

Not just old and sick – the ‘will to health’ in later life

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ABSTRACT

The end of the ‘Golden Age’ of welfare capitalism in the 1970s was the prelude to a period of greater individualisation within societies and was accompanied by an increase in the importance of consumption as a way of organising social relations. During the same period there was also an expansion in the discourses aimed at enhancing the government of the autonomous self. One such discourse operates around what has been termed the ‘will to health’: it suggests that health has become a required goal for individual behaviour and has become synonymous with health itself. The generational groups whose lifecourses were most exposed to these changes are now approaching later life. We explore the extent to which social transformations related to risk, consumption and individualisation are reflected in the construction of later-life identities around health and ageing. We examine how the growth in health-related ‘technologies of the self’ have fostered a distinction between natural and normal ageing, wherein the former is associated with coming to terms with physical decline and the latter associated with maintaining norms of self-care aimed at delaying such decline. Finally, we consider anti-ageing medicine as a developing arena for the construction of later-life identities and discuss the implications of the social changes for researching later life.

KEY WORDS – ageing, individualisation, ‘will to health’, third age.

Introduction

The end of the ‘Golden Age’ of welfare capitalism in the 1970s in Western Europe was the prelude to a long process of institutional and cultural change; key features of which were the embedding of an individualised social order within consumer society and the dominance of neo-liberal ideas and policies within western governments (Streck and Thelen 2005).

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These changes were enacted by and upon generational groups that are now approaching or entering later life. This is a later life that is very different in character from that experienced by previous generations. Health and life expectancy have continued to improve and many diseases that would have meant a poor prognosis for older people have become amenable to health-care intervention (Kirkwood 1999). In the past, social gerontology has tended to focus on poverty and lack of agency in later life (Gilleard and Higgs 2000). However, more recent work has challenged this approach and highlighted improvements in health and income among retired people (Parker and Thorslund 2007), even when compared with younger age groups and with earlier cohorts of elderly people (Hills 2004). These improvements have also been accompanied by the emergence of what Peter Laslett (1989) among others termed the 'third age', in which both self-realisation and activity are seen as possibilities. This is a departure from the past when many saw old age as foreclosed by the processes of rolelessness and dependency (Burgess 1960). Alongside these opportunities, and in some senses embodied by them, has been the emergence of a consumer society in Britain where consumption and lifestyle choices have become culturally pervasive and engrained with many aspects of later life, even for those who lack the material means to pursue such choices (Jones *et al.* 2008).

The emergence of consumer culture and consumer societies has not been entirely a development ushered in by the neo-liberal governments of the 1980s and 1990s. Rather, such changes arose out of more complex movements in the nature of society, movements that first arose during the 1950s and 1960s and which came to fruition in the closing decades of the 20th century. The growth of youth culture in the post-war period had a formative impact on the cultures of consumption (Marwick 1998; Rosen 2003). Consequently, many of the cultural co-ordinates of the 21st century, such as the fusing of fashion and identity (Breward 2004), the commodification of lifestyle practices and the erosion of status and tradition (Beck and Beck-Gernsheim 2001), were set up in this period and continue to resonate. These cultural tropes and practices have also been the focus of rethinking the nature of contemporary society as a form of reflexive modernisation in which individualisation and choice are seen as the guiding principles of social action (Beck 1992; Beck, Bonss and Lau 2003; Giddens 1991).

The affinities between these ideas and neo-liberalism may seem close but it is not the case that they are interchangeable. As Rose (2001) pointed out, neo-liberalism is not simply a form of *laissez faire* politics; rather, it is a form of government that necessitates the conscious moulding of citizens with the aim of constructing a society in which markets function in altered

circumstances. All social behaviour under these circumstances becomes defined and legitimised in terms of rational calculation of the costs and benefits of competing choices and potential risks. Freedom becomes the capacity for self-realisation through individual actions in the face of multiple risks and opportunities. Ageing and the hazards of growing older form another arena in which the autonomous self is expected to act and to make the right choices. The growth in technologies aimed at enhancing the government of the autonomous self has attracted comment (Rose 2007). What has received less attention is the way in which the reconstruction of contemporary later life has meant that these responsibilities and techniques have become part of the generational habitus of the first cohorts to engage fully with reflexive modernisation throughout their lives as they age.

In this paper, we examine one of the key areas where these new technologies of human individuality (Miller and Rose 1997) are most apparent; namely within the rise to prominence of the 'will to health' in later life. Health has become a fundamental and required goal of the individual. Our aim is to explore the extent to which social transformations related to risk, consumption and increasing individualisation are reflected in the construction of third-age identities. Health is central to an agentic third-age lifestyle, as is the need to prevent physical and mental decline, which are the markers of a 'fourth age' recognised as a time of frailty and dependency. First, we consider the emergence of the 'will to health' as a dominant discourse in later life and a driver in the construction of third-age identities. Following from this, we examine how the growth in technologies of the self has fostered a distinction between natural and normal ageing, with the former being associated with a cultural and ethical ideal of old age as a time of physical and mental decline, while the latter is associated with an increasing emphasis on maintaining norms of self-care aimed at delaying or denying such a decline. This distinction is then related to how the older consumer is increasingly tied into contradictory notions of natural and normal ageing through the construction of risk and the marketisation of health technologies. Finally, we consider the case of anti-ageing medicine as a developing arena for the construction of third-age identities.

Third age identities and the rise of the will to health

Peter Laslett (1989) conceptualised the third age as a life-phase in which older people are able to seek self-fulfilment beyond the constraints of work and/or child rearing; a stage of life only ended by a 'fourth age' of frailty,

decline, disability and ultimately death. Katz and Marshall (2003) suggested that the third age places a social obligation on older people to lead active and independent lives so as to minimise the life phase of physical and mental decline in which they might require social support. Katz (2000) even suggested that older people need to demonstrate their capacity for 'activity' in much the same way that unemployed people need to 'demonstrate' that they are actively seeking work rather than being allowed to enjoy the fruits of retirement. That there is a need to justify the significance of post-working life from the point of view of activity can be seen in the debates around what is termed 'productive ageing' in the United States (Hinterlong, Morrow-Howell and Sherraden 2001). More analytically Gilleard and Higgs (2000, 2005) argued that the third age is as much concerned with resisting the effects of ageing on the body as it is with maintaining a continuing engagement with consumer society. The growth in material affluence among older people has allowed them to integrate these somatic concerns with consumerist lifestyles (Jones *et al.* 2008). These lifestyles have formed a strong part of what has been termed the 'generational habitus' long before these cohorts entered retirement (Gilleard and Higgs 2007). In addition, self-realisation has become a central part of the third agers' identity with engagement in a range of leisure activities from shopping, holidays to lifelong-learning providing meaning in the third age as well as opportunities for consumption. This development coincides with the broader shift of social values to self-realisation and autonomy noted by Giddens (1991) and Beck and Beck-Gernsheim (2001).

Central both to these wider social changes and to the development of third-age identities is the way in which health has become a fundamental expectation and required goal of individual lifecourses. Self-esteem is inextricably linked to individual health, and the individual's pursuit of health maintenance is seen as important in health promotion. This concern with health and the 'healthiness' of a wide range of activities has saturated many aspects of social life, so much so that discourses of health have overwhelmed our understanding of later life. Health in later life not only enables a state of personal wellbeing but is increasingly seen as central to leading an agentic, self-fulfilled old age. This places older people in a position where their health might determine their social status, either as active 'third agers' or as dependent 'fourth agers'. The importance of maintaining health lies in the need to stay an active producer of a positive health status rather than being a passive consumer of health care; a status indicating entry into the fourth age (Gilleard and Higgs 1998: 234).

Increasingly, the means to promote good health has been seen to be dependent on individual behaviour and is considered to be the personal

responsibility of a good citizen (Higgs 1998; Lupton 1995). These attitudes apply across the population. As Rose argues, the state's role has shifted towards that of the enabling state, the facilitating state and the state as animator (Rose 2001). Many commentators suggest that the 'will to health' can be seen as part of a shift in neo-liberal states towards forms of governmentality based on diverse technologies of the self (Bauman 2001; Dean 1999; Lemke 2001; Rose 2001). Studies of older people's engagement with different forms of health maintenance suggest that there are push factors, such as governmental interventions, and pull factors, such as perceptions of personal wellbeing, that drive the uptake of such technologies (Paulson 2005). They also suggest that the diffusion of discourses of personal responsibility for health translates at the individual level to the 'will to health' and this is a defining feature of 'successful' third age identities. One of the ways in which the will to health dominates later life is through the construction of normal ageing as distinct from an idealised notion of natural ageing.

Natural and normal ageing

The growth in technologies of the self has fostered a distinction between natural and normal ageing, where the former derives much of its sense from cultural or ethical considerations about the length and purpose of human life, while the latter is more concerned with the boundaries that might or might not exist to both longevity and healthy old age. Thomas Cole, in his seminal cultural history of ageing in America *The Journey of Life* (1992), pointed out that there have been a number of different cultural understandings of old age and death over the past two centuries in the United States, but that the current situation is one where there is a 'relentless hostility to physical decline and ... [a] tendency to regard health as a form of secular salvation' (1992: 239). Cole, like others such as Vincent (2003*a*), has a very strong ethical sense that ageing is fundamentally about coming to terms with physical and mental decline and the acceptance of a natural order of life stages. Cole explicitly called for 'resymbolising the ages of life and the journey of life' (Cole 1992: 239) and targeted what he sees as the increasing emphasis in society on maintaining norms of self-care aimed at delaying such decline. This distinction, which he described as the 'scientific management of ageing', draws its strength from the idea that the limits to life can be extended if not abolished. Work done in biogerontology by researchers such as James Fries (1980; 1989; 2003) suggests that what is taken as 'normal ageing' is something that is more malleable than previously thought. The 'compression of morbidity' thesis argues

that, even under the conditions of increased life expectancy, the proportion of life spent in ill health becomes concentrated into ever shorter periods prior to death. In this fashion a separation between natural and normal ageing occurs.

Both Thomas Cole and Harry Moody (1995) believe that the idea of natural ageing has been replaced by attempts to transcend it through technology and individual behaviour. Moody echoes Cole in calling for a return to a 'shared meaning of old age' where limits are placed on what he sees as life extending treatment after a commonly accepted point. Such an approach, Moody argues, would not only defuse potential intergenerational conflict over resources, but would also restore ageing to its 'natural' place within the lifeworld, a place from which it has become disembedded as science and bio-medicine change the certainties of the past.

Cole's 'scientific management of old age' is closely related to the ways in which bio-medicine acts as a disciplinary regime that shapes the human body and its existence around notions of normality and abnormality (Foucault 1977). One tool with which such dominance is established in contemporary society is through 'surveillance medicine' (Armstrong 1995) where bodies are monitored by regulatory controls, such as regular health checks and screenings. These are then transformed into public health campaigns designed to monitor and induce good health practices (Petersen and Lupton 1996). Here, the absence of disease is not the same as health, nor are patients' (subjective) symptoms the centre of attention. Instead individual health behaviours, including those of older people, are placed under scrutiny. Ageing bodies are seen through the 'gaze' of the third age. Not only are older people scrutinised in this fashion but their personal responsibility for the risks they face are also evaluated. As Katz and Marshall pointed out:

On the one hand, they are led to understand that the expectations for them to be active (...), mobile, autonomous, experimental, knowable, networked, and consumer-niched will contribute to their care, well being, visibility, and inclusion within public worlds of participation and care. On the other hand, retired and older people are governed within lifestyle profiles allied with neoliberal and antiwelfarist agendas to restructure dependency and problematize their ageing bodies and identities as vulnerable, risky, and in need of self-vigilance (2003: 12).

Rose (2001) argued that such 'self-vigilance' is the result of bio-power over individuals who have learnt to see health as imperative to all life-stages and to accept personal responsibility for their health. This he calls 'somatic individuality'. He goes on to argue that bio-power regimes determine what is considered to be 'normal' in regard to health and ageing. By drawing on the five most prescribed medicines in the United States, he showed how the treatment of menopausal symptoms, thyroid deficiency,

high levels of blood lipids, depression and peptic disorders have construed a reality in which events in the lifecourse that might previously have been described as 'natural' can now be 'reverse engineered' and modified so that they unfold in a different and potentially optimal way. In terms of ageing, what is considered normal lies within the healthy living paradigm of bio-medicine and an active third-age paradigm. Both these approaches stand in contrast to notions of ageing that might accept physical and mental decline as part of a natural life-course.

The distinction between natural and normal ageing resonates with Featherstone and Hepworth's analysis of the social construction of ageing (1998). Here the authors argue that the ageing body and the lifecourse are constructed by both biology (*i.e.* the biological finitude of the human body which owing to increased life expectancy allows people to expect death in old age) and culture (*i.e.* the discourses through which later life is viewed, *e.g.* the state-funded old-age pensioner or the active third-ager). However, in practice, as Katz and Marshall pointed out, biology (or nature) is also socially constructed, something that creates difficulties in delineating the 'zones of penetration and territories of meaning' of the two spheres (Katz and Marshall 2004: 54). With the advancement of technology and its use in diagnosis, treatments or enhancements at different stages of the lifecourse, Featherstone and Hepworth (1998) predicted that advanced forms of bio-cultural destabilisation can be anticipated, leading to a further blurring of the distinction between natural and normal.

One arena in which the natural-normal dualism and the role of technology are played out is in the literature on 'normal' sexual ageing and in particular the focus on erectile dysfunction and the use of Viagra (*e.g.* Katz and Marshall 2003; Potts *et al.* 2003, 2006; Vainionpää and Topo 2005). Here the natural ageing process might be described as one in which a gradual decrease in sexual activity and erectile capacity are accepted as part of ageing, whereas the normal ageing approach entails a rejection of the inevitability of decline and sees opportunities for the use of technology (*e.g.* Viagra) to counteract instances of sexual decline. In a qualitative interview study involving men aged 54 to 70 years, Potts *et al.* (2006) compared the popular self-help literature and medical texts from before and after the Viagra era in order to establish whether these narratives had an influence on the experiences of their participants. The pre-Viagra era texts described a potential decrease in the trajectory of male sexuality with ageing, but highlighted that male sexual experience in mid-to-later life had the capacity to 'expand' and 'take on new dimensions' (Potts *et al.* 2006: 310), suggesting a more emotional and physical sexuality beyond mere penetrative sex. In contrast, the Viagra era texts showed two different kinds of narratives. One the authors called the 'anti-decline narrative',

which suggested and encouraged a restoration of sexual functioning. The other they called the 'revised progress narrative', which portrayed a vision of sexual performance like that of a young man or of a better level than ever experienced before.

In their analysis of experiences of men using Viagra (Potts *et al.* 2006) and women in relationships with men using Viagra (Potts *et al.* 2003), the authors illustrated the overlapping boundaries of natural and normal ageing when it comes to choosing a preference at an individual/couple level. Key to this shift in portraying the possibilities of mid-to-later life male sexuality is that, with the onset of technological involvement, the ageing trajectory is reinterpreted as a set of bodily functions that can be measured and reverse-engineered. In their analysis of how the 'functional' became 'normal', Katz and Marshall (2004) identified the developments in bio-medicine, in particular diagnostic medicine (*e.g.* the Activities of Daily Living test), that have created 'function' as the imperative of understanding the ageing body instead of 'being'. In other words, the ability to do things oneself rather than having to rely on others to do them is the new gold standard of normal ageing. Interestingly, in this 'functional normality' the role of social programmes or networks is considered to create dependency, whereas the use of technology (be it Viagra, glucosamine or human growth hormones) is considered to be enabling.¹ This development echoes Beck and Beck-Gernsheim's (2001) arguments about individualisation, that the individual takes sole responsibility for functioning in society, and the body and health are central to fulfilling that role:

The value of the body and everything connected with it is hugely enhanced. For health and a smoothly running body are now the one and only guarantee of our existence, all through our lives (Beck and Beck-Gernsheim 2001: 141).

This is a widespread view of many in the medical profession as the titles of just two journal papers illustrates. The first, *Ageing Successfully: The Importance of Activity in Maintaining Health and Functioning* (Galloway and Jokl 2000), not only lists the age associated with decline in muscle loss but also the difficulties that accompany such loss. The paper advocates the adoption of an appropriate training regimen by older individuals in order to decrease their rate of decline and to preserve health and function in later life. What is noteworthy about this paper is not its message of physical exercise but that it situates the potential for exercise against the performance of elite competitive athletes whom it records as having surprisingly high levels of performance which can be built up over time. The second paper, *Encouraging Patients To Become More Physically Active* (Andersen *et al.* 1997), addresses the issue from the perspective of those with a 'sedentary' lifestyle and discusses not only the connection between this 'lifestyle' and

poor health, but also the role of the physician in motivating patients to undertake regular exercise as part of their daily routines. Again, the significance of the paper is found in the way it draws out the discourses of active ageing; the clear message being that a sedentary lifestyle will kill you. It is also noteworthy that the paper suggests the need to address patients' fears that embarking on such exercise programmes might result in sudden cardiac death.

The shift towards a greater individualisation of health can be seen in a study by McMullin and Shuey (2006) that measured the perceptions of ageing and disability in relation to the need to make accommodations at workplaces for older workers. They found that workers who interpreted their functional limitations as part of their natural ageing process were less likely to believe that they needed such accommodation. Furthermore, if they attributed their condition to ageing, their needs for compensation for this were less likely to be met. The authors concluded that those workers conceptualised ageing as a natural process, one that produced functional limitations that they did not describe as disabilities. In doing so, they assumed that everyone's body deteriorated in a similar way, and dismissed their own age-related functional limitations, often by saying 'I'm just getting old' (2006: 843). This suggests that the concept of disability, defined through such manuals as the *International Classification of Functioning, Disability and Health* (WHO 2001), is considered to be a stronger measure for functioning than ageing, and that the concept of ageing as a natural process still holds strong among social actors. However, the emergence of normal ageing based on the use of technology and the idea of maintaining or rejuvenating levels of functioning has altered the normative expectations of ageing. Conrad and Potter (2004) linked much of this to what they call the 'medicalisation of underperformance' (2000). In their work on human growth hormone, Conrad and Potter (2004) described the difficulty in differentiating between using such interventions as a therapy for a defined condition, e.g. lack sufficient growth hormone in children, or as an enhancement for conditions that can move in and out of medical jurisdiction, e.g. 'growth hormone menopause' which was deemed by Foreman (1992) to cause body deterioration:

Hence, while there are certainly disorders where there is general agreement that a biological disease exists, there are also many disorders that are contestable or controversial. The potentials of medicalisation sensitise us to the fine line between biomedical therapy and enhancement (Conrad and Potter 2004: 200).

Conrad and Potter acknowledged that interventions such as the use of human growth hormones target specifically social problems e.g. shortness and ageing, but at the same time their example shows how deviation from

normative levels of (adult/social) functioning can be medicalised if not as a condition then as under-performance. In summary, and at a conceptual level, the 'end' of natural ageing has been brought about by the bio-power regimes that determine what is considered normal, functional or adequate performance. In addition, normal ageing is enabled through the availability of technological interventions that can either be interpreted as therapies or enhancements, depending on the circumstances of the individual in question, *e.g.* age of the person, private payment/insurance and treatment outside of mainstream medicine, but the distinction between natural and normal ageing is not clearly cut at the personal level. As Potts *et al.* (2003, 2006) found, individuals found it difficult to decide between natural and normal ageing, not least because of the different narratives that reached them from self-help literature, friends and family, medical texts, advertising and other media representations. The women felt disenfranchised by their partner's decision to take Viagra and felt that it denied the changes of a natural ageing trajectory of their sex life. All but one described a mismatch between their normal trajectory and the 'reverse engineered' trajectories of their partners. Similarly, Potts *et al.* (2006) found that the older men in their study, who had used Viagra, challenged the anti-decline or revised progress narratives as suggested in the literature because it marginalises the alternative perspective and positive changes associated with slowing down and relaxing more about sex (2006: 325).

In a study of osteoarthritis by Sanders, Donovan and Dieppe (2002), it also appeared that age is central to understanding bodily decline and personal notions of natural and normal ageing. During in-depth interviews, participants aged from the mid-60s to 91 described their osteoarthritis as a natural trajectory of their age and their life history, which did not warrant much medical attention despite their high levels of suffering. In contrast, the four youngest participants, aged 51–64, did not refer to their joint problems as being natural and inevitably degenerative. Instead, they cited hereditary and specific injuries as contributory factors, which determined their assertiveness in accessing treatment. It was not suggested, however, that the different attitudes of the younger group might be related to a generational habitus that developed in conjunction with the rise of consumer society (Gilleard and Higgs 2005, 2007). Thus it could be argued that interacting with a lifecourse effect for this group is a greater susceptibility to a third age identity of active life enhancement and age denial. The reference point for normal ageing therefore is derived from notions of somatic individuality in the wider context of discourses of what is normal, and this is put into practice by individual choices that express the 'will to health'. In this way, normal ageing sets up an imperative for health

maintenance behaviour in later life that aims for a prolongation of youthfulness. It stands in contrast to natural ageing that accepts in passing physical and mental decline as part of a life trajectory. The idea of normal ageing is created within a healthy living paradigm that requires increasing intervention as mental and physical decline threaten or occur. Nikolas Rose (2001) argued that what is considered normal is achieved through an extended use of bio-molecular medicine in many spheres of life:

Once one has seen the norms of female ageing reshaped by hormone replacement therapy, or the norms of ageing male sexuality reshaped by Viagra, the 'normal' process of growing old seems only one possibility in a field of choices, at least for those in the wealthy West (2001: 16).

With the advancement of medicine, more areas of life are open to such manipulation, thus changing what has previously been seen as a natural trajectory of decline into one of potential intervention. The problem with the distinction between the natural and normal conceptions of ageing, however, is that the natural concept of ageing is a reminder to individuals that, at its starkest, ageing is associated with decline and death. The more that ageing, the signs of ageing and the difficulties of ageing, come to dominate the individual's life, the more intense is the pressure to adopt strategies of demarcation and acquiescence. The great danger for many in the third age is that the normal becomes the natural. With this in mind we suggest that the increasing importance of risk in the construction of later life needs to be addressed.

Risk and consumer society

Ulrich Beck (1992) has argued that modernity has reached a stage in which the threats produced by modernisation itself affect the whole of society; in other words, that such threats as pollution or global warming become supra-national and non-class-specific. This creates a paradox in that while the distribution of these risks may have moved beyond the control of individuals, at a policy level the individual has become the principal focus for risk-minimisation strategies (Ziguras 2004). While this seems to reflect a common strategy of shifting responsibility from states to individuals, Ziguras suggested that the role of the state in the individualisation of risk management is not the sole issue because most risk management techniques are developed and promoted by private corporations. As their aim is to sell their products or services, such corporations are not particularly interested in tackling the causes of risk. In an important point, Ziguras

pointed out that producers make selective use of expert systems, such as the opinions of scientists, in order to convince consumers that not only do certain risks exist but that their product can minimise the risk. Little or nothing is said about other forms of minimising risks because the consumer needs to be convinced that the featured product is the best form of protection. Ziguras also added that not only does the private sector have little interest in reducing the causes of risks; they have every interest in identifying more risks to which they can respond with more ‘innovative’ products of individual risk management. Webster (2002) made a similar point regarding innovative health technologies which are driven by pharmaceutical and medical device industries that fuel a demand for what he calls ‘techno-medicine’. An example with respect to the construction of risks in later life is ‘Centrum 50+’, a multi-vitamin and mineral complex specifically targeted at older consumers. By developing a product that is tailored for an older population, the nutritional needs of older people are distinguished from those of the rest of the population (similar examples can be found at the younger end of the market) and away from collective solutions to nutritional needs. Instead of wider changes in food production and consumption, products such as ‘Centrum 50+’ draw attention to the individual risks of poor nutrition which is linked to the risk of faster ageing, and how individual action (*i.e.* consuming the product) can reduce that risk.

Most advertising is aimed at a young audience; the objects and technologies promoted look innovative and youthful and involve young bodies and voices in awaking consumers’ desires (Carrigan and Szmigin 2000). With the rapid growth of the 60-plus population and their associated affluence, however, marketers have recognised that they need to shift their attention to the ‘mature market’ (Ahmad 2003; Moschis 2007). This has required changes in the way marketers perceive older people. Until recently, older people were seen to be ‘the same’, sharing the unattractive characteristics of poor, ill, reclusive and insignificant people, but the advertising industry still holds strongly to the view that older consumers do not necessarily identify with their age cohort (Sawchuk 1995). They are more likely to be drawn to products that are promoted by younger people. As a result, the third-age consumer is addressed as though he/she were at least 20 years younger. As Sawchuk argued, this might be because this generation of 60-plus year-olds so strongly identified with youth culture in the past that they do not wish to be identified as old now. Having said this, advertising aimed at older people does not always deny the presence of age (Annie Leibovitz’s photographs for the *Dove* advertising campaign in 2005 are a striking example). Advertisements can also appeal to the consumer’s age by playing on their life experience. Such an example can be found in

an advertisement for a skin-care product that promises to reduce the signs of ageing:

Remember when looking beautiful means hours in front of the mirror? Now you're older you know what you want. What's right for you skin. What works. Like the improvement you see using *Clarins Super Restorative Skin Care*. It compensates for what time takes away from your skin, promoting a firmer, fresher, more even complexion. You're free to get on with your life, looking and feeling great (Clarins 2005).

What advertising strategies have in common for all age groups, however, is that they aim to evoke desires. Products are created to satisfy desires; new products are created ostensibly to satisfy previously evoked and not quite satisfied desires. In this process, there is a shift in abstraction, so that advertisers do not necessarily name the product for what it is or does, but for the emotions it creates. In the instance of health foods, 'life stage nutrition ranges' appear, which offer products with names such as *Prime Years – Nutrition for the 40+*. By pitching the age group at 40-plus, it attracts a larger population at the same time as inviting older people to consume a product with a youthful appearance.

The shift to individualised responsibility for health has not only taken place at the level of state and individual but also in the context of expanding markets based on risk and health where more anxieties and desires are created. The 'will to health' becomes increasingly commodified and based on minimising the risks of falling into a fourth age and amplifying health in the third age. Thus, in Katz and Marshall's (2004) view, acts and actors of consumption, the production of technological enhancements as well as normal ageing attitudes have become indistinguishable. The phenomenal growth of anti-ageing products and medicine² can be seen as an exemplar of how social changes such as governmentality, consumerism, risk and perceptions of health and body maintenance, have created an arena in which third-age identities are constructed and reconstructed. It is to this arena of anti-ageing that we now turn.

Anti-ageing: a developing arena for third age identities

The arena of anti-ageing medicine is a highly contested one, to the point that even experts in the field cannot agree on a definition. Anti-ageing medicine encompasses a large variety of treatments, therapies and methods that seek to overcome the ageing process or mask the signs of ageing. These include cosmetic surgery, cosmaceuticals, dietary supplements as

well as artificial body parts. There are also possible developments that seek to manipulate core biological processes such as telomere cellular shortening, hormonal enhancements, cloning and embryonic stem-cell technology (Katz 2005). It is therefore not surprising that one commentator argues that anti-ageing needs to be seen as a 'new social movement', one that challenges mainstream biomedical approaches to ageing by viewing it as treatable (Mykytyn 2006*a*). Vincent (2006) adopted a more critical approach and has classified the different components of anti-ageing in relation to what they claim they can achieve. He divides them along the following schema: *symptom alleviation*, *short-term life extension*, *long-term life extension*, and *elimination of ageing*. The efficacy of these activities, in particular the latter two, has been hotly contested and has been the target of ethical, moral and economic as well as paradigmatic criticism (Olshansky, Hayflick and Bruce 2002; Binstock 2003; Moody 2002; See also the special issue in the *Journal of Gerontology: Biosciences* 2004, **59A**, 6; Vincent 2003*b*).

While the nature of the discussion about anti-ageing medicine goes beyond the scope of this paper (see Higgs and Jones (2009) for a more detailed discussion), an outline of the views held by some of the principal proponents throws light on the contradictory role that anti-ageing medicine plays in the health agenda of later life. The debates, which include many public displays of interpersonal feuding (*e.g.* Rae 2005; Hayflick 2005), point to fundamental differences in thinking about ageing, the end of life and the role of science and medicine in constructing the differences between the natural and the normal outlined earlier. These controversies reveal four main arguments. There are those who work at the forefront of advancing long-term life-extension and the elimination of ageing and argue that significant break-throughs are merely a matter of time (*e.g.* de Grey 2003; Stock 2003). Their fiercest critics in the gerontological community generally seek to distance themselves and gerontology from the anti-ageing movement and demand instead that research money and interest be channelled towards research on improving health in later life (see Binstock 2003 for a detailed discussion). That there are considerable commercial interests at stake further polarises the debate. Moving away from the discussion of mainly scientific issues, there is also a concern to address the potential social impact of anti-ageing approaches. In a debate between Stock and Callahan (2004), the latter argued that quality of life (*i.e.* health) is more important than life extension, and that in order to have a 'successful' and 'meaningful' life, a life trajectory needs to come to an end – an argument based on the work of the philosopher Leon Kass (1985). Once again, the contradiction between such approaches and the 'ageless' cultures of consumption that constitute part of the social space of

the third age is implicit. These contradictions are also echoed in Vincent's (2003*b*, 2006*b*) position not only advocates an ideal of natural ageing but also regards anti-ageing medicine as a kind of 'Frankenstein science' where:

Striving for an ever-longer life span represents a denial of old age as a valued final part of the life course, and allocates old people to a cultural category characterised by redundancy and despair. (Vincent 2003*b*: 683).

Vincent challenges the focus on the third age because it seeks to liberate older people *from* old age by prolonging youth rather than leading to the liberation *of* old age by embracing the inevitability of decline (Vincent 2006*b*: 168). Consequently anti-ageing medicine is considered to be a deviant form of health care that is promoted by quacks, charlatans and corporate medicine in an attempt to mask that which is normal and necessary and leads to fantasies of immortality.

The inevitable conflict between these critical approaches and the individualised health management expected of everybody operating in a culture exercised by the will to health is apparent. Anti-ageing techniques have the potential to link health and wellbeing with aesthetic concerns relating to bodily decline. As a consequence, it could be argued that the market has successfully commodified the individualised will to health through building on anti-ageing medicine's promise to treat ageing and to link it to a cultural 'will to youth'. As we have seen in relation to consumerism and health, the beauty and health industries promote certain products and treatments to help people counteract external health risks. Such products are created to satisfy desires which they are unable fully to meet; however, instead of being seen as failing they are replaced by new products that evoke yet newer desires and thus maintain a cycle of production and development. In this way the image of needing to keep running to maintain one's place is as true for anti-ageing as it is for the will to health. Practitioners within the field of plastic surgery have drawn attention to this continuous circle by highlighting the addictiveness of botox and its temporary effects on the signs of ageing:

Botox is efficacious in providing the opportunity to shut away signs of upper facial ageing into a cupboard—a cupboard with a faulty lock. When the doors swing open after a few months, and the contents spill out before the mirror, the reaction of some of these patients is one of genuine horror. Those who have tasted the heady mixture that locks youth into place find it all too addictive, and develop a pathological preoccupation of chasing a desire to become eternally youthful. This obsession with attempting to retard the natural ageing process results in becoming addicted not only to botox but to the unrealistic hope of what botox can actually offer (Singh and Kelly 2003: 274).

As Lucke, Ryan and Hall (2006) pointed out, the views of the public regarding these scientific and technical possibilities does not figure highly in the debates about anti-ageing medicine. They highlight a paradox in which there is a substantial market for cosmetic and other interventions that delay the appearance of ageing, yet bioethicists assume that the public will be reluctant to embrace life-span extension (2006: 181). In their qualitative study of 31 interviews with participants aged 50 plus, they found that a distinction was made between life-extension, health/quality of life, and an ageing appearance. Good health was regarded as a pre-requisite of enjoying a long life and more important than extreme life extension. Focusing on health, some were enthusiastic about retaining a youthful look, though they did not see this as a high priority but rather as a by-product of feeling good; not as a product of surgical intervention, suggesting a level of what Klerman (1982) termed 'pharmaceutical Calvinism'. However, in linking a youthful look with health the views expressed showed a strong 'will to health' as well as an awareness of the moral components that surround the use of anti-ageing technologies.

Some forms of anti-ageing medicine, especially those involving cosmetic treatments, have been considered merely 'cosmetic' rather than 'health relevant', thus introducing a moral label as well as drawing a distinction between health and youthfulness. Treatments that enable people to live an active and independent life with a positive contribution to society (*i.e.* by not being a burden) are seen as essential and important, whereas treatments that are considered to be centred on individual vanity and self-fulfilment are criticised for being hedonistic or frivolous. In returning to the natural-normal dichotomy, the term 'natural' is often taken as a proxy for 'good' (Conrad and Potter 2004: 205), but such a distinction is difficult to achieve. As Moody (2007) argued, despite the problems associated with the wilder shores of anti-ageing medicine, it is becoming increasingly difficult to make a distinction between 'good natural ageing' and 'bad anti-ageing'. Ziguas (2004) argued that the critics tend to take a high moral tone ignoring the effects of late modernity, such as de-traditionalisation and the loss of religious authority over the mundane, and this leads to a failure to understand that consumerism and body maintenance may become important conduits for maintaining personhood. With the loss of social support and the fragmentation of lives, as well as the individualisation of risk management, self-care or anti-ageing medicine may enable a form of secular search for meaning. If we are to better understand these developments, we need to adopt a more neutral and objective stance to the arena of anti-ageing and its part in the construction of third-age identities.

Conclusion

This paper has discussed the rise of the 'will to health' and explored the extent to which social transformations related to risk, consumption and increasing individualisation are reflected in the construction of third-age identities. This paper has argued that health is central to the pursuit of an agentic third-age lifestyle and that the will to health is emerging as a powerful discourse in later life. At the same time, the growth in technologies of the self has been based on a distinction between natural and normal ageing, with the former associated with a sense of coming to terms with physical and mental decline, and the latter associated with an increasing emphasis on maintaining norms of self-care aimed at delaying such decline. This distinction is apparent in the construction of risk and the marketing of health technologies. We have highlighted anti-ageing medicine and anti-ageing products as arenas where these trends are becoming increasingly apparent. If we are to understand better why older people may or may not engage with health technologies, we need to see older people as members of generations that both instigated and experienced the rise of consumer society and not as a homogeneous and passive group entering a stable and predictable stage of the lifecourse. Research is required in order to establish whether and how the structural developments outlined in this paper shape older people's engagement with the will to health. For instance, we need to ask what are older people's personal preferences as well as their consumer choices; what are their financial priorities and what is their awareness of change regarding health care, the body and the nature of ageing. In this new agenda of research on later life, the focus needs to go beyond understanding older people as merely old and sick. Instead, the new realities of ageing in a consumer society can steer research towards examining the potential of older people to engage in agency at both the level of society in general and at the level of personal health concerns.

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NOTES

- 1 Some of Potts *et al.*'s (2003) female participants who were in relationships with men using Viagra witnessed their partner's immediate dependency on Viagra. The women

described how their partners would not consider having sex without taking 'the pill'. A similar form of dependence is reported by Singh and Kelly (2003) who observed the temporary effects of Botox on users. These studies suggest that technological enhancements can cause a high level of dependency, although this form of dependency is not problematised as much as social dependency is.

- 2 The phenomenal growth of anti-ageing treatments is also due its popularity among younger age groups.

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