of old age. The physicality that is the essence of old age seems to wipe away the imprint of class, gender and race that is so salient in earlier life. This view is illustrated in a comment made by Kathleen Woodward in her book *Aging and Its Discontents*:

> As we approach the extremity of old age we approach in the West the limit of the pure cultural construction of aging.[11]

Faced with the physicality of old age – the changes in appearance and function that are seen socially as defining adult ageing – it seems impossible to argue that ageing can be understood as rooted not in the domain of biology but in social relations.[12] It is in the biological materiality of the body that the 'cultural' approach toward understanding ageing meets its greatest challenge.

Postmodernism has developed a fascination with the body – particularly its plastic potential to fashion identities out of a cultural rather than a biological reality. The new sociology of the body reflects this fascination – with its focus on sexuality, physical culture, the aestheticization of the body and its products and the 'disciplinary' regimes to which the bodies of late modernity are subject. At first sight it might seem that ageing and old age are excluded from this discourse of bodily signification. Body image preoccupies teenagers wrestling with the problems of puberty and popular culture; bodily aesthetics provide a site for young artists, including the young disabled and the young whose bodies have been shaped by the knife and the scalpel. Physical culture offers

both active and passive means of reshaping the body, but its domain too is youth and the youthful middle aged, those who are not intimidated by tireless work on the treadmill and the weights bench. At some point, it seems, age draws a line, effectively disengaging individuals from such cultural practices.

But now, at the start of a new century and a new millennium, drenched in the hyperreal cyber-cultures that promise endless human possibilities, discernible elements of 'modern' culture can be identified that continue to shape the body across the lifecourse. It is to these current cultural and technological practices that influence both the external appearance and the inner mechanisms of 'ageing' that we wish to turn our attention.[13] Highlighting such considerations serves to challenge any straightforwardly foundationalist position that seeks to establish the body as the unquestionable 'bottom line' in the discourse on ageing, enabling an examination of how the ageing body might be, and we would argue, is culturally differentiated.

Anti-ageing and the aesthetics of the body

Cosmetic surgery is available only to a limited number of people. It is not funded within either taxation-based or insurance-based health-care systems. There are still relatively few people whose lives create sufficient dissonance between their public and private selves that they would go so much out of their way to realize a wish to look younger. Anti-ageing medicine remains very much a private business. Nevertheless, the rising popularity of cosmetic surgery has more than merely iconic value in demonstrating the plasticity of the ageing body. That a significant minority of people – usually those with considerable material resources – do choose to have aesthetic surgery to rejuvenate their appearance shows what the many without those resources might also do had they similar opportunities.[14]

Much of the work of cosmetic surgeons concentrates primarily upon 'anti-ageing' procedures. These are becoming more various and more technically sophisticated year on year. Current practice includes chemical skin peels to rejuvenate the appearance of the skin, scleropathy (removing distended veins on the legs), hair transplantation, facelifts and tucks, forehead lifts and blepharoplasty (correction of drooping

eyelids). New techniques are constantly being introduced such as laser hair transplanting and 'botox' injections to relax lined and wrinkled skin. These developments are driven by market forces originating largely from the baby-boomer generation.[15] What is surprising is that 'anti-ageing' cosmetic surgery is sought not only by the middle-aged/third-age population but also by significant numbers of people in their twenties and thirties. As we pointed out in Chapter 5, 'age concerns' have spread across significant sections of the adult population. Surveys conducted in 1998 and 1999 in the United States indicate that the majority of 20-year-olds, 30-year-olds, 40-year-olds, 50-year-olds and 60-year-olds 'approve' of cosmetic surgery. Only after age 65 do the approval ratings decline. Equally significant, though less surprising, is the finding that approval ratings are lower, the lower the individual's income.

It seems probable that these cohort effects will persist, and cosmetic surgery and related procedures will become part of everyday life, providing more and more people with the opportunity to mould their appearance to how they would like to be. Surgeons themselves see techniques improving as they become more widely used and the growth of computerized systems using photographs of patients that were taken in their youth in order to 'redesign' the face in advance of surgery offers further evidence of what Baudrillard termed the simulation and hyperreality of modern life.

People aged 65 and over currently make up a small sector of the market for cosmetic surgery (teenagers are the smallest) but figures from the American Society for Aesthetic Plastic Surgery indicate a steady rise in the numbers of retired people undertaking such procedures. Moreover, members of each new mid-life cohort who undergo anti-ageing procedures face a further dilemma deciding when to 'get out of' the market. One recent study indicates considerable variation between individuals about deciding when and whether to stop.[16] The growing individualization of the ageing experience makes it likely that such decisions will create still further distinctions amongst third-agers, between those adopting 'managed ageing' strategies and those opting for a strategy of 'lifelong prolongevity'.

In the absence of an inner logic to ageing, the play of signification that is involved in choosing how and when to age offers a wide scope for the marketing of desire. Skin peels, tummy tucks, forehead lifts, hair

transplants, botox injections and facial fat grafting do not 'restore' a youthful appearance so much as improve the 'aesthetic' appearance of the ageing face. To that extent cosmetic surgery is less about anti-ageing and more to do with a general desire felt by many people to improve on their 'natural' appearance. The public appearance of 'agedness' is no deep signifier of incipient disability or closeness to death.[17] It is in that sense exquisitely concerned with the surface plane of 'signification'. However, without this connectivity to the interior pathways of old age, the increasing lifestyle aestheticization exemplified by anti-ageing cosmetic surgery might seem a cultural epiphenomenon of the commodification and marketing of health rather than posing a serious challenge to the foundationalist position of bio-ageing. At the same time, dissatisfaction with ageing is highly predictive of mortality amongst older adults – even after taking account of chronological age, socioeconomic status, health and other risk factors.[18] If aesthetic surgery succeeds in reducing such dissatisfaction it may contribute quite incidentally to distancing chronological agedness from both decline and death.

Other anti-ageing technologies offer a more direct route toward preventing or delaying bio-ageing. Continuing medical research into various steroids, steroid-like compounds, vitamins and related nutrients (dehydroepiandrosterone (DHEA); estrogens and phytoestrogens; coenzyme Q-10; vitamin E; superoxide dismutase (SOD); etc.) suggests small but measurable benefits in terms of later-life disease prevention. Cross-national and temporal variations in the age-specific rates of cardiovascular disease and various cancers also suggest that there is scope for further gains in 'healthy years of life' by modification of lifestyle and dietary habits.[19] More radical proposals exist.

Ronald Klatz, a major proponent of anti-ageing medicine, confidently predicts that in the near future:

> A minimum of 40 000 lifespans [will be] extended annually by eliminating heart failure by a combination of medical options: totally implantable artificial hearts, a modified heart assist device, xenograph transplant/repair or micro-transplanation of fetal heart cells in devitalized heart tissue . . . A 30 year reversal in the aging process will be achieved by means of an implantable hormonal/pacemaker device to deliver a concentrated mixture of growth factors/hormones in cyclic rhythm to improve basic cellular function resulting in maintenance of bone density, muscle strength and overall cardiovascular fitness.[20]

The ageing body is rapidly becoming a key element in the postmodern uncertainty over what constitutes the natural. While cosmetic surgery exploits the possibilities of surgical technology to re-aestheticize the ageing body in one swift act, it remains a private and risky enterprise that currently possesses a rather limited social value. Consumption of over-the-counter medicines and all the various 'anti-ageing' cosmeceuticals and nutraceuticals offers a less risky strategy but requires sustained lifestyle changes with little obvious to show for them. Both practices nevertheless represent the active choices of consumers. Other aspects of anti-ageing medicine relate less to consumerism and the health market. Rather they seek to derive their status from their ability to represent themselves as a continuing part of medicine's modernist 'triumph over nature'. Prophylactic high-technology surgery is a small but significant component of a largely private health-care industry that actively promotes itself as 'anti-ageing medicine'. The evidence base for such practices is extremely limited and often rather tenuously linked to experimental gerontological research. In fact, much of the secular and cross-national variation in age-specific morbidity seems to derive not from variations in access to the latest technology but from variation in lifestyle and environment. The claims of anti-ageing medicine represent more an aspirational science which has flourished within postmodern culture than traditional 'modern medicine'. Indeed all three elements of 'anti-ageing' health care can be seen as deriving from and reinforcing that particular form of 'ageism' ushered in by modernity. In the next section we examine the impact of such 'ageism' on the experience of bio-ageing.

Ageism: the personal and the public

Using cosmetic surgery to determine whether and how to 'age' is not just a matter of personal aesthetics. It reflects the public valuing of 'agedness'. Expenditure of over $15 billion on anti-ageing nutritional compounds in the USA is not just a matter of consumer choice. It represents a massive social dread of old age. While negative attitudes toward old age have been in evidence for centuries, they have rarely played the role that they do in contemporary society. What is unique about the ageism of modernity is that it is represented in numerous institutional

practices that treat 'agedness' as a proxy for poverty, neediness and proximity to death. Therefore, we shall argue, current ageist assumptions constitute more than mere cultural by-products of particular economic and biological power relations. They exercise a direct and proximal influence upon the processes of bio-ageing itself.

Three routes mediate the effects of ageism on bio-ageing. In the first place secular changes in the economy have resulted until relatively recently in older adults occupying positions of lowered socioeconomic status. This position of socioeconomic disadvantage enhances their risks of ill-health, disability and death. Secondly, the internalization of negative attitudes about ageing and old age undermines the confidence of older adults in their dealings with the physical and social world, leading them to entertain lower expectations of themselves as agents. Such self-imposed limitations lead in turn to poorer health and fitness, increased risk of disability and ultimately a reduced chance of survival. Finally, institutional ageism limits access to those facilities and resources that promote health and well-being, prevent disease and facilitate recovery. Although this is most obvious in relation to health-care practices, it applies to a much wider set of institutions including the workplace, personal finance institutions and the educational system.

In short, ageism has economic, psychological and social effects that potentially impact upon the physical well-being of retired people. We shall consider the evidence for each of these propositions in turn.

Ageism and economic disadvantage

Cowgill and Holmes were amongst the first social gerontologists to argue that the status accorded to older people varies across cultures and over time, depending upon the organization of productive forces.[21] They argued that systematic shifts in the status of older adults arise as a function of the economic power which older adults control within society. The economic power of older adults in turn is determined by the extent to which the productive forces within a society support the accumulation and transfer of both cultural and material resources within the patrilineal family.[22] Within this perspective, ageism reflects the devalued status given to older people resulting from their lack of economic and cultural power *vis-à-vis* the younger members of society. This is most marked during periods of social and economic change. The transition

from an agrarian/mercantile to an industrial economy alters the control of the domestic economy exercised by older men. With industrialization, the future economic well-being of adult children is less dependent upon what they might inherit. Manufacturing industry provides increasing opportunities to sell one's labour/earn one's living independently of the home, with the prospect of gaining access to a wider range of resources than could be obtained by patiently working the land while waiting to inherit. This aspect of modernization theory – the term used by Cowgill and Holmes to describe this doctrine – has received a surprising amount of empirical support.[23] There is also evidence now that with current trends towards a new affluence amongst the younger members of the retired community, at least, a reversal of this status decline is taking place.[24] The impact of this 'post-industrial' turn should lead to consequent improvements in health and well-being. Such trends of improving health and reductions in disability do seem to be emerging and we shall consider them in more detail in the next chapter. For now it is sufficient to note that there are consistent signs of a steady improvement in the overall economic status of older adults – both in the US[25] and in the UK[26] – which might well be seen as predictable from the basis of modernization theory and all that it implies concerning ageism and relative economic disadvantage. These trends in improved economic well-being are associated with increased longevity and reduced disability.

What remains is the impact of economic disadvantage on groups within the retired population who remain 'vulnerable' by still retaining the devalued status that modernization conferred upon 'the old' in general. People from racial/ethnic minorities, widows from working-class backgrounds and people whose working lives have been locked into welfare remain particularly vulnerable. Table 7.1 illustrates the relative economic position of black and white householders in the United States at the onset of working life and after retirement.

Between 1987 and 1997 the average income of white retired US householders rose by 17 per cent from 75 per cent to 84 per cent of that of white younger adults; in contrast black retired US householders' average income rose by only 9 per cent during the same period, and actually fell from 75 per cent to 72 per cent of the average income of younger black adults. The position of retired householders from hispanic backgrounds was intermediate to that of white and black householders. In

TABLE 7.1 Average income in US dollars for US white, black and hispanic householders at ages 25–34 and 65–74 years*

Year	*White householder mean income: 25–34 years*	*Black householder mean income: 25–34 years*	*Hispanic householder mean income: 25–34 years*	*White householder mean income: 65–74 years*	*Black householder mean income: 65–74 years*	*Hispanic householder mean income: 65–74 years*
1987	$45 963	$27 644	$34 296	$34 438	$20 765	$23 375
1997	$48 082	$31 646	$35 464	$40 194	$22 637	$26 883

* Data derived from US Census Bureau, *Historical Income Tables*, Tables H-10A to H-10C, http://www.census.gov/hhes/income/histinc/h10.html

1987, their average income was only 68 per cent of younger adult hispanic householders, but, by 1997, it had risen by 14 per cent to 75 per cent of the average income of younger adults.

Paralleling this selective economic disadvantage are indications of a similar health-related disadvantage. Data from Medicare files for this same period indicate that, amongst those aged 65 years and over, age-adjusted mortality rates were 19 per cent higher for black men and 16 per cent higher for black women compared with white men and women. Hospital discharges likewise were 14 per cent and 15 per cent higher amongst black men and women.[27] These and other studies we shall examine later indicate the potential costs to older people arising from remaining at a disadvantaged socioeconomic position. That a positive 'postmodern' transformation in socioeconomic status has occurred for the majority of older people in Western societies seems undeniable; but for those still occupying such disadvantaged statuses, there are clear consequences for their health and expectation of life.

Ageism and the internalization of failure

Several writers have argued that the widespread negative attitudes toward old age evident in contemporary society lead to an internalization of these values by older people themselves. This internalized ageism erodes the self-confidence of older people, reducing expectations, leading to poorer physical and mental performance, which are then treated as 'objective' evidence of an age-related decline.[28]

Evidence to support this argument is less well established. Nevertheless, there is some direct empirical support. Two particular examples

are used as illustration. The first is a study examining the relationship between age, memory performance and attitudes toward ageing conducted by two social psychologists, Levy and Langer.[29] They sought to test the hypothesis that cultures which held positive views of old age would lead older adult members of that culture to experience less 'internalized' ageism. Consequently they would have greater confidence in their personal competence and perform better on mental performance tests – in this case memory tests. Comparing groups of younger and older adults in three different cultural groups – Americans, American Sign Language using deaf Americans and Chinese – they observed that the Chinese showed least evidence of 'questionnaire-measured' ageism and least evidence of age differences in memory test performance. In stark contrast, the Americans reported considerable 'ageism' in both young and old samples and highly significant age differences on the memory tests in favour of the younger adults. Results from the American deaf sample were intermediate between the other two groups.

A second study examined the impact of subtly reinforcing positive messages about ageing on measures of gait. Two matched groups of older people were filmed walking before and after playing a computer game during which they 'subconsciously' received either positive or negative messages about old age and the ageing process. Significant improvements in the speed and 'spring' of walking were observed in those receiving the positive message while those receiving the negative message showed no change.[30] The implications of both these 'experimental' studies are that at least part of the so-called age-related decline in physical and mental performance can be attributed to social and cultural forces rather than chronological age *per se*.

Bytheway has argued that all categorizations of old age are inherently ageist since such language first reifies then sets apart a group of people whose differences from others are a matter of degree rather than indicative of a fundamental discontinuity.[31] For Bytheway, the very act of distinguishing a period within the lifespan called old age carries with it connotations of 'otherness' that ignore the very real continuities across adult life. Certainly there is evidence that self-definitions of being 'old' or 'elderly' are associated with poorer health, reduced well-being and greater mortality. Just as self-rated health predicts future life expectancy,

self-defined old age reflects a similar relationship[32] – suggesting either that the act of defining one's status as 'aged' influences how 'aged' one becomes or that self-defined agedness serves as an experiential marker of biological fitness. Whatever the mechanism, individual and cultural variation in the exposure to and acceptance of messages concerning fitness or 'agedness' does appear to be related to variations in late-life outcomes. Older people's pessimistic beliefs about their agedness, their health and their ability to 'control' these characteristics contribute to functional decline and death in later life.[33] These effects appear constant across quite disparate cultures.[34] More assertive attitudes amongst future generations of older people are likely. Asked whether they would be willing, as 'older' patients, to stand aside in waiting list queues for surgery in favour of younger patients, the majority of those not yet 'old' replied that when their turn came they definitely would not 'step aside' – in marked contrast to the willingness to do so evidenced amongst contemporary older adults.[35]

Ageism and its institutionalization

Alongside the economic and cultural devaluing of age, there are other structurally embedded forms of ageism still evident in many of the institutions operating within the modern state. Numerous reports have found evidence of institutionalized ageism in health-care systems, in educational institutions, in the workplace and in the financial services sector.[36] Institutionalized ageism involves selective exclusion from, or reduction in access to, particular societal resources on the explicit basis of people's adult age. Within health-care systems this includes inadequate access to health care; inadequate investigation of health problems; and inadequate and/or inappropriate treatment of identified health problems.[37] Specific examples include failure to provide routine breast screening for women aged over 65; limited investigations performed on older patients following admission to hospital after a heart attack; denial of access to cardiac rehabilitation programmes; a more limited range of investigations and treatments offered to older people with various types of cancer; refusal to make available certain types of day surgery to patients aged over 70; excess use of neuroleptics (anti-psychotics) in nursing homes; widespread polypharmacy associated with a raised incidence of hospital admissions of older adults – the list is extensive and exhausting in its cumulative

potential to demote the health of older people.[38] Although it is not possible currently to determine how much age-related restrictions on access to health care contribute to the excess morbidity and mortality of older people, it seems likely that there is a significant and measurable impact on the health and physical function of older people, which goes well beyond that which can be accounted for by the clinical 'risk' of being a certain age.[39]

The impact of age discrimination in the provision and range of financial services offered by the various private investment, insurance and pension schemes has not been subject to the same kind of research scrutiny as that conducted in the health field. Nevertheless, numerous examples have been reported to organizations such as Age Concern England. These complaints range from unwarranted restrictions on insurance covers to lack of access to some types of pension schemes, limited credit facilities and investment opportunities, and so on. The general conclusion to be drawn from these and other related reports is that older people are less able to invest in ways that can maximally improve their material conditions in comparison with younger adults.[40]

Ageism is not just a problem of cultural representation – the lack of representation or lack of respect given to older people. It has material consequences in the lives of older people, in their access to material resources, in their capacity to benefit from health care and in their own expectations of themselves. The power of cultural representations to influence the physical experience of later life may not be easily demonstrated, but there are plenty of reasons to believe that it can and does do so. The nonchalant acceptance of difference and the infinite potential to work and rework regimes of signification that are meant to be the hallmarks of postmodern life have yet to fully penetrate the lives of older people. Age and ageing remain largely, though by no means completely, outside the play of the more extreme transgressions of postmodern culture. However, while it may be possible to ridicule some of the naivety of postmodern writings, the fact remains that it is the institutions of modernity that have oppressed older people. The institutions that were built up in the nineteenth and early twentieth centuries – the foundations both of our industrial economy and of our welfare state – are the principal sites where the exclusion and the marginalization of older people have taken place. The embodiment of ageing that takes place

in the institutional practices of geriatrics and gerontology reinforces the idea that ageing is at bottom a physiological affair and that the resolution of the ageism that exists in society requires primarily the moral exhortation of the state and other welfare institutions to stop it. Such an approach fails to engage with the nature of the dilemma – that cultures of ageing are also primarily cultures of resistance to age, not ways of embracing old age. They express the same antipathy to old age that has been present throughout recorded history. Anti-ageing surgical practices and anti-ageing medicines are not designed to counteract or to challenge ageism. They represent an aesthetic preference not to look like an old person; not to appear elderly. If resistance to ageism also requires opposition to such surgery (much in the same way that the advocates of deaf culture oppose cochlear implants) it is likely to collapse under the weight of contradictions that reside within conceptualizations of a 'positive' old age.[41]

Ageing: appearance, reality and then some

If sex reassignment surgery is poised to be incorporated into the British National Health Service's 'free at the point of delivery' services, establishing a place for itself alongside sexual dysfunction clinics for people wanting a better sex life and infertility clinics for couples wanting to have a better family life, then why should not NHS surgeons be permitted to lift and abrade the skin, replace and re-position the fatty tissue and musculature of the face in order to restore a more youthful look to older men and women who feel they need an improved appearance? Why should health insurance programmes not include such procedures amongst their list of approved medical services? Why should general practitioners not be permitted to prescribe Viagra to all those older men who wish to have more regular and reliable erections? Why should peri- and postmenopausal women not be able to get a choice of estrogen-replacing prescriptions? Moreover, why should people approaching retirement not be entitled to the prophylactic benefits of grafts, transplants and other 'rejuvenating' forms of surgery? Why are limits drawn round those practices that could prevent aspects of bodily ageing which, in turn, put at risk the viability and opportunity for post-work lifestyles that aim at staying young?

Is it ageism, in short, that causes people to undergo cosmetic surgery – or is it ageism that prevents or restricts the accessibility of such surgery; is it ageism that seeks to set limits on how old a woman can be to receive fertility treatments; that asserts that death should be the appropriate fate of 'old' people but not 'young' people? Resolutions of these dilemmas will not arise from the shrinking postmodern state. Creating viable cultures of ageing depends upon establishing a sufficient economic base to sustain a level of consumption that will enable them to be expressed through the strength of individual demand. For most older people, the body is still too dangerous to serve such ends and after all consumer culture is not really about instilling physical self-confidence. Its success comes from achieving the very opposite. Our bodies are still too little our own. Retired people are establishing an increasing variety of post-work lifestyles, yet the body remains problematic, occupying a complex and contradictory position in relation to ageing and its cultural possibilities. Should one exercise it, dress it and decorate it or simply ignore it? Should it be tinkered with, tarted up or is it best left alone? Should the signs of age – grey hair, wrinkled and lined skin – be the basis of a new form of identity politics: should we be glad to be grey? And what features of bodily ageing should be selected as positive sources of significance and what features should be excluded?

Ensuring that people have access to effective health care, sound financial advice and savings systems, and a wide range of opportunities to develop their skills and knowledge, is an agenda that can be supported by adults irrespective of their working status. While access to the social material and cultural resources might be expected to yield benefits in terms of health, well-being and fitness, the principle of ensuring an age-irrelevant equity of access might garner more popular support than the principle of ensuring equalization of the lifespan. The body clearly is not without a material reality, but that reality can only be expressed through social means. There can be no pure human 'ageing'; no ageing under glass. Advice exists in many forms about how the body can be treated to reduce its significance as a marker of personal ageing and proximity to death. The aim of such advice is more or less the same as that of anti-ageing medicine – to reduce the negative markers of old age. What remains after the success of such an enterprise may well never be known – indeed it may not be knowable. Making clear the

reasonableness of a position that states that people do not want to look old and unattractive, do not want to feel fatigue, pain and sickness, do not want to be incapable of carrying out those everyday acts that confer adult status and adult competence, in short that people are happy to age but not be aged, is a necessary step in establishing a cultural and political agenda to combat ageism. That agenda must be to resist those practices which seek to thwart such desires and support those practices which render them more likely to be expressed, legitimated and embodied in practice. It is a policy to reduce inequalities amongst adults as adults, and not to improve the treatment of old age.

Such a platform seems in keeping with the personal aesthetic that characterizes postmodern culture – including the inherent contradiction that lies at the heart of this message, namely that one day we must fail. The failure that is old age cannot be translated into a rallying cry. Seeking collective redress about the social revaluing of old age cannot ignite the kind of identity politics that exists around skin colour, gender or sexual orientation. Realizing virtue despite the handicap of age is clearly one widespread form of recognition that is often claimed – praise for doing something 'despite' one's age. But it privileges exception and requires that most people of that age remain unable. Resisting and challenging the structured inequalities within society may provide a firmer platform in that it promises to improve both the quality and length of life while offering a programme whose support is not determined by an age-based constituency. The extent to which such inequalities can and do structure bio-ageing is addressed in the next chapter.

Notes

1 Turner, B.S. (1991) *Regulating Bodies*, Routledge, London, p. 34.
2 See for example Turner, B.S. (1984) *The Body and Society*, Sage Publications, London; Featherstone, M., Hepworth, M. and Turner, B.S. (eds), *The Body: Social Processes and Cultural Theory*, Sage Publications, London; Falk, P. (1994) *The Consuming Body*, Sage Publications, London; Shilling, C. (1996) *The Body and Social Theory*, Sage Publications, London, as well as the new academic journal *Body and Society* (from 1997).
3 Sulkunen, P. (1997) Introduction, in P. Sulkunen, J. Holmwood, H. Radner and G. Schulze (eds), *Constructing the New Consumer Society*, Macmillan, London, pp. 6–7.
4 It has been estimated that around 50 per cent of the adult population of the United States are taking vitamin supplements.

5 Shilling, C. (1996) *op. cit.*, p. 38.
6 See Featherstone, M. and Hepworth, M. (1998) 'Ageing, the lifecourse and the sociology of embodiment', in G. Scambler and P. Higgs, *Modernity, Medicine and Health*, Routledge, London, pp. 147–75; Haraway, D. (1991) *Simians, Cyborgs and Women: the Reinvention of Nature*, Routledge, London.
7 Postmodern challenges to fixed ideas of beauty can be traced back to the rise of photography as an art form, converting the marginal and the ugly into objects of aesthetic reflection (see Sontag, S. (1979) *On Photography*, Penguin, Harmondsworth, especially her essay entitled 'The heroism of vision', pp. 85–112: 'Photographs create the beautiful and . . . use it up' (p. 85)). See also Mellor and Shilling's discussion of the 'baroque modern body' in Mellor, P.A. and Shilling, C. (1997) *Reforming the Body: Religion, Community and Modernity*, Sage, London.
8 See Markle, R.C. (1997) 'Nanotechnology and medicine', in R.M. Klatz (ed.), *Advances in Anti-Aging Medicine*, vol. 1, Mary Ann Liebert Inc., New York, pp. 277–86.
9 Maier and Smith, in their paper on predictors of mortality in the Berlin Longitudinal Study of Ageing, suggest that, with increasing age, genetically determined processes take over increasingly in shaping old age morbidity and mortality. See Maier, H. and Smith, J. (1999) 'Psychological predictors of mortality in old age', *Journal of Gerontology*, 54B: P44–54.
10 This viewpoint is clearly expressed in Fries' 1980 paper on the rectangularization of the lifespan in which he proposed a 'natural' lifespan of 85 years and argued that progress in health and social care would lead to an accumulation of deaths around this maximal point (Fries, J.F. (1980) 'Aging, natural death and the compression of morbidity', *New England Journal of Medicine*, 303: 130–5).
11 Woodward, K. (1991) *Aging and Its Discontents: Freud and Other Fictions*, Indiana University Press, Bloomington, IN, p. 194.
12 In Andrew Blaikie's recent book, with much of which we have considerable sympathy, still there is this sense of an unwavering 'bottom line', as when he writes: 'increased longevity also means more incontinence, more dementia, more bodily betrayals and breakdowns in communication' (Blaikie, A. (1999) *Ageing and Popular Culture*, Cambridge University Press, Cambridge, p. 109).
13 As one example, scientists in the research and development laboratories of L'Oreal are reportedly researching the mechanisms of age-related changes in human hair with the intent of delivering products that will reverse hair loss and prevent hair greying – see *Business Week*, June 28 1999, p. 28.
14 Figures from the American Society for Aesthetic Plastic Surgery state that nearly 2.8 million cosmetic operations were performed in 1998; figures from the American Academy of Cosmetic Surgery are much higher – they report 2.65 million operations performed in 1994 rising to 3.35 million operations in 1996.
15 Botulinum toxin is a major source of food poisoning. However, it also has antispasmodic properties which led to its use in the treatment of various neuromuscular disorders. Since the early 1990s it has been used as a means of reducing lines and wrinkles, through repeated injections spread out over several months.
16 See Ancheta, R.W. (1998) 'Masking mid-life: cosmetic surgery and women's experiences of ageing', *British Sociological Association Meeting, Making Sense of the Body*, Edinburgh, Scotland.

17 Peter Schnohr and his colleagues found in a study of 13 000 men and women that greying hair, baldness, skin wrinkles and changes in the appearance of the eye were unrelated to mortality (Schnohr, P., Nyboe, J., Lange, P. and Jensen, G. (1998) 'Longevity and gray hair, baldness, facial wrinkles and arcus senilis in 13 000 men and women: the Copenhagen City Heart Study', *Journal of Gerontology*, 53A, M347–50).
18 See Maier, H. and Smith, J. (1999) *op. cit.*, Table 2.
19 See for example Khaw, K-T. (1997) 'Healthy aging', *British Medical Journal*, 315: 1090–6.
20 Klatz, R.M. (1996) *op. cit.*, p. xiv.
21 Cowgill, D. and Holmes, C. (1972) *Aging and Modernization*, Appleton Century Crofts, New York.
22 See also Lee, G.R. (1984) 'Status of the elderly, economic and family antecedents', *Journal of Marriage and the Family*, 46: 267–75.
23 Clark, R. (1992) 'Modernization and status change among aged men and women', *International Journal of Aging and Human Development*, 36: 171–86. Cohn, R.M. (1982) 'Economic development and status change of the aged', *American Journal of Sociology*, 87: 1150–61. Gilleard, C.J. and Gurkan, A.A. (1987) 'Socioeconomic development and the status of elderly men in Turkey: a critical evaluation of modernization theory', *Journal of Gerontology*, 42: 353–7. Lee, G.R. (1984) *op. cit.*
24 Pampel, F.C. (1981) *Social Change and the Aged*, Lexington Books, Lexington, MA. Harris, R.J. (1986) 'Recent trends in the relative economic status of older adults', *Journal of Gerontology*, 41: 401–7; Smolensky, E., Danziger, S. and Gottschalk, P. (1988) 'The declining significance of age in the United States: trends in the well-being of children and the elderly since 1939', in J.L. Palmer, T.M. Smeeding and B.B. Torrey (eds), *The Vulnerable*, Urban Institute Press, Washington, DC, pp. 29–54.
25 Hurd, M.D. (1989) 'The economic status of the elderly', *Science*, 244: 659–64.
26 Johnson, P. and Falkingham, J. (1992) *Ageing and Economic Welfare*, Sage Publications, London.
27 Gornick, M.E., Eggers, P.W., Reilly, T.W., Mentnech, R.M., Fitterman, L.K., Kucken, L.E. and Vladeck, B.C. (1996) 'Effects of race and income on mortality and use of services among medicare beneficiaries', *New England Journal of Medicine*, 335: 791–9.
28 One of the earliest expositions of the malignant impact of cultural ageism was expressed by Robert Butler in his paper, 'Age-ism: another form of bigotry' (Butler, R. (1969) *The Gerontologist*, 9: 243–6).
29 Levy, B. and Langer, E. (1994) 'Aging free from negative stereotypes: successful memory in China and among the American deaf', *Journal of Personality and Social Psychology*, 66: 989–97.
30 Hausdorff, J.M., Levy, B.R. and Wei, J.Y. (1999) 'The power of ageism on physical function of older persons: reversibility of age-related gait changes', *Journal of the American Geriatrics Society*, 47: 1346–9.
31 Bytheway, B. (1995) *Ageism*, Open University Books, Milton Keynes.
32 One of the first studies to demonstrate the links between self-perceptions of being 'old' or 'elderly' and morbidity was conducted by Bultena, G.L. and Powers, E.A. (1978) 'Denial of aging: age identification and reference group orientations', *Journal of Gerontology*, 33: 748–54.

33 See for example Boult *et al.*'s study which indicated that older people's lack of belief in their control over their health accounted for more late life transitions to the status of having 'functional limitations' than did either arthritis, cancer, confusion, coronary disease or diabetes (Boult, C., Altmann, M., Gilbertson, D., Yu, C. and Kane, R.L. (1996) 'Decreasing disability in the 21st century', *American Journal of Public Health*, 86: 1388–93, Table 1).

34 Yu, E.S.H., Kean, Y.M., Slymen, D.J., Liu, W.T., Zhang, M. and Katzman, R. (1998) 'Self perceived health and five year mortality risks among the elderly in Shanghai, China', *Journal of Epidemiology*, 147: 880–90.

35 Mariotto, A., De Leo, D., Buono, M.D., Favaretti, C., Austin, P. and Naylor, C.D. (1999) 'Will elderly patients stand aside for younger patients in the queue for cardiac services?', *The Lancet*, 354: 467–70.

36 Age Concern (1998) *Age Discrimination: Make it a Thing of the Past*, Age Concern England, London.

37 Age Concern (1997) 'Healthcare rights for older people – the ageism issue', *Age Concern and Nursing Times Briefing Paper*, Age Concern England Policy Unit, London. Gilleard, C.J., Askham, J., Biggs, S., Gibson, H.B. and Woods, R.T. (1995) 'Psychology, ageism and healthcare', *Clinical Psychology Forum*, 85: 14–16.

38 The role of ageism in health care systems was clearly outlined in a *JAMA* editorial published in 1987 (Wetle, T. (1987) 'Age as a risk factor for inadequate treatment', *Journal of the American Medical Association*, 258: 516). Since then there has been a steady stream of papers providing specific examples of ageism in relation to the treatment and investigation of particular medical conditions. For an overview of ageism operating in health screening programmes, see Sutton, G.C. (1997) 'Will you still need me, will you still screen me, when I'm past 64?', *British Medical Journal*, 315: 1032–3. Evidence of inadequate investigation and treatment of various cancers has been documented by Turner *et al.* (Turner, N.J., Haward, R.A., Mulley, G.P. and Selby, P.J. (1999) 'Cancer in old age – is it inadequately investigated and treated?', *British Medical Journal*, 319: 309–12). Similar observations have been made about the treatment of cardiovascular disease – see, for example, Reynen, K. and Bachmann, K. (1997) 'Coronary arteriography in elderly patients: risk, therapeutic consequences and long term follow up', *Coronary Arterial Disease*, 8: 657–66; and Naylor, C.D., Levinton, C.M., Baigrie, R.S. and Goldman, B.S. (1992) 'Placing patients in the queue for coronary surgery: do age and work status alter Canadian specialists' decisions?', *Journal of General Internal Medicine*, 7: 492–8. There is consistent evidence of inadequate investigation and intervention of older patients with coronary heart disease (Bearden, D., Allman, R., McDonald, R., Miller, S., Pressel, S. and Petrovitch, H. (1994) 'Age, race and gender variation in the utilization of coronary artery bypass surgery and angioplasty in SHEP', *Journal of the American Geriatrics Society*, 42: 1143–9) and after a heart attack (Udvarhelyi, I.S., Gatsonis, C., Epstein, A.M. (1992) 'Acute myocardial infarction in the Medicare population: process of care and clinical outcomes', *Journal of the American Medical Association*, 268: 2530–6). The role of polypharmacy in contributing to older people's admission to hospital has been documented by Williamson, J. and Chopin, J.M. (1980) 'Adverse reaction to prescribed drugs in the elderly', *Age and Ageing*, 9: 73–80; while the health risks attending older people after hospitalization may be five times those of younger adults (Gillick, M.R., Serrell, N.A. and Gillick, L.S. (1982) 'Adverse consequences of hospitalisation in the elderly', *Social Science and Medicine*, 16: 1033–8).

39 There is evidence, for example, that although late survival after coronary artery bypass grafting is similar in young and older patients, it is offered to younger adult patients more commonly than older ones (Rohrer-Gubler, I., Niederhauser, U. and Turina, M.I. (1998) 'Late outcome of coronary artery bypass grafting in young versus older patients', *Annals of Thoracic Surgery*, 65: 377–82). Likewise evidence from the Heart Center, Dresden, indicates that although bypass surgery and balloon angioplasty confer significant advantages over standard medical treatment for over-75-year-old patients with symptomatic coronary heart disease, such patients less often received this type of surgery than younger patients (Reynen, K. and Bachmann, K. (1997) *op. cit.*).

40 Age Concern (1998) *op. cit.*

41 If bio-ageing represents an increased risk of developing disability and dying, then all bio-markers of age are also associated with such enhanced risks. It is only by not accumulating such markers – i.e. a relative absence of markers of bio-ageing – that one can consider a person to be 'successful' in resisting what otherwise seems the fate of those living for an increasing number of years.