

Ageing and China: Towards Theory, Policy and Practice

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ABSTRACT

In the 21st Century, economists and social analysts around the globe are increasingly concerned about the rising numbers of older people in their society. There is a genuine concern about the inadequacy of pension funds, of growing pressures on welfare systems, and on the inability of shrinking numbers of younger people to carry the burden of their elders. This article focuses on such gerontological issues in China, where the older people have become a rapidly expanding proportion of the population. While resources do need to be targeted on the vulnerable older people, the presumption that older people as a whole are an economic and social burden must be questioned. This is an ageist view that needs to be combated by locating how bio-medical views on aging seep into policy spaces in China that position negative perceptions of aging as both individual and populational problems. The article then moves to observe the implications of biomedicine for older people in China in terms of "vulnerable" aging but deconstruct such "fixed" extensions by juxtaposing *active aging* as key narrative that epitomizes "declining to decline" as espoused by bio-medical sciences.

Keywords: aging; China; policy; declining to decline through active ageing

1. INTRODUCTION

There is no doubt that in many societies around the globe older people are a growing proportion of the global population (Krug 2002). There are 7.1 billion people living on the planet earth in 2015. The age structure of the global population is changing from one in which younger people predominated to a society in which people in later life constitute a substantial proportion of the total population. While the biological and psychological models of aging inscribed as an "inevitable" and "universal" process, an aging population is neither (Phillips 1998). Transformations in the age profile of a population are a response to political and economic structures. A major concern for organizations such as the United Nations and World Bank focuses on the number of such "dependent" older people in world society (Krug 2002).

Indeed, older people in particular constitute a large section of populations in global aging. In relation to public services that have to be paid for by "younger" working people, the percentage of the population has been used to signify such "burdensome" numbers. Not only are older people seen as dependent but also children under school leaving age and people over the retirement age. Dependency rates—that is, the number of dependants related to those of working age—altered little over the twentieth century and yet the notion of "burden" group

retains its legitimacy. The reason there has been so little change during a period of so-called rapid aging populations is that there has been a fall in the total fertility rate (the average number of children that would be born to each woman if the current age-specific birth rates persisted throughout her child-bearing life) (Phillipson, 1998).

Changes in the age structures of all societies also affect total levels of labor force participation in society, because the likelihood that an individual will be in the labor force varies systematically by age. Concurrently, global population aging is projected to lead to lower proportions of the population in the labor force in highly industrialized nations, threatening both productivity and the ability to support an aging population (Powell, 2009). Coupled with rapid growth in the young adult population in Third World countries, the World Bank (1994) foresees growing “threats” to international stability, pitting different demographic-economic regions against one another. That the United Nations (2000) views the relationship between aging populations and labor force participation with panic recognizes important policy challenges, including the need to reverse recent trends toward decreasing labor force participation of workers in late-middle and old age despite mandatory retirement in both Western and Eastern countries such as the UK (Jackson and Powell, 2001) and China (Chen and Powell, 2011).

Notwithstanding this, in China there is also an ongoing large increase in the aging population that replicates global trends. It can be seen that the percentage of the aging population has increased from just over 4.4 percent to just under 7 percent from 1953 to 2000 (Cook and Murray 2001). Note that the increase has not been constant, reflecting the negative impact of the Great Leap Forward and the successive famines upon the demographic profile, shown in the results of the 1964 Census.

Since that latter date, the percentage of elderly has nearly doubled, while the actual numbers have more than tripled, being approximately three times that of 1964 by the year 2000. By 2000, there were 88 million Chinese aged 65 or over, compared to just under 25 million in 1964, an increase of 63 million plus more years.

As is well known, China's population policy, most usually referred to as the Single Child Family Program (although some Chinese commentators regard the phrase as a misnomer, given that more than one child is possible within a number of situations), has led to a rapid deceleration in the birth rate, which was only 13.38 per thousand in 2001, compared to 21.06 in 1990 and 48.25 in 1972 (Cook and Murray 2001).

This controversial policy lambasted and praised in equal measure depending on perspective, has meant a rapid expansion in the number of single children only households at the very same time that the proportion of the elderly has also increased as a new era of prosperity has revealed many households in China.

Estimates suggest that up to 300 million less people have been born as a result of this program of state intervention, but Murray (2004) has built on the earlier work of D.G. Johnson and others to suggest that improved living standards via modernization would have led to the same outcome voluntarily as growing numbers of urban dwellers in particular chose to reduce their family size. This last point hints at the important spatial dimension of demographic change in China. There is on the one hand a marked contrast between urban and rural life in China and, closely related to this, a marked contrast between Eastern China and Western China (Cook and Powell, 2007). It is in the heavily urbanized “Gold Coast” of the Eastern Seaboard in which China's spatial transformation is most dramatic, with fast-expanding cities being especially concentrated in the Pearl River delta of the Southeast and the Yangtse Delta in Central East China (Cook and Murray 2001).

Hence, it is not simply that the Chinese government has belatedly recognized “the greying” of populational constructions and policy implications, it is that they continue to look for knowledge of aging as the power to define old age as a social problem in terms of dualistic distinctions between deviancy and normality. An aging population, like that of an individual being studied by bio-medical models, is seen as a “burden” problem in terms of economic management of Eastern (and Western) economies.

It could be argued when looking at the effects of a so-called “demographic time bomb” across US, Europe, and Asia, it may have been grossly exaggerated.

Such old age, therefore, has been perceived negatively via a process of “ageism”—stereotyping older people simply because of their chronological age. Ageist stereotypes such as “aging populations” act to stigmatize and consequently marginalize older people and differentiate them from groups across the life-course who are not labeled “old” (Bytheway, 1993).

One of the ways to interpret social aging such as being a categorization, whether in individual or populational terms is through use of theorizing on what it means to age in society; that is, concerns and social issues associated with aging and the ways in which these themes are influenced and at the same time influence the societies in which people live. Thus, to understand the process of aging, looking through the lens of the “sociological imagination” is not to see it as an individualized problem rather as a social issue that is faced by both First World and Third World nations as a whole.

In supporting this latter view, there is a need to focus on how populational discourses of aging in China are influenced and reinforced by bio-medical models of aging that help drive perceptions of older people as a burdensome group.

2. WHERE DOES THE AMBIVALENCE TO AGING COME FROM?

There are important implications for how aging is viewed by not only in terms of global aging but more specifically in China and the arrangement of political and economic structures that create and sanction social policies grounded in knowledge bases of “burdensome” populations (cf Powell, 2000). Such knowledge bases are focused on: one, “biological aging” which refers to the internal and external physiological changes that take place in the individual body; two, psychological aging is understood as the developmental changes in mental functioning—emotional and cognitive capacities.

Bio-medical theories of aging can be distinguished from social construction of aging: (1) focusing on the bio-psychological constituent of aging, and (2) on how aging has been socially constructed. One perspective is driven from “within” and privileges the expression from one’s inner worlds. The other is much more concerned with the power of external structures that shape individuality. In essence, this social constructionism poses the problem from the perspective of an observer looking in, whilst the biomedical model takes the stance of inside the individual looking out (Powell and Biggs, 2000). There has long been a tendency in matters of aging and old age to reduce the social experience of aging to its biological dimension from which are derived a set of normative “stages” which over-determine the experience of aging.

Accordingly being “old,” for example, would primarily be an individualized experience of adaptation to inevitable physical and mental decline and of preparation for death. The paradox of course is that the homogenizing of the experience of old age which the reliance on

the biological dimension of old age entails is in fact one of the key elements of the dominant discourse on aging and old age.

It is interesting that comparative historical research on aging in Eastern culture highlights an alternative perception of aging; in 18th Century China has highlighted a rather different path as to the conceptualization of aging as a scientific process developed by western rationality. For example, Cook and Powell (2003) observe that traditional Chinese society placed older people on a pedestal. They were valued for their accumulated knowledge, their position within the extended family, and the sense of history and identity that they helped the family to develop (Murray, 1998). Respect for elderly people was an integral part of Confucian doctrine, especially for the family patriarch.

This was a view that was also prevalent in Ancient Greece with the notion of “respect” for older people especially regarding gendered issues of patriarchy (cf. Bytheway, 1993). Prior to industrialization, in India, there was a bestowment that older people had responsible leadership roles and powerful decision-making positions because of their vast “experience,” “wisdom” and “knowledge” (Katz, 1996).

It seems with the instigation of Western science and rationality, aging began to be viewed in a different more problematic context than to the Confucian doctrine of aging epitomized in China and issues of respect for aging in India. Martin Heidegger (1971) makes the similar point when he spoke of the Westernization of the World through the principles of Western science and language.

Indeed, the technological developments due to industrialization, Westernization, and urbanization—under the purview of distorted forms of modernity—have neglected these statuses of aging by downgrading its conceptualization. In the understanding of individuality in Western culture, the birth of “science” gave legitimate credibility to a range of bio-medical disciplines of whom were part of its umbrella. In particular, the bio-medical model has become one of the most controversial yet powerful of both disciplines and practice with regard to aging (Powell and Biggs, 2009).

The bio-medical model presents the contested terrain of decisions reflecting both normative claims and technological possibilities. Bio-medicine refers to medical techniques that privilege a biological and psychological understanding of the human condition and rely upon “scientific assumptions” that position attitudes to aging in society for their existence and practice. Hence, scientific medicine is based on the biological and psychological sciences. Some doctrines of the biomedical model more closely reflect the basic sciences while others refer to the primary concern of medicine, namely diseases located in the human body. Most important is that these beliefs hold together, thereby reinforcing one another and forming a coherent orientation toward the mind and body. Indeed, the mind-body dualism had become the location of regimen and control for emergence of scientific in a positivist methodological search for objective “truth.” The end product of this process in the West is the “biomedical model.”

In this sense, bio-medicine is based on the biological and psychological sciences. Some doctrines of the biomedical model more closely reflect the basic sciences while others refer to the primary concern of medicine, namely diseases located in the human body. Most important is that these beliefs hold together, thereby reinforcing one another and forming a coherent whole (Powell, 2001). By developing an all-encompassing range of bio-medical discourses, many forms of social injustice could be justified as “natural,” inevitable and necessary for the successful equilibrium of the social whole such as mandatory retirement and allocation of pensions (Phillipson, 1998).

Bio-medical gerontology is a fundamental domain where medical discourses on aging have become located and this is very powerful in articulating “truths” about aging. Under the guise of science and its perceived tenets of value-freedom, objectivity and precision (Biggs, 1993), bio-medical gerontology has a cloth of legitimacy. Biological and psychological characteristics associated with aging have been used to construct scientific representations of aging in modern society. The characteristics of biological aging as associated with loss of skin elasticity, wrinkled skin, hair loss or physical frailty perpetuates powerful assumptions that help facilitate attitudes and perceptions of aging. It may be argued that rather than provide a scientific explanation of aging, such an approach homogenizes the experiences of aging by suggesting these characteristics are universal, natural and inevitable. These assumptions are powerful in creating a knowledge base for health and social welfare professionals who work with older people in particular medical settings such as a hospital or general doctors surgery and also for social workers (Powell 2009).

These new forms of social regulation were also reflected in the family and the community. Hence, modern systems of social regulation have become increasingly blurred and wide-ranging (Powell, 2009). Increasingly, modern society regulates the populational construct by sanctioning the knowledge and practices of the new human sciences—particularly psychology and biology. These are called gerontological “epistemes” which are “the total set of relations that unite at a given period, the discursive practices that give rise to epistemological figures, sciences and possibly formalized systems” (Foucault, 1972: 191). The “psy” complex or bio-medical epistemes refers to the network of ideas about the “nature” of individuals, their perfectability, the reasons for their behavior and the way they may be classified, selected and controlled. It aims to manipulate and improve individuals by the manipulation of their qualities and attributes, independent upon scientific knowledge and professional interventions and expertise. Human qualities are seen as measurable and calculable and thereby can be changed and improved. The new human sciences had as their central aim the prediction of future behavior (Powell, 2009).

Powell and Biggs (2000) suggest that a prevailing ideology of ageism manifests itself in the bio-medical model via a suggestion that persons with such biological traits have entered a spiral of decay, decline and deterioration. Along with this goes certain assumptions about the ways in which people with outward signs of aging are likely to think and behave. For example, there are assumptions that “older people are poor drivers” or that older people have little interest in relationships that involve sexual pleasure that are all explained away by “decline” and “deterioration” master narratives that comprise an aging culture. The effects of the “decline” and “decay” analogies can be most clearly seen in the dominance of medico-technical solutions to the problems that aging and even an “aging population” (Phillipson, 1999) is thought to pose. Here, the bio-medical model has both come to colonize notions of age and reinforce ageist social prejudices to the extent that “decline” has come to stand for the process of aging itself (Powell, 2001).

Estes and Binney (1989 cited in Powell, 2001) have used the expression “biomedicalization of aging” which has two closely related narratives: (1) the social construction of aging as a medical problem, and (2) ageist practices and policies growing out of thinking of aging as a medical problem. They suggest:

“Equating old age with illness has encouraged society to think about aging as pathological or abnormal. The undesirability of conditions labeled as sickness or illness transfer to those who have these conditions, shaping the attitudes of the persons themselves and those of others towards them. Sick role

expectations may result in such behaviors as social withdrawal, reduction in activity, increased dependency and the loss of effectiveness and personal control—all of which may result in the social control of the elderly through medical definition, management and treatment” (Estes and Binney, 1989, quoted in Powell, 2001: 119).

These authors highlight how individual lives and physical and mental capacities that were thought to be determined solely by biological and psychological factors, are, in fact, heavily influenced by social environments in which people live. This remains invisible to the bio-medical approach because they stem from the societal interaction before becoming embedded and recognizable as an “illness” in the aging body of the person. For example, the “sociology of emotions” the excursion of inquiry has proposed that “stress is not only rooted in individualistic emotional responses but also regulated, classified, and shaped by social norms of western culture (Powell and Biggs, 2000).

This type of research enables the scope of aging to be broadened beyond the medical individualistic accounts of the body. On this basis alone, sociology invites us to recognize that aging is not only a socially constructed problem by bio-medical science, but also the symptomatic deep manifestation of underlying relations of power and inequality that cuts across and through age, class, gender, disability and sexuality (Powell and Biggs, 2000; Powell, 2001).

At this level of analysis, sociology addresses bio-medicine as one of the elements of social control and domination legitimated through power/knowledge of “experts” (Powell and Biggs, 2000). Such expert formation has also been labeled as ageism (Bytheway, 1993). Ageism is where the assumptions made about old age are negative, which treats older people not as individuals but as a homogenous group, which can be discriminated against (Bytheway, 1993).

Chinese society uses age categories to divide this ongoing process into stages or segments of life. These life stages are socially constructed rather than inevitable. Aging, too, is a production of social category. At any point of life span, age simultaneously denotes a set of social constructs, defined by the terms specific to a given society at a specific point in history. Thus, a specific period of life—infancy, childhood, adolescence, adulthood, middle age or old age is influenced by the structural entities of a given society. Therefore, aging is not to be considered the mere product of biological-psychological function rather a consequence of socio-cultural factors and subsequent life-chances. Indeed, society has a number of culturally and socially defined notions of what Phillipson (1998) calls the “stages of life.” However, a fundamental question is how bio-medical gerontology has stabilized itself with a positivist discourse that not only reflects history but also the total preoccupation with the “problem” of aging that have important implications for older people and health lifestyles in China.

3. BIO-MEDICINE, FAMILY CARE, AND AGING: IMPLICATIONS FOR CHINA

The dominant bio-medical discourse of aging in China dwells on the processes of physical deterioration associated with becoming older. In this perspective, the aging body has to deal with increased levels of incapacity, both physical and mental, and becomes increasingly dependent on younger others for sustenance and survival; it is the family through informal care that has to provide care of older people who may have illnesses, according to

the Law on the Rights and Interests of the Elderly, introduced by the PRC in 1996. The bio-medical problematization of aging has secreted wider questions of power and inequality; especially influential is occidental modernity. A powerful discourse is thus developed which follows that of the West, via notions of “social inclusion” and “family care,” and the all-important role of the consumer in buying products for the elderly, from disability aids through to private pensions (Powell and Cook, 2001). The latter suggest that this process constructs the aging body as a site of surveillance by the Chinese state, constructing them as, following Foucault, objects of power and knowledge in which “its your age” is the prevailing authority response to the elderly “customer.”

Powell and Cook (2001) have further noted that older people will be increasingly probed for social, psychological and economic factors such as “frailty” or “expected level of supervision.” “There are indications, for example, that where care homes are provided, these are for the more active elderly, rather than those in greatest need” (Powell and Cook, 2001: 7).

This Foucauldian point has been borne out via an article on Shanghai (China Daily, 2004) with “most nursing homes in Shanghai have entry criteria that target a narrow minority of elderly people. Some admit only those who are capable of independent living while others accept only bedridden patients. While dementia is a common condition among the elderly, those afflicted by it are generally excluded by the criteria.” “Even more seriously, if a patient’s condition changes according to these criteria, he or she is forced to leave the home. “The lack of a continuum of care creates devastating situations for the patients and their families.” Further, nursing homes have only minimal level of medical support available, and patients are transferred to hospitals too readily if they have an ailment much beyond the common cold. The patient can then lose their place in the nursing home as their bed is transferred and thus be subject to further stress. “Preventive care, physical therapy, and spiritual care, which are crucial components of care for the elderly, are generally overlooked. Many nursing homes do not provide such services out of concerns for cost or accident liabilities.” The Shanghai article also notes, damningly, that:

“The financial burden on long-term care accumulates on an elderly population already enduring tighter budget constraints because of retirement and unemployment. In the absence of government subsidy, the higher fees charged by self-sustaining nursing homes deprive elderly people with limited financial means of their access to care” (China Daily, 2004).

In the light of these and other issues the PRC government is attempting to change the ways in which the elderly are perceived, via campaign slogans such as “respect the elderly” and “people first.” The former campaign seeks to encourage younger people to visit the elderly on a regular basis in order to reduce the sense of isolation that the elderly can feel, to look out for their needs out on the streets and to generally raise awareness of the situation of older people. There is a resonance here with ancient Confucian tradition in which the elderly were venerated. There have also been attempts to encourage younger people to think about “healthy aging,” but this is meant in terms of ensuring that they themselves have adequate financial provision as they age. “People first” is the attempt to recognize that “aging is an individual-specific process” and that “a functional healthcare system for the elderly should integrate all aspects of care ... emphasizing and fulfilling individual needs and preferences” (CD, 2004).

Older people in rural areas are more likely to have to face emigration of their children to the cities as China’s urbanization proceeds apace. This can leave them physically and socially

isolated in a remote rural area, no longer able to rely upon their family to look after them in their old age, as was once the tradition.

Indeed, as social norms and values change, younger people may no longer be willing, even when they are able, to support elderly parents, and in recent years the law has been used to take children to court in order to force them to support their parents. For example, a new law came into force on October 1, 1996 on “The Rights and Interests of the Elderly” that explicitly states that: “the elderly shall be provided for mainly by their families, and their family members shall care for and look after them” (Du and Tu, 2000).

Notwithstanding the legal process, at its most extreme, the concerns of elderly people are expressed via suicide—gerontocide. The elderly can struggle in the face of the massive social changes that China is facing, and the abandonment of the tradition in which they themselves would have looked after their own parents and grandparents. They may feel so stressed and alienated that suicide seems the preferred option.

For example, a 76 year old man blew himself up in a courtroom in protest during a case against his family, who had offered only 350 Yuan a month to support him when 1000 Yuan was required (8 Yuan = 1 USD) (Cook and Murray 2001). In a society of rapid transformation, older people in particular may be vulnerable to the sense of abandonment within a more materialistic and selfish new world epitomized by the forces of global capitalism and seeping impingement into day to day living of older people in China.

4. DECLINING TO DECLINE—ACTIVE AGING

At the other end of the scale is the active elderly, probably the ideal state for all elderly people. Briefly, older people traditionally were more likely to be active within rural areas of China, in part because they had to be in order to maintain their livelihood. This particular tradition continues today; official data for the 1990s showed that 26 percent of people in rural areas still depended on their own labor earnings compared to only 7 percent in urban areas.

This is not about advocating that elderly people should have to work to continue to earn a living, but we are suggesting that an active lifestyle be promoted where possible. In the cities of China today, it is heartening to see the colonization of open space throughout the hours of daylight and even into the evening by the elderly who are engaged in a wide variety of activities, from the traditional (such as taijiquan and qigong), walking one’s pet bird, traditional dance or poetry writing using brushes dipped in water only, illustrating the ephemeral and passing nature of life itself). Hopefully, the increased pollution which China’s cities face will not erode the potential gains from these and other activities for older people. An alternative discourse on aging can point to ways in which the elderly can be *depoliticized* as a negative medical, economic, political and social category.

It must begin with appreciation of older people first of all as people rather than as a category (Cowell 2006). Older people share, however, apart from their longevity, a wide and deep experience of life itself, and thus of life situations. In China, older people used to be venerated because they were, almost literally, the fountains of wisdom, the holders of accumulated knowledge far in advance of the younger members of the family and community. Today, knowledge is far less likely to be oral, and far less dependent on accumulation by the individual. Instead, it is increasingly available at the touch of a button via an Internet search engine, even if there are some restrictions on web provision in the PRC. But, it can be suggested, there should still be a major role for the accumulated wisdom of older people’s experiences as carriers of historical wisdom.

In China, there is a growing awareness of the need to have a sophisticated, multidimensional policy to respond to the needs of older people. But there is still a strong bio-medical emphasis on surveillance and control. It could be suggested that policy needs to be driven by the elderly themselves wherever possible. They should be encouraged to define and state their own needs, provided with support when this is required, but the overriding emphasis should be on providing support that fosters active lifestyle and independent living wherever and whenever possible. This means encouragement to the elderly to share their accumulated experience, to provide their oral histories and their views on the momentous changes that they, along with China itself, have lived through. Older people should be valued, and involved in wider society on terms that they themselves desire, recognizing that a wish for privacy and seclusion might be their preference.

5. CONCLUSION

Finally, it is worth noting that cases exist where narratives and micro-histories coexist and play a role in producing and strengthening social exclusion. The medical “gaze” refers here to discourses, languages, and ways of seeing that shape the understanding of aging into questions that center on, and increase the power of, the state, and restrict or de-legitimize other possibilities. A consequence is that areas of policy may at first seem tangential to the medical project come to be reflected in its particular distorting mirror. The Chinese “Duomin”—a subcategory of a wider population officially catalogued as fallen people, beggars or ruined households—were seen as inferior and condemned to bear low status on account of a number of beliefs prevailing in mainstream society. The narrative concerns a creational myth that asserts that the Doumin were closely related to Chinese ethnic minorities like the She and Yao and that all these groups shared the belief in Pan-hu, a common dog ancestor. As to micro-histories, we run into different stories which state that the Doumin were either: (1) descendants of Song Dynasty traitors, deserters or prisoners; (2) remnants of antique non-Chinese ethnic groups; (3) foreigners who adopted the customs of Chinese lower social strata; and (4) descendants of domestic slaves. Yet in all cases the Doumin's excluded and despised status came about as a punishment society bestowed upon them. They were reduced to performing polluting occupations (ox head lanterns making, ironwork, barbers, caretakers, dog-catching, entertaining, among others) and limited to live in segregated quarters outside town. Furthermore, the Doumin were not allowed to study or take public office, to serve as officers and were obliged to marry among themselves. This suggests that their social identity was a result of the legal status imposed on them and not the other way around. Ahlansson (1996: 87) expresses it: “Once fallen people had been labeled as beggars they had little choice but to conform to the behavior expected from people who had the social identity associated with their legal status.” For older people if they are regarded as an inferior category then their behavior will begin to mimic this categorization. “Dependent is as dependent does” is a major danger in the continuation of the dominance of the bio-medical model of aging.

A key point here is that the notion of the “bio-medical gaze,” not only draws our attention to the ways that aging has become “medicalized” as a social issue in China, it also highlights the way in which older people are encouraged for as long as possible to “work on themselves” as active subjects. Thus, as Blaikie (1999) has pointed out, older citizens are encouraged to take greater personal responsibility for their health and for extending this period of their active aging. Those who are defined in relation to their health then discover

themselves transformed into passive objects of medical power in China. How do we go beyond this in managing old age?

We could suggest macro-social practices have become translated into particular ways of growing old that not only shape what it is to age successfully, but are also adopted by older adults, modified to fit their own life circumstances and then fed back into wider narratives of aging well. Harry R. Moody (1998) coins this as the “Illderly” and “Wellderly” and managing aging experiences is about resistance to dominant discourses of bio-medicine. According to Frank (1998), the personal experience of illness is mediated by bio-medical procedures that shape and contribute to how the older people recognizes their own process of ill health and recover. Katz (2000) notes that the maxim of “activity for its own sake” as a means of managing later life not only reflects wider social values concerning work and non-work, it also provides personal means of control and acts as grounds for resistance. In addition, Phillipson (1998) argues that changes in westernized policies has occurred from seeing old age as a burden to seeing it as an opportunity to promote productive aging. This reflects an attempt to shape acceptable forms of aging whilst encouraging older adults to self-monitor their own success at conforming to the challenging paradigm of hegemony of bio-medicine and its neglect of the human agency of older people.

BIOGRAPHY

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