# Contents

**List of Illustrations**                   vi  
**Preface**                             vii  
**Acknowledgements**                  xii  

1 The Idea of a Fourth Age                      1  
2 The Shadow of Long-Term Care                 20  
3 Demographic and Epidemiological Aspects of the Fourth Age 42  
4 Frailty and the Fourth Age                   62  
5 Abjection and the Fourth Age                78  
6 Care and the Moral Identity of the Fourth Age 95  
7 Bridges and Barriers between the Third and the Fourth Age 115  
8 Fashioning a Future for Fourth Age Studies 128  

**References**                                139  
**Index**                                     169
Chapter 1

The Idea of a Fourth Age

Ageing and old age: an introduction

At the beginning of a book on the fourth age it is probably useful to describe some of the concepts we are going to be using and how they provide the context for the development of our arguments about this topic. We start by making a distinction between ageing and old age. This might seem obvious but failing to do so can have important consequences. Generally, ageing is seen as the process or processes that emerge from a person living a long life, which is a life that extends beyond the period of reproductive fitness. Despite radically differing life expectancies across time and space, there have been people in all societies who have lived ‘long’ lives (in the above sense of living beyond the period of reproductive fitness) and there have always been others able to both observe the changes that accompany these long lives and formulate ideas about what ageing is and what might be its cause. These ideas about ageing form part of societies’ cultural knowledge of life, its origins, development and decline. In contrast to such narratives of ageing as a process, old age has typically been represented as a status or social category conferred on individuals at a particular point in their lives. The bases of such ascriptions have varied, though usually they have emphasised some particular set of physical signs, characterological features and social markers. More recently, they have included a person’s recorded chronological age. A point that needs to be acknowledged is that the processes that lead to people being designated as old are therefore distinct from the processes that embody ageing. In contrast to the process of attributing old age to a
person or persons, ageing has been thought of as a more diffuse process, referring more often to all that takes away or lessens ‘youth’ and ‘fitness’ than to what the ageing individual acquires.

In situating the themes in this book it is also important to distinguish between different types of change over the life course, particularly the distinction between the processes of ageing and those of development. Strehler (1962), a pioneering biologist of ageing, defined ageing in terms of four key principles. First, it must be universal affecting all members of a species even if it is subject to some variation over its timing and effect. Second, it must be intrinsic in that the causes must not depend on external factors. Third, it must be progressive in that changes due to ageing must occur progressively during the latter part of the lifespan. Finally, ageing must be deleterious to the individual’s health and survival. Development, like ageing, is also considered to be universal, intrinsic and progressive but, unlike ageing, it is beneficial rather than deleterious for health and survival. It is this last principle – that of deleterious change – that has made ageing so important for individuals and for society.

It is generally accepted that at some point in the life course, there is a gradual transition from increasing to decreasing fitness, and from a declining to a growing risk of illness, disability and death. Across the human lifespan, decreases and increases in morbidity and mortality can be represented on a graph as ‘U shaped’. Throughout recorded history, birth and infancy have been periods of greater risk of death and disease than have been the periods of childhood and adolescence. Similarly old age, however defined, has also been a period of greater risk than has youth and young adulthood. Understood graphically the precise shape of this U curve in the risk of morbidity and mortality has varied from place to place and time to time. For much of human history death has been a significant risk at all ages a point well summed up in the words of the Old Testament’s Psalm 23 where it is stated that: ‘we live in the shadow of the valley of death’.

As long as life expectancy was limited by high infant mortality rates and high attrition rates throughout the life course, the personal experience of ageing and the acquisition of the status of ‘old age’ were confined to a relatively small minority of the population. There are many epidemiological reasons for this. Contaminated water and food-borne diseases such as cholera alongside vector-borne diseases such as the bubonic plague had devastating effects on mortality as did periods of crop failure and civil wars. These circumstances began to change during the course of the second half of the nineteenth century when a number of initiatives in Europe and North America were
undertaken to improve public health (McKeowan, 1976). These measures included the construction of sewerage systems, the provision of clean water and legislation to ensure food safety and safety at work. The cumulative effect of these processes of ‘modernisation’ and the improved control over the environment they achieved was to lessen the effect of infectious diseases across the life course changing the traditional pattern of morbidity and mortality – and the shape of the U curve of survival across the life course. Known as the ‘epidemiological transition’ (Omran, 1971), the decline in infectious diseases during development was matched by a rise in diseases that mainly affected older members of the population. During the course of the twentieth century, morbidity gradually became patterned around the so-called ‘degenerative diseases’ of long life such as cancer, cardiovascular and respiratory disease and metabolic illnesses such as diabetes, liver and kidney disease. This change affected both ageing and old age leading to what has come to be called the ‘rectangularisation of the survival curve’ (Fries, 1980). This is the next conceptualisation that we shall introduce.

Rectangularisation of the survival curve

The idea of the ‘rectangularisation’ of the survival curve was articulated by Fries in a paper he published in the *New England Journal of Medicine* (1980) on the ‘compression’ of morbidity. Fries observed that contemporary Western populations exhibit diminishing levels of mortality from childhood until mid-adulthood and then demonstrate an acceleration of mortality, roughly from the age 50 and beyond. After this point in the life course there is a steady acceleration of morbidity and mortality resulting in the greatest mortality rate in ‘old age.’ There is considerable variability when different populations reach the point at which this acceleration occurs and its rate. Current trends are shifting both the age at which accelerative mortality occurs as well as its speed, leading to an ever sharper ‘rectangularisation’ of the curve. This trend is illustrated in Figure 1.1 that demonstrates, using modelled data from the UK, the progressive shift toward a rectangular pattern of survival over the lifespan that has taken place during the course of the second half of the twentieth century.

Assuming a theoretically fixed lifespan, and following the epidemiological transition from infectious to degenerative disease, the rectangularisation of survival becomes more evident as survival in later life increases (even in the presence of morbidity) and death is compressed
within a narrow chronological age range. These trends – of delayed onset of morbidity, less steep decline and greater compression of mortality – have led some writers to propose a further ‘epidemiological transition’, the transition to ‘the age of delayed degenerative diseases’ (Olshansky and Ault, 1986). These relatively rapid changes in morbidity and mortality make it difficult to ascertain whether we are ageing less precipitously and at later chronological ages, or whether we are ageing at much the same rate and manner as ever but simply surviving longer in the presence of similar or even greater levels of morbidity.

This uncertainty over the rate and nature of ageing has been the subject of a number of debates both within gerontology and within the related disciplines of demography and epidemiology. One particular issue has been whether the increases in life expectancy of the last century represent a real change in the processes of ageing or whether they are simply the result of an expansion of later life morbidity (Gruenberg, 1977; Olshansky et al., 1991; Verbrugge, 1984). Gruenberg’s ‘failure of success’ approach argues that ageing remains much the same as it ever was, a universal process whose speed and direction
of travel is fixed by our biological make up. Consequently, all the apparent gains in life expectancy only mean that we are ‘living longer and sicker’ instead of dying ‘quicker and fitter’ (Schneider and Brody, 1983). Instead of the rectangularisation of the survival curve and the compression of morbidity, disease and disability are becoming ever larger features of our longer ‘unhealthier’ lives.

Despite such claims, Fries’ prediction of a ‘compression of morbidity’ has challenged many of the old assumptions about the connections between ageing, illness and death. Although some analyses of subjective measures of health do seem to suggest that longer lives are resulting in an increasing burden of disease in later life, others using more objective indicators of disability suggest a different scenario (Schoeni, Freedman and Martin, 2008). For some time, US disability rates have been falling, mirroring the decline in mortality rates (Manton, Gu and Lamb, 2006). These changes look even more significant when looked at over a longer timeframe. Using US data going back to 1900, Costa has demonstrated that age associated morbidity – the diseases associated with mid-life and beyond – fell dramatically over the course of the twentieth century. She calculated that functional disability ‘has fallen at an average rate of 0.6% per year among men age 50 to 74 from the early twentieth century...[with] a large proportion of the decline in disability at older ages...occur[ing] only recently’ (2002: 38). This is further substantiated by data on ‘healthy’ and ‘unhealthy’ life expectancy among older people in Austria over the last two decades of the twentieth century. There has been a clear increase in the former and a clear decrease in the latter, with ill health becoming ‘more and more compressed into the later years of life’ (Doblhammer and Kytir, 2001: 385). These findings are illustrated in Figure 1.2 which shows the growth in Austrian women’s healthy life expectancy in later life as a function of their overall life expectancy (i.e., the compression of morbidity in later life).

The accumulation of this kind of empirical data is helping shift the weight of evidence in the debate over whether ageing is an endogenously determined, universal process of bodily decline, the inevitable consequence of an unchanging and unchangeable human nature or whether it can be seen as a set of interlinked processes that are contingent on time, circumstance and the organisation of social relations. Evidence of such observed variability suggests that ageing possesses an intrinsic indeterminacy, even if that exists within some notional set of biological limits.

Some bio-gerontologists argue that age-related mortality occurs primarily because of accumulated, unrepaired damage to cells and
tissues. This ‘neglect’, it is suggested, arises from the limited investment that evolutionary processes have made in developing efficient, long-term body repair mechanisms which is said to be a consequence of somatic cells only ‘needing’ to last the body one generation to ensure the survival of the genotype. This is in contrast to the resources ‘needed’ by those cells that provide the germ lines which can then survive across innumerable generations (Kirkwood, 1999). These ideas have led more speculative bio-gerontologists such as de Grey (2008) to argue that if and when the basic biological processes of somatic maintenance and error repair are understood, longevity can be extended indefinitely.

Such speculations are encouraged by evidence of continuing increases in later life expectancy. Although Fries had originally assumed a fixed life span in his model of rectangularisation, evidence now suggests a degree of open-ness in how long a human life might last. As Rau and his colleagues (2006) have pointed out, while mortality rates for men aged 80–89 dropped by a mere 0.81 per cent between 1950s and 1960s, they have dropped by more than twice that rate (1.88%) from the 1980s to the 1990s. For similarly aged women, their rates of ‘declining to decline’ went further, rising from 0.91 per cent to 2.45 per cent during this period. Schoeni, Freedman and Martin (2008) have pointed out that greater educational attainment and declines in poverty have affected the decline in disability levels in the
US and have opined that as long as standards of living continue to improve, ageing is likely to follow suit. Increasing lengths of life have been observed throughout much of the developed world, resulting in increasing numbers of centenarians and even super-centenarians. Evidence is mounting that the clock of life can be changed although some have questioned the idea of unending life extension (Olshansky et al., 2005; Turner, 2009).

The changing status of old age

If there are signs of contingency in the processes of ageing, contingency is even more evident – and perhaps less controversial – when it comes to the status of old age. In traditional or pre-modern societies where the experience of ageing was less common and the numbers of people surviving into old age were fewer, the status of old age was often quite high, or perhaps more accurately, the status of older men from elite groups was often high. According to ‘modernization theory’ the status of old age declined as societies transformed from agricultural to industrial economies (Cowgill and Holmes, 1972). The introduction of industrialisation put a premium on the selling of labour power and encouraged the migration of younger men and women to the cities where wages were often higher than in the countryside. Urbanisation favoured younger people, and old age became increasingly linked to poverty. The rise and decline of earning power over the course of a man’s working life came to reflect the rise and fall in his capacity to provide for his family leading to a corresponding decline in status. Concerns about the pauperisation of old age rose markedly in the urbanised industrial society of the nineteenth century. These concerns led eventually to the introduction of the state old age pension as a means of financially securing old age. This marked the consolidation of the modern, institutionalised life course that was organised sequentially around home, school, work, retirement and death. In all of this ‘chronometric’ institutionalisation, women’s ageing was less socially visible. It was men’s old age as defined by state chosen retirement age that declined in status. In the US and UK, despite increasing numbers of men leaving work and collecting their pension at age 65, for many men retirement represented an imprisonment in a ‘role-less role’ within society (Burgess, 1960: 20) and a tragic loss of status within the home (Townsend, 1963).

The endless debates about when old age began that had been actively conducted in books, periodicals, reports and in the UK
parliament during the latter decades of the nineteenth century were soon forgotten (Roebuck, 1979). By the time that the post-war welfare state was established in the late 1940s, old age was unquestionably placed at the chronological ages of 65 for men and 60 for women. The discrepancy in men and women’s pension age that had been established as the basis for pension entitlement seemed permissible at the time, in part because women’s ageing counted so much less. Her ‘ageless’ role within the family meant that it was her husband’s retirement – or death – that represented the public onset of her old age. The internal markers of women’s ageing such as the menopause and its consequences were matters that went largely unspoken, whether they were experienced personally as a loss or greeted as a relief while within the sphere of home and family, the exterior signs of ageing went equally unremarked.

Change in the social organisation of old age and its gendered nature came about after the cultural ferment of the ‘long’ 1960s. During this period the principal features of ‘modernity’ – stable occupational identities, ascribed class and ethnic identities, marriage and the nuclear family – became looser. In their place came a culture based upon consumption and lifestyle, a culture that put a premium on youth and innovation rather than age and experience. This affected the circumstances situating old age. There was a steady increase in the number of women entering, staying in, and/or returning to the workforce with a corresponding fall in the number of men staying in work into their 60s and beyond. Old age now framed as retirement was turning into a broader, less impoverishing and more heterogeneous experience, all the while becoming ever more universal. The standard of living in retirement rose, accounted for in the UK by an expansion of occupational pensions and home ownership, and in the US as a result of improvements in the coverage and adequacy of Social Security, the introduction of Medicare and rising levels of home ownership. In much of continental Europe, retirement benefited from the rise in the value of state administered pensions that were linked directly to the general rise in wages during the post-war decades of growth.

From the late 1980s, the standard of living of retired people has risen at a faster rate than that of working people (Jones et al., 2008). A new ‘third age’ has been fashioned from these developments, one that contrasts sharply with the narrow and gendered old age that was constructed by modernity’s chronology (Gilleard and Higgs, 2005). The boundaries of what constitutes ‘old age’ have been challenged by these new possibilities as the circumstances of people in later life have lost much of their connection with what was once considered ‘real’
old age. At the same time, the last institutions housing this ‘real old age’, the welfare homes, the ex-workhouse infirmaries and the long stay hospitals in which the ‘elderly poor and infirm’ had long been confined were now seen as expensive, inhospitable and out-dated resources. De-institutionalisation and disinvestment followed in the wake of the mid-1970s ‘crisis’ of the welfare state (O’Connor 1987). The rhetoric of ‘community care’ saw the numbers of the people aged 60 and above living ‘independently’ steadily increase. Despite more ageing than ever, there appeared to be less ‘real’ old age.

A crucial point for the analyses presented in this book is that the 1980s witnessed the demise of the category ‘old age pensioner’ (OAP) as the alternative archetype of old age. Rising standards of living, increased numbers of women in the work force, falling rates of employment and increased wealth and earnings redefined the economic situation of people aged 60 and above in Western societies. ‘Real’ old age, physically dependent, psychically impoverished and socially isolated was confined to a shrinking segment of the population while the numbers of people solely dependent on state support declined. As ageing expanded, its social identity became increasingly confusing while ‘real’, ‘deep’ or ‘dependent’ old age became narrower and narrower. Instead there began to emerge a new and more fearful image of old age as references to a ‘rising tide’ of dementia began to pervade the professional and popular media (Health Advisory Service, 1982; Arie and Jolley, 1983). Alzheimer’s disease, once the little-known psychiatric name for a rare form of ‘pre-senile’ mental decay began to replace the term ‘senility’ or ‘senile dementia’ as the ‘cause’ of later life mental decline. Following the putative identification in the late 1970s of the neuro-chemical lesion associated with late life mental deterioration, and drawing parallels with the potentially treatable Parkinson’s disease, the ‘Alzheimerization’ of ageing was underway (Adelman, 1995; Gilleard and Higgs, 2000).

By the 1990s the cultural ferment of the 1960s had settled down, its ‘radical sell’ more or less successfully integrated into post-war consumer society (Heath and Potter, 2005). Ageing was becoming ever more diverse as it was immersed in a mass of competing and conflicting interests. Critical gerontologists were busy identifying the accumulating economic inequalities of later life. Cultural gerontologists were equally eager to draw attention to the double standard of ageing that endorsed the status of men while consigning women to be reflections of their younger selves. In a similar fashion the increased acceptability of diversity created new cohorts of older men and women distinguished as much by their ethnicity, gender and sexuality as by their agedness.
Alongside this profound change in the nature of old age, some older people were starting to be seen as becoming distinctly ‘more equal’ than others. Politicians and policy think tanks began to fulminate over a growing ‘generational inequity’ (Kotlikoff, 1992). In this formulation older people were seen to be leaving the ranks of the poor at a faster rate than other age groups – but rather than celebrating what had been overcome, the focus was on the future ‘disorder’ that was threatened by this overturning of the rational economic order of the life course. In short, ‘diversity’ in ageing competed with ‘inequality’ in ageing as the dominant gerontological narrative, and generation rather than age became a focus of future division.

The new diversity of ageing became a source of commercial opportunity. Almost as soon as it had freed itself from the mantle of old age, later life became surrounded by uncertainty and confusion. Within this new anxiety over ageing – and no doubt contributing to it – anti-ageing practices and products appeared as part of a new mass market whose raison d’être was helping people of all ages prevent ‘the signs of ageing’ (Gilleard and Higgs, 2013). Following the emergence of ‘cosmeceuticals’ consumers across the world started to discover that ‘anti-ageing’ remedies could be found on the shelves of pharmacies and supermarkets. A few years later minimally invasive rejuvenative procedures such as Botox, fillers and skin smoothening agents became available and soon grew in popularity and cultural acceptability. This combination of diversity, life-style consumerism and a powerful desire to avoid the attributions of old age in later life helped shape the new culture of the third age. All the while policies and welfare constraints were busy narrowing the boundaries of ‘real’ or ‘deep’ old age.

**Dividing later life into a third and a fourth age**

The distinction between the third and the fourth age is of critical importance to this volume. The term ‘the third age’ was introduced into gerontological thinking by Laslett in his book *A Fresh Map of Life* (1989). Following a then well-established tradition of ordering the life course into distinct stages and ages, he coupled the term with the idea of a ‘fourth age’ and in so doing drew attention to one of the principal binary oppositions in the way later life is represented; namely the distinction between a fit, healthy and productive later life and an old age dogged by ill health, incapacity and neediness. Laslett assigned people reaching later life to one or other of these statuses, with those most aged, ill and disabled being placed in the fourth age, while those
still ‘young enough’ to demonstrate ‘tremendous reserve capacity, plasticity or latent potential’ were assigned to the third age (see also Baltes, 1998: 412 for a similar argument).

But while Laslett considered the third age a distinct life stage, he was reluctant to see it ‘bounded by birthday ages’, insisting that ‘the decision as to who is and who is not in the Third Age is (not) a straightforward matter (1996: 443). He considered the fourth age also ‘idiosyncratic’ for several reasons – ‘because it does not necessarily occur in every individual, it can come at any point in the life course and can be very variable in length’ (444). Others like Paul and Margret Baltes made extensive use of the third age versus fourth distinction, but in contrast to Laslett, they have emphasised the importance of chronological age in framing this distinction (Baltes and Smith, 2003; M. Baltes, 1998). For the Baltes, the third versus fourth age script is primarily an elaboration of the ‘young-old’ versus ‘old-old’ distinction that was introduced by Neugarten (1974) in her seminal paper on ‘the rise of the young old’. They define the third age or ‘young old’ as ‘those aged between 60 and 70 years’ (M. Baltes, 1998: 411) with the ‘watershed’ transition into the fourth age taking place sometime after 70 or 75. Using data from a variety of sources, Baltes and Smith claimed that during this transitional period, the resilience of later life breaks down and ‘the positivity of the news about human ageing begins to crumble’ (2003: 128). Although they acknowledge the contingencies of place and period in determining exactly when this ‘fourth age’ watershed occurs, they argue that it can be operationalised by ‘the chronological age at which 50% of the birth cohort are no longer alive’ (125). Under these assumptions, increasing life expectancy would lead to a concomitant increase in the age at which individuals or cohorts reach the fourth age. What we can see is that very quickly the third age and the fourth age have become concepts that can be either loosely framed as ‘life stages’ or tightly operationalised as ‘chronological age boundaries’ with each framework leading to different conclusions regarding the nature and ‘inevitability’ of a fourth age.

Alternative perspectives exist that critique the ‘third age/fourth age’ framework, arguing instead that by using it divisive categories are created among the community of old age shattering what is otherwise a common bond that exists among ‘old’ people flowing out of their shared experience of discrimination and social and cultural marginality (Neuberger, 2009). A slightly different criticism is postulated by those who argue that the projection of such distinctions masks a more fundamental division between ‘two nations’ in retirement, the rich and the poor (Holstein, 2011; Scharf, 2009). Calasanti and King (2011) argue
that multiple divisions exist within later life, but these divisions of gender, class and ethnicity act primarily as sites of inequality rather than as sources of differential adaptability and/or success. Against this position it can be argued that none of these ‘divisions’ are necessarily distinctive of later life. They represent divisions permeating the whole of society advantaging or disadvantaging people in every age group. Treating the issue of the divide between the third and fourth age as no more than an issue of generational solidarity or the inevitable consequence of the divisions between those who are better and those who are worse off does not address the difference in kind that lies between a third and a fourth age. In a similar fashion, treating the distinction in purely chronological terms assumes that it arises from some intrinsic mechanism operating within the body; thus essentialised it becomes no more meaningful than any other distinctions based purely on time. It also begs the question, why not a fourth and a fifth age? Why not talk of age in terms of decades, of age cohorts, of generations?

The fourth age: defining a social imaginary

In a number of publications we have argued that the third age can be interpreted as a cultural field that is developed most extensively – though not exclusively – during post-working life (Gilleard and Higgs, 2000; 2005; 2009; 2011a). Some people in later life participate in it more extensively than others, but it is their participation not their identity that defines this cultural field. Part of this definition of the third age is its active exclusion of ‘old age’ and ‘agedness’: This cultural rejection of agedness helps drive the desire to consume and in so doing helps determine the contours of the fourth age. This latter phenomenon appears as a kind of distortion in the ‘mirror’ of the third age, playing a key role in forming a ‘social imaginary’ of ‘real’ old age, within the changing circumstances of ageing.

When Laslett wrote A Fresh Map of Life, he sought to rescue the third age from what he termed the ‘ignominy’ of the fourth age (1989: 3–5). For Laslett the fourth age was a period of decline and decrepitude that particularly affected those who lived beyond their mid-80s (41). While he periodised the fourth age within the lifespan of individuals, he located the third age within the history of society. The fourth age was not a matter of collective achievement but an ontological and existential end that can at best be minimised by being confined to the outer edges of life. Although we share Laslett’s view of the third age as a socio-historical phenomenon situated in the confluence of particular
The Idea of a Fourth Age

social and historical trends, we do not see the fourth age as simply a domain of exclusion from the third. The fourth age is about much more than not participating in this cultural field. It is more distinct and in some sense more unfathomable. It is we believe a social imaginary.

The term ‘social imaginary’ originated with the twentieth century French social theorist Castoriadis in his book, *The Imaginary Institution of Society* (1987). In this book, he argued that all social institutions possess a central imaginary, situated ‘on the level of elementary symbols or of global meaning’ that link the functions of social institutions with their symbolic forms. ‘[E]very society’, he writes, ‘posits a “view of itself” which is at the same time a “view of the world” ...[which]...is part of its truth or its reflected reality...without being reducible to it’ (39). As social institutions are necessarily human inventions, their particular functions are inevitably invested with symbolic meaning that make sense of their functioning within the broader structures of society. He contends that social institutions can only be understood through the organisation or network of signifiers and signified held within the social imaginary. A ‘social imaginary’ gives meaning to modern society’s unstructured and inarticulate sense of the world.

The idea that society can be represented as a social imaginary has been explored most recently by Taylor in his book *Modern Social Imaginaries* (2004). For Taylor, the social imaginary refers to ‘the ways people imagine their social existence, how they fit together with others, how things go on between them and their fellows...and the deeper normative notions and images that underlie these expectations’ (23). Though linked to Castoriadis’ more general formulation of society as a ‘magma of magmas’, Taylor’s notion of ‘a common understanding’ among members of a society once again echoes Durkheim’s notion of ‘collective representations’ compounded with the anthropologist Anderson’s (1983) argument of how the modern nation state emerged as an ‘imagined community’.

Taylor’s modern social imaginary can be linked to concepts of ‘social trust’ or ‘social capital’, those shared expectations and assumptions that are deemed necessary for a society to hold together (cf. Fukuyama, 1995; Misztal, 1996). Gaonkar has summarised the various components of Taylor’s social imaginary into five key ideas – (1) ‘that social imaginaries are ways of understanding the social that become social entities themselves’, (2) ‘that modernity in its multiple forms relies on a special form of social imaginary that is based on relations among strangers’, (3) ‘that the national people are a paradigmatic case of the modern social imaginary’, (4) ‘that other social imaginaries exist alongside and compete with these national social imaginaries’, and
‘that the agency of social imaginaries comes into being in a number of secular temporalities rather than existing eternally in cosmos or higher time’ (Gaonkar, 2002: 4–5).

We posit that the fourth age functions as such a social imaginary because it represents a collectively imagined terminal destination in life – a location stripped of the social and cultural capital of later life which allows for the articulation of choice, autonomy, self-expression and pleasure (see Gilleard and Higgs, 2010; 2011a; Higgs and Gilleard 2014). In this manner the institutional structures framing the fourth age first emerged as sites for those too poor and too ill to manage on their own. By the time of the post-war welfare state, policies addressing old age were institutionalised as either issues concerning social security and income maintenance or issues concerning sickness and infirmity. The institutional outlines of an incipient fourth age retained much of what had been most feared from the new poor law era, namely enforced indoor relief (Thane, 2000) but added to it a deeper neediness that went beyond that located within a framework of poverty and social need. These institutions helped frame the social imaginary of a fourth age as, in Laslett’s terms, an ‘unwanted condition of half life’ whose ‘onset and hence...duration should be put off for as long as possible’ (1996: 154).

The post-war paternalism toward ‘old folks at home’ has in more recent times, been outflanked by the demands of an ‘individualized’ second modernity of risk management, with its emphasis on self-management of disease and the expectation of universal precautionary self-care for everyone in and approaching later life (Barlow, Turner and Wright, 2000; Higgs et al., 2009; Lorig and Holman, 2003). While in earlier times the fate of ending one’s days in the workhouse cast a shadow over the working class, ending one’s days in a nursing home has become a fate more universal in its potential coverage. It is a more personalised risk, and if all are at risk, then everyone must look out for themselves. Health promotion and precautionary self-care, as aspects of the ‘citizen consumer’ have insinuated themselves into the third age, distorting and disturbing its emancipatory messages while further darkening its borders.

Part of the social imaginary of the fourth age arises from the institutional densification of long-term care. By this we mean that reductions in the public provision of long-term care combined with the increased size of the population aged 60 and above has changed the nature of long-term institutional care toward one of greater agedness and more profound infirmity among the ‘care recipients’. Ever fewer nursing home residents are able to self-manage basic activities such as
bathing and dressing (Decker, 2005; Bowman, Whistler and Ellerby, 2004). The progressive concentration of infirmity that has taken place within the nursing home sector has nevertheless made long-term care an increasingly real yet alienating prospect for what may be as many as one in three of those who reach the age of 65 (Liang et al., 1996; Liu, 2000; Murtaugh et al., 1990). Predicting who will be that one in three implicates everyone aged above 65, as medicalised disabilities rather than socio-economic status form the principal determinants of nursing home admission (Agüero-Torres et al., 2001; Bharucha et al., 2004). The fourth age appears neither as a moral and final stage of life, nor as the cumulative consequence of a materially unsecured position in society. Rather it seems the result of individual misfortune.

Accompanying this interpretive change in the nature of care in old age is the abandonment of any reversibility in the status of those assigned to the communities of the old, sick and poor – the modern prototype of the fourth age. When the English medical journal *The Lancet* surveyed the state of the chronic sick in the Victorian workhouses of England, it claimed that

*If, as we assert ought to be the case, all the infirm were medically treated, there would be a very large percentage of recovery and consequently an important saving of the rates.* (*The Lancet*, 1865: 9)

Similar claims of reversibility were made by other Victorian reformers who believed that

*they (workhouse inmates) are indigent in their old age after a life of toil because they have been robbed of the fruits of their labour by the class from whom our guardians and magistrates are mostly drawn.* (‘Nunquam’, *The Clarion*, 17 September 1892)

Whatever the successes of the social and medical reformers of first modernity in creating ‘rationalized’ institutions, the result in second modernity has been the refashioning of these communities into positions characterised by the depth and the irreversibility of their infirmity – an ‘event horizon’ of historical contingency by which the fourth age is imagined more darkly than before.

**The fourth age and its ‘event horizon’**

If the cultural field of the third age emerged successfully from past social contestations around ‘lack’ in old age, the fourth age might appear the bitter fruit of that victory. Unlike the habitus of autonomy,
choice and leisure that are associated with the third age, the fourth age we would contend can neither sustain any set of cultural dispositions, nor support any subjectively construed forms of symbolic differentiation. It remains an imagined state or position that is undesired by, and distasteful to, all of those subject to its pull. The distortions in the mirror of the third age that shape it are more than the concerns of ‘third agers’ finding themselves at the receiving end of services labelled as ‘geriatric medicine’ or ‘care of the elderly’; they serve as a fundamental ontological and existential challenge. The irreversibility of nursing home admission, the minimisation and often disappearance of any personal exchange in the processes of admission, and the ‘deprivatisation of experience’ that results from long-term care placement (Gubrium and Holstein, 1995; 1999) create an immense negative pull on both the third age that surrounds but remains imperceptive of it and the public’s attitudes to what is seen as ‘real’ old age. In short, the fourth age acts as a metaphorical ‘black hole’ of ageing (Gilleard and Higgs, 2010).

This metaphor might seem too strong but our object in using it is to convey the inherent unknowability of the fourth age. In astronomy, a black hole creates a massive gravitational pull that sucks in everything that comes within range including light itself. This generates the phenomenon of the ‘event horizon’ which is a point where light disappears completely. Any light emitted from beyond this horizon can never reach the observer. To many people in or approaching ‘later’ life, the position of those in the fourth age can be likened to that of an object that has strayed too close to the event horizon and has now gone over it, beyond any chance of return. Equally, no light shines back once the event horizon is traversed. In the absence of any reflexive return it becomes impossible to separate what is projected into it and what occurs within it. The fear of the fourth age is a fear of passing beyond any possibility of agency, human intimacy or social exchange, of becoming lost in the death of the social, a hyper-reality from which there is no reality to return to. This fear is neither confined to those in the third age nor is it exclusive to contemporary society’s citizen consumers. The social imaginary of the fourth age contains a universal ontological quality. As de Beauvoir remarks ‘every society...dreads the worn-out sterility, the decrepitude of age’ (1977: 46) and this is what makes it more than just the particular institutional organisation of frailty or the ‘perspectivism’ of the third age, although both play their part.

In extending this metaphor of the black hole, we are seeking to argue for an interpretive frame for old age that differs from both the
classical distaste for bodily ageing and the modern stigma attached to the pauperisation of age. The fourth age represented as an imaginary black hole carries with it the notion of passing beyond the social world, beyond its connections as well as its contradictions. For observers, influenced in varying degrees by the commodification of their life world, the fourth age offers no opportunity to be able to create a status or articulate a lifestyle. In a similar fashion, nor is there reason to trust that previous choices based on personal agency will be honoured or even acted upon (Higgs and Gilleard 2006). Borrowing a phrase from the Slovenian philosopher Žižek, this is indeed ‘the desert of the Real’, a place where our greatest fears reside, ones that can only be addressed by allusion and metaphor (Žižek, 2002).

Attempts to measure this space within society fail to assuage its power. As relativity theory in the natural sciences has failed to resolve the dilemmas posed by quantum mechanics, so too the attempts of geriatricians and gerontologists to calibrate frailty; the efforts of policy analysts and health economists to assess the equivalencies of different forms of long-term care; and the aspirations of third sector advocates to give voice to the disempowered all cannot contain the forces that emanate from the fourth age. The inference that we are making is that as with the ‘mass’ of a black hole that can only be apprehended through its effects on the objects that surround it, the cultural perturbations created within the third age by the fourth age may offer the nearest approximations to what cannot itself be fully grasped.

If social reflexivity is the marker of modern social relations empowering the agency of the third age, the fourth age is marked by its opposite. There are no chosen choices in the fourth age. What may appear as choices – in terms of food, clothing or activity – are the attributions of choice created by others’ actions, a ‘hyper-reality’ of choice. As with the event horizon where light emitted from the outside disappears, so the intentions of carers and professionals generated from outside the fourth age also get lost within it. The discourses of care and concern create their own interpretive frameworks that can never receive the confirmation of mutuality and reciprocity that characterise other everyday social relations.

The seeming mindlessness and immobility attributed to the fourth age is just that. However difficult it may be to grasp the ‘real’ effects that any individual has upon another, the circumstances of the fourth age are such that struggles to establish a conscious social exchange seem too intractable, beyond any possible resolution other than death and grief. All that is evident are the various ‘civilized’ exchanges of professionals and carers, whose discursive reality exists within the
context of the agreed understandings that inevitably lie external to the fourth age itself. Although such discourses are rendered sensible by the institutional structures that generate them – the normative frameworks of professionalised care – the objects of that discourse play little active role in any part of them.

**Conclusions**

In this introductory chapter we have sketched out some of the key terms necessary for understanding the fourth age as a social imaginary, and outlined the elements of a model of the fourth age that we believe offers the social sciences a particularly productive way of understanding the fractured nature of old age in contemporary society. We began the chapter by outlining a distinction between ageing – as process – and old age – as status. While biological models have dominated the discourse concerning what ageing ‘is’, psychological and social models have focused upon what old age is – what status or social identity it possesses. It has, for this reason, been easier to accept the contingency and social construction of ‘old age’ than it has been to consider the processes of ageing in similar terms. Yet as we have argued the facticity of ageing and old age are equally bounded by uncertainties, subject to changing views and changing practices, their temporality provisional and forever contingent.

Most provisional of all is old age. Once rendered as a clearly chronological category, an established part of the modern institutionalised life course of childhood, work, retirement and death, much of its modern certainty has gone. The processes that institutionalised men’s life course have created in their turn the conditions for its subsequent ‘de-standardisation’. Later life, perhaps more than most other periods of life, has become more diverse, richer and paradoxically less distinct. Its’ gendered, racialised and class-based constitution has been blurred as has its ‘aged’ nature. People in later life have been given the capacity to fashion new, ‘third age’ cultures that reject old age as both an identity and a destination. Since the generational schism that opened up in the 1960s, new voices, new narratives and new practices have begun to embody age differently – themes that we have explored extensively elsewhere (Gilleard and Higgs, 2005; 2013). While the writings of Laslett and of Margret and Paul Baltes have sought to explore the division between a third and a fourth age, their emphasis upon chronological age in the latter case and moral agency in the former renders this distinction less than helpful in understanding what
is going on in later life in late modernity. We have outlined an alternative framework, one that draws upon this division between a third and a fourth age, but that posits a different conceptual approach, contrasting the cultural field of the third age with the social imaginary of the fourth.

In doing so, we recognise their inter-connectedness. While some have sought to prohibit such distinctions on the grounds that the one merely serves to oppress the other, or that the distinction masks more profound inequalities that fracture our societies – that of rich and poor – played out in later life (Grenier, 2012), we feel that this distinction reveals a very different source of tension, one that goes beyond divisions of wealth, gender, justice and rights. It concerns the problem of living well or living badly – and the problem of solidarity – of what Erikson once called ‘pseudo speciation’ – the cultural privileging of ‘we-ness’ from ‘other-ness’. The third age, we have argued, contributes to the social imaginary of the fourth age, advanced as ‘real’ old age. By advocating diverse lifestyles, a timeless self, and an endless journey through life, the third age helps paint a darker picture of ‘old age’, contributes a darker narrative and exaggerates the gap between the fit and the frail; it does not mean to but, in a world of unintended consequences, it does, just as the institutional securing of later life in first modernity created the conditions for its subsequent fracturing.

In the following chapters of this book we shall explore the social imaginary that has been created of ‘deep’, ‘real’ or ‘frail’ old age, casting it as our model for the fourth age. In doing so, we shall investigate its origins, explore its parameters and interrogate the practices and policies that perpetuate its imaginary powers. Our purpose in providing this account is twofold. In the first place we think that such an understanding illuminates the social changes taking place in contemporary society particularly one enmeshed in reflexivity. Second and equally important, we hope this account can reduce the power and reach of this particular imaginary in framing the experiences, narratives and practices that surround illness, disability and care in later life.

Note

1. ‘Nunquam’ was the ‘nom de plume’ of Robert Blatchford, editor and co-owner of the Clarion, a late nineteenth-century socialist paper published in Manchester.
Index

embodiment of, 89
gender and, 81
abuse, 33, 93–4, 104, 110–11, 125, 131

agedness, 9, 14, 42, 64, 66–8, 73, 77–8, 83, 88, 90, 96, 112, 117, 126, 134
abjection and, 81, see also abjection
indignities of, 130
rejection of, 12

ageing, 4–5, 9–10, 43, 60, 64–6, 68, 74–5, 86, 129
active, 75, 126
of ageing population(s), 36, 43
alzheimerization of, 9
biological, 68
bodily, 17
definition of, 2
differently, 129
diversity of, 10
fear of, 132
healthy, 75
new, 96, 129
and old age, 1, 3, 18, 58–60, 66, 117, 128
population, 56–60, 136

processes of, 2, 4, 7, 18
productive, 118, 126
signs of, 10
successful, 53, 74–5, 116–18
unsuccessful, 74, 77, 107, 118, 123
women’s, 7–8
ageing society (ies), 34, 42, 44, 46, 48, 83, 116, 122, 126, 130
ageing of, 42, 44, 56–61
agency (individual, personal, social), 14, 16–18, 63, 67, 81, 83, 86, 89, 96–7, 101, 112–13, 121–4, 132
almshouse(s), 29, 71, 131
Alzheimer’s, 9, 61, 76, 119, 134–6, see also dementia
anti-ageing, 10, 120
apocalyptic demography, see under demography
arthritis/osteoarthritis, 48, 50–2

baby boomers, 43
Baltes, Paul, 11, 18
Beck, Ulrich, 125, 134
Beckett, Samuel, 138

body, 6, 12, 73, 78–9, 81, 89, 130
ageing, 78
corporeality of/corporeal, 84, 96
products, 80–1
repair mechanisms, 6

cancer, 3, 47–8, 50, 52, 123, 135
cardiocascular disease, 3, 48
cardiocascular system, ageing of, 74
care, 15, 19–39, 44, 49, 51, 63, 68, 73, 76–8, 94–114, 123, 125, 127, 131–7, see also dementia care; long term care; reciprocity; self-care
community, 9, 35–6, 104, 110, 135
cost(s), 44, 53–6
discourses/narratives of, 17, 137

169
Index

care – Continued
  health, 31, 36, 44, 46, 53–8, 61, 68–71, 118, 126, 130, 137
  health-care expenditure, 54–5, 61
  health-care worker(s), 86, 91
  imperative of/to, 73, 95–98, 108, 131, 138
  informal, 56, 101–2, 108
  Nordic model of, 126
  recipients, 14
  social, 31, 35, 46, 55, 68–70, 76, 105, 125, 132
  standards of, 24
  carers, 17, 91, 93–4, 102–3, 107–14
  abuse, 93
  advocacy, 72
  burden, 109
  family, 111
  formal, 110–11, 121
  informal, 109–10, 121
  casa de misericordia, 27
  chronic disease, 44, 48–9, 51–3, 60, 73
  citizen(ship), 35, 39, 67, 95–6, 108, 111, 125–6, 131, 135–6
  consumer, 14, 16
  corporeal, 67, 97
  senior, 43
  class/classes, 8, 12, 15, 18, 22, 30, 76, 106, 115, 133–5
  abject, 79, 133, see also abjection
dangerous, 59–60
  working, 14
  compassion, 89, 100–9, 113–14, 130
  compression of morbidity, 3–5, 38, 40, 90, 122
  consumer choice, 21, 38
  consumerism, 10, 41, 105
  consumer(s), 14, 16, 35, 38, 105
directed care, 111
  consumption, 8, 137
  corporeality, 82, 84, 112, 132
  corrodies, 22

dementia, 9, 44, 48, 60, 89–90, 119, see also Alzheimer’s
care, 109
  diagnosis of, 50, 52
  and senility, 9
demography, 4, 34, 42–6, 52–6, 58–60
  apocalyptic, 43–6, 53–9, 122, 126, 130, 135
  depots de mendicite, 26–9, 39, 41
diabetes, 3, 48, 119, 135
  disability, 2, 5–6, 19, 45, 49, 51–3, 61–8, 73–7, 118, 122, 134
decline in, 5–6
densification of, 38, 40, 71, 121, 126, 137
epidemiology of, 47
  learning, 104
  movement, 106–8
disgust, 78, 80–4, 86, 89–90, 93, 98
epidemiology of, 4, 42–4
  black box, 73
  of disease in old age, 47–51, 56, 59, 61
  of incontinence, 86
  transition (epidemiological), 3–4, 44, 47
fourth age, 10–19, 36, 41, 47, 56, 72, 78, 95, 104, 108, 113, see also old age; third age
  boundary(ies) of, 62, 66, 96, 117–19
  and dementia, 135–6
  effects of, 120
  embodiment of, 113
  entering/entry to, 72
  enumeration of, 42
  fear of, 16, 20
  humanising, 124
  (social) imaginary of, 42, 44, 60–2, 77, 81, 84, 93, 95–6, 98, 110, 114, 116, 125–6
  and its event horizon, 15–17, 63, 119, 127
  moral identity of, 95–113
  resistance to, 122–3, 126
  shadow(s) of, 36, 56, 79, 94, 98, 113, 119, 123, 125, 132
  signifiers of, 72, 83
  as a social imaginary, 12–14, 115–16, 128–9
  studies, 136–8
  un-imagining, 123–4
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>fear of, 118</td>
</tr>
<tr>
<td>gender and, 65, 69–79, 79, 130</td>
</tr>
<tr>
<td>indicators/index, 68, 70</td>
</tr>
<tr>
<td>nature of, 63–6</td>
</tr>
<tr>
<td>rates of, 68–9</td>
</tr>
<tr>
<td>sarcopenia and, 66</td>
</tr>
<tr>
<td>social construction of, 69</td>
</tr>
<tr>
<td>Fries, James, 3, 5–6, 122–3</td>
</tr>
<tr>
<td>Galen, 75, 122</td>
</tr>
<tr>
<td>gender, 9, 12, 19, 49, 58, 70, 87, 96–7, 115–17, 135</td>
</tr>
<tr>
<td>frailty and, 69–70, 79</td>
</tr>
<tr>
<td>sarcopenia and, 66</td>
</tr>
<tr>
<td>use of incontinence aids and, 87</td>
</tr>
<tr>
<td>gendered nature of old age, 8, 18, 82–3</td>
</tr>
<tr>
<td>( \text{Hôpitaux généraux, 26–8, 39} )</td>
</tr>
<tr>
<td>incontinence, 84–9, 131</td>
</tr>
<tr>
<td>abjection of, 86</td>
</tr>
<tr>
<td>aids/pads, use of, 87</td>
</tr>
<tr>
<td>epidemiology of, 87–8</td>
</tr>
<tr>
<td>faecal, 83, 85</td>
</tr>
<tr>
<td>urinary, 83–5</td>
</tr>
<tr>
<td>( \text{kidney disease, 3, 52, 135} )</td>
</tr>
<tr>
<td>Kirkwood, Thomas, 6</td>
</tr>
<tr>
<td>Kitwood, Tom, 132</td>
</tr>
<tr>
<td>Kristeva, Julia, 78–82, 84–5</td>
</tr>
<tr>
<td>Laslett, Peter, 10–12, 14, 18, 71</td>
</tr>
<tr>
<td>Lenin, Vladimir, 132</td>
</tr>
<tr>
<td>life expectancy, 2, 4–6, 11, 43, 45–6, 49, 52, 129</td>
</tr>
<tr>
<td>long term care, 14–17, 20–41, 51, 54, 133, 135</td>
</tr>
<tr>
<td>expenditure, 56–7</td>
</tr>
<tr>
<td>insurance, 38, 120</td>
</tr>
<tr>
<td>workforce, 92</td>
</tr>
<tr>
<td>( \text{media (mass), 9, 45, 56–60, 93, 104, 110, 116, 119, 129} )</td>
</tr>
<tr>
<td>( \text{Mild Cognitive Impairment (MCI), 119} )</td>
</tr>
<tr>
<td>moral identity, 20, 93, 101–3, 107, 110–11, 113, ( \text{see also under fourth age} )</td>
</tr>
<tr>
<td>moral imperative, 63, 73, 94–5, 113, 131, 138, ( \text{see also under care} )</td>
</tr>
<tr>
<td>morality, 98, 106–7, 126, ( \text{see also ethics} )</td>
</tr>
<tr>
<td>multi-morbidity, 44, 47–9, 52, 122</td>
</tr>
<tr>
<td>Nietzsche, Friedrich, 107–8, 114</td>
</tr>
<tr>
<td>nursing home, 14–16, 20, 33–4, 38, 51, 71, 88, 90, 111, 120–1, 132–6</td>
</tr>
<tr>
<td>abolition of term in Sweden, 40</td>
</tr>
<tr>
<td>admission, 15–16, 109, 134</td>
</tr>
<tr>
<td>deep, 10, 56, 63, 72, 84, 91, 115</td>
</tr>
<tr>
<td>dirty, 78, 85</td>
</tr>
<tr>
<td>early, 134</td>
</tr>
<tr>
<td>fear of, 117</td>
</tr>
<tr>
<td>home(s), 33, 133</td>
</tr>
<tr>
<td>real, 9, 12, 16, 19, 71, 124, 137</td>
</tr>
<tr>
<td>status of, 2, 7</td>
</tr>
<tr>
<td>Omran, Abdel, 3, 44, 47, 57</td>
</tr>
<tr>
<td>osteoarthritis, ( \text{see under arthritis} )</td>
</tr>
<tr>
<td>othering (of old age), 62, 76–7</td>
</tr>
<tr>
<td>( \text{pension(s), 71, 137} )</td>
</tr>
<tr>
<td>personhood, 94, 108–10, 132</td>
</tr>
<tr>
<td>pity, 41, 89, 98, 100–9, 113–14, 128, 130, 132</td>
</tr>
<tr>
<td>poor law(s), 14, 20, 26, 28, 32, 121, 130</td>
</tr>
<tr>
<td>poorhouse, 20–34, 39–40</td>
</tr>
<tr>
<td>reciprocity, 17, 94, 100, 102–3, 106–14, 125</td>
</tr>
<tr>
<td>retirement, 7–8, 18, 23, 32, 125</td>
</tr>
<tr>
<td>two nations in, 11</td>
</tr>
<tr>
<td>sarcopenia, 65–6, 72, 74, ( \text{see also frailty; gender} )</td>
</tr>
<tr>
<td>prevalence of, 66</td>
</tr>
<tr>
<td>self–care, 14</td>
</tr>
<tr>
<td>Strehler, Bernard, 2</td>
</tr>
<tr>
<td>stroke, 47–52, 135</td>
</tr>
</tbody>
</table>
third age, 8, 10–19, 62, 93, 96, 130, 136, see also fourth age; old age
bridges and barriers between, 115–26
culture(s), 18, 96, 126, 138
studies, 137
third versus fourth age, 10–12
Townsend, Peter, 7, 32, 38, 133, 135

vetula, 82–3
workhouse, 14–15, 20–4, 27–32, 37–9, 71, 133–5
infirmaries, 9, 121, 133–4
Zizek, Slavoj, 17, 132