Open Journal of Geriatrics

ISSN: 2639-359X

Volume 2, Issue 2, 2019, PP: 1-11

Aging, Discourse and Subject Positioning: The Case of Health and Social Care – A Foucauldian Excursion

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Abstract

In recent times, there has been an extraordinary global rise in debate about aging, despite the frequent charge that the subject of "aging" has been relatively underdeveloped in social policy shaping and practice (Phillipson 2013). This article draws upon the theoretical work of French philosopher Michel Foucault in order to map out a conceptual and methodological "tool-kit" for the analytical investigation of aging as it has been characterized in social discourse. Further, I claim that Foucault's extensive conceptual and methodological works can be used to understand the construction of old age as a core focus of health and social care and that, in many cases, health and social care has simultaneously come to stand for old age itself.

INTRODUCTION

An interesting observation to make is that there has been little Foucauldian study of aging, and critical theorists have had to rely on a limited number of sources in the work of American and Canadian writers such as Katz (1997) and Frank (1998) and more recently from writers in the United Kingdom (Biggs & Powell, 1999; Powell & Biggs, 2000; Powell 2005; Powell 2017). Together with the United States, the United Kingdom has been subject to a succession of social policy trials, from welfare paternalism following the Second World War vis a vis William Beveridge, through the Thatcher turn to marketization to save public resources in health and social care and on into the Blair "third way" endorsement of Communitarianism. The focus on this is basically local communities become important to 'manage' old age was an interesting way to deviate the State away from care of older people through 'action at a distance' and focus on communities and families, professions and older people themselves for their own care. (Powell 2017) The current focus in the UK is on integrated health and social care but has led to a situation where health far outweighs social care in terms of priority, resources and staffing. Whilst the aspiration is integrated, the reality is a disconnect in terms of governmental priority. A further concern is the Boris Johnson administration has talked up the importance of social care of older people but provided no consultation or even suggests they are unsure how it will be funded. This is especially contentious given that the UK government has committed billions of pounds on a new nuclear missile system (Phillipson 2013). Such changes has had significant implications for the social discourses that impinge upon the social construction of aging and focus given to old age itself. The key question is: how did we get here and where is the health and social care of older people traversing?

The Biomedical Model and Aging

One of the startling continuities of dominant discourses on aging and old age have traditionally con-sisted of the construction of aging as a process of a disciplinary matrix of economic, social, and physical decline. In occidental culture in particular, the aging body is perceived to be the "bottom line," subjecting us to relentless "betrayals" of the human body through physical deterioration (Powell 2017) and the consequent tasks of maintenance (Dittman-Kohli, 1991) and compensation (Baltes & Carlestensen, 1996). Insofar as there is a history of aging, there is also a history of efforts to control, supervise, and self-regulate the aging body.

The consequences of the decline discourse can be seen most clearly in the dominance of medico-technical solutions to the problems that aging is thought to pose. Older people as subjects rather than as people plays into the ageist stereotype of how older people are not just viewed but treated in terms of care. This, according to Katz (1997), has lead to a fundamentalbias of gerontological theorizing and research toward geriatric medicine and the relative failure of more broadly-based life-course approaches to impinge upon engaging and therefore old age. There have been some important exceptions to this trend, most notably in attempts to develop a humanistic gerontology (Cole et al., 1992), and a flirtation with the impacts of post modernity on aging identity (Powell 2017), based primarily in the United States and United Kingdom. However, it is arguable whether these debates have had a broader impact on everyday perceptions of age and aging. Indeed, a preoccupation with the medical challenges presented by aging, underpinned by privatized and insurance-driven health provisions, has resulted in what Michel Foucault (1973) may have observed as an expansion of the medical ‘‘gaze’’ into all areas of social policy. 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 health professions in particular, and restrict or de-legitimize other imagined, strategic or real possibilities. A consequence is that areas of policy that may at first seem tangential to the medical project come to be reflected in its particular distorting mirror. The impingement of the medical gaze can be seen in recent policy debates about the consequences of BREXIT concerning disadvantaged groups over a shrinking public purse, decline of GDP and fears of a breakdown of an intergenerational social contract, considered to be a foundation of post-war welfare policy (Phillipson, 1998). The impact of medicalized notions of aging and its construction. as a threat to other sections of the population can also be seen in Moody’s (1998) critique of bioethics and aging and the proposed rationing of Medicare coverage in American welfare policy. Here, medical care has come both to colonize notions of old age and to reinforce ageist social prejudices to the extent that infirmity has come to stand for the process of aging itself and medicine its potential facilitator (Powell 2017).

A key point here is that the notion of a ‘‘medical gaze,’’ as first described by Foucault, not only draws our attention to the ways that aging has become ‘‘medicalized’’ as a social issue, it also highlights the way in which older people are encouraged for as long as possible to ‘‘work on themselves’’ as active subjects (Powell 2017). 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 aging. Those who move into a fourth age, defined as a relative failure of that ‘‘work’’ and direct dependence on health and welfare services, then discover themselves transformed into passive subjects who have a voice but not (and ins some cases, never) listened to (Powell and Biggs 2000).

While significant sections of public debate on aging have been rooted in this bio-medical gaze, the growth of an able-bodied and pension-rich cohort of older people has lead to a parallel discourse on consumer-aging – much blame of the 52% BREXIT vote in the UK has been blamed on older people whilst no evidence has been provided (Powell 2017). The consequences for theorists such as Katz (1998) has catalogued the rise of the older consumer who are rich and an identification of a ‘‘gray market’’ for consumer goods and services. This gives a misleading view that all older people are rich and are at fault for public policy decisions and votes associated with the future of the UKs relationship with the EU. Discourses of consumption and having huge resources can pull from theoretical traditions such as activity theory (Blaikie, 1999) and more recent postmodern interpretations of aging lifestyles which fail to take into account poverty in old age (Phillipson 2013) which causes ill health requiring health and social care services. In poverty, to have a brutal choice of eat or heat based on minimum resources has not been researched sufficiently.

It appears, at least in the United Kingdom, that established and emerging ‘‘master narratives’’ of biological decline on the one hand and alleged being a consumer who is rich on the other co-exist, talking to different populations which underplays the real consequences of low pensions and a care system that is not fixed (Powell 2017). This is contradictory as one can see.

They are contradictory in their relation to notions of autonomy, independence, and dependency on others, yet linked through the importance of the adoption of ''golden-age'' lifestyles of rich 'baby boomers'. However, this focus on medicalization and lifestyle has tended to obscure a third discourse on aging that has traditionally been strong in Europe, the United Kingdom, and Australia, namely, the association between old age and health and social care.

This association needs unpacking with a strong theoretical analytical base to draw out the implications of health and social care for older people. Drawing from Michel Foucault, his conceptual excavations and methodologies will be utilized to discourses of care and their related technologies embedded in social work that have emerged in relation to successive stages of aging as an issue in social care policy. Thisfocus on care as a factor in the reconstruction of contemporary aging will draw most heavily on the areas with which we are most familiar, namely the United Kingdom's manifestations of wider global trends in care policy (Powell 2017).

Foucault and Aging: An Important Conceptual Toolkit

Michel Foucault's theoretical challenges are always posed in complicated, complex and multifaceted terms. He urges people to ''refuse what we are'' (1982, p. 216), meaning that we should refuse to remain tied to fixed identities to which older people, for example, are subjected – having the ability to change one's own identity He linked his own project with all those who struggle against the ways in which they are individualized, particularized, and objectified by controlling discourses.

The main point of Foucault's methodology, called a genealogy because of its emphasis on tracing historical pathways that have contributed to contemporary circumstances, was to identify discourses. His concept of ''discourse'' is a key term both in understanding Foucault's work and in explaining facets of care. Foucault identified discourses as historically variable ways of specifying knowledge and truth. They function as sets of rules, and the exercise of these rules and discourses in programs that specify what is or is not the case–what constitutes ''old age,'' for example. Those who are labeled ''old'' are in the grip of power. This power would include that operated by professionals through institutions and face-to-face interactions with their patients and clients. Power is constituted in discourses, and it is in discourses such as those of ''social work'' that power lies. Genealogy is concerned, then, with the historical limits and conditions of socially deter-mined discourses, which then direct and distort the personal and institutional narratives that can subsist within them. When a discourse has stabilized historically, it can be referred to as a ''discursive formation,'' which can come to characterize a particular period of welfare development and the associated possibilities for identity performance that it contains (Foucault 1977).

Michel Foucault (1967) was particularly interested in the limits and potentials of discourses from ''human sciences'' because of their at-tempts to define human subjectivity. His attention shifts to the power of professionals because Foucault found that the conditions of potential for ''true'' discourses about human subjects include complex relations between knowledge about people and systems of power. Here Foucault focuses on the techniques of power/knowledge that operate within an institution and that simultaneously create ''a whole domain of knowledge and a whole type of power'' (1977, p. 185). These domains effectively destroy the legitimacy of other, competing, discourses; just as a professional medical opinion might de-legitimize voices arising from folk medicine or informal care. The genealogical work of uncloaking these power relations is characterized, by Foucault, as setting out the ''political regime of the production of truth'' (Davidson, 1986, p. 224).

The effects of the reflexive relationship between power and knowledge that is implied here would include the tendency for 'professional power' (espoused by health and social care professions) to be reinforced by the sorts of questions professionals ask and the data they collect – in the main known as "evidence based research" which undermines qualitative research from the narratives of patients or older people. This hegemonic knowledge then progresses to a certain definition of a problem area that then feeds back to stabilize the original formulation of the ''problem'' itself. By the same token, diverse public policy positions point such professionals to seek out certain forms of knowledge that tend to reinforce the assumption base of the position of that public policy and its associated discourses. As part of this process, certain powerful voices increase their legitimacy, while other, often dissenting, voices become irrelevant (Powell 2017).

A consequence of the mutually reinforcing relationship between power and knowledge that emerges from the above is to construct older people concurrently as subjects and as objects. First, people are seen as objects by someone else, through control and restraint. Second, people are deemed to actively subject their own identity to personal direction through processes such as conscience and mediated self-knowledge. Foucault (1988) refers to this second process as ''technologies of self.'' Foucault's formulation of ''technologies of self'' claims that individual lives are never quite complete and finished–that in order to function socially individuals must somehow work on themselves to turn themselves into subjects. The notion of ''technologies'' offers the scope for an analysis of the sites whereby certain effects on old age are brought about. As Foucault puts it: ''Both meanings [of control and self-conscience] suggest a form of power which subjugates and makes subject to'' (1982, p. 212).

In terms of care, itself a discourse, both clients and social workers would need not simply to follow the rules that legitimize what they can say and do, but also to work on themselves so each can become the sort of person who can be seen and heard within that discourse. If they are not careful, both professionals and users of health and social care systems become trapped in a dance of mutually maintained positions that serves to sustain a particular view of aging and the remedies, the technologies, that can be brought to bear on it (Phillipson 2013). The question then is: how do we "dig" underneath such powerful discourses that opens up the relationship based on trust and reciprocity rather than ageism and assumption-based relationships?

An analysis of the contested notion of power itself, which follows the methodological pathway as mapped out by Michel Foucault, must assess three aspects of how such power is created and maintained. First, the analysis must examine the genealogy of existing relations, how they have emerged, and the discourses they both reflect and reinforce with respect to aging as seen as both objects and subjects. Second, attention must be given to the broad distribution of power and knowledge that these relations imply – this is difficult to capture but a challenge a health researcher must investigate and disseminate. Lastly, technologies of care such as care management will need to be critically assessed as approaches to the self that hold certain webs of power in place. Each will contribute to the ways in which older people as subjects enmeshed in certain relations apply techniques of identity control to themselves. This needs historically unpacking and what the policy and practice implications are for the care and positioning of old age.

A History of the Present: The Management of Aging by Social Work

The past two hundred years has witnessed an increasing institutionalization of the life stage of ''old age,'' both in the United States (Chudacoff, 1989) and in the United Kingdom (Powell, 2017). The emergence of what could be called 'professional power' in what has since come to be called modernity is also associated with transformations that took place from the nineteenth century onwards. In the case of care, these transformations have been associated with a series of moral panics about the family in which the state was expected to intervene (Jones, 1983). Professional social work developed as a hybrid in this space between the public and private spheres and was produced by new sets of relations among the law, administration, medicine, the school, and the family.

The rise and alliance of social work was seen as a ''benevolent'' solution to a major problem posed to the State; namely, how can the State establish the health and development of family members who are ''dependent'' while promoting the family as the ''natural'' sphere for caring for those individuals and thus not intervening in all families? Thus, social work developed between individual families, older people and the State, which would be in risk of taking responsibility for everybody's human needs and hence undermining the responsibility and role of the family. Did the family need such intervention? This somewhat ambivalent positioning of a new discipline of "social work" meant that from its beginning, the social work profession has had to carefully negotiate the boundary between public expectation and private conduct – an enormously difficult task. As such, the social work project has disguised with a double perspective of external coercion of family life and 'personal cure' (Phillipson, 2013) as it embraced both the judicial and the therapeutic in acts of intervention in older people's lives.

There can be little doubt that much of the traditional identity of professional social work rests on what can be identified as ‘‘modern’’ foundations of the formation of society (Powell 2017). While nursing and medicine have drawn heavily on technical/scientific knowledge to justify their legitimate status, social work has drawn, with relative degrees of success and in succeeding periods, on arguably both psychoanalysis and applied social sciences. Both health and social care have been part of a great movement for ‘‘progress’’ characteristic of the 20th century ‘‘grand narrative.’’ Of intervening in family lives. The key question, as Phillipson (1998) acutely observes, is this the case of all families or families who have been problematized as needing intervention because members may have been unemployed or in poverty. Would the same tenacity of intervention have been the same for rich families and their older siblings?

As the 20th century has proceeded, the growth of professional social work has become increasingly dependent upon its inter-relationships with the Welfare State, which provided its primary rationale and legitimacy to intervene and cement its power base. As a consequence, social work mediated not only between potentially socially excluded individuals and the State, but also with diverse private and voluntary agencies. Further, social work became closely related to the development of new forms of social regulation associated with the increased complexity of modern society. To put it another way, these new forms of social surveillance were characterized by notions of normalization, discipline, and surveillance (Foucault, 1977). For Foucault, such arrangements come to constitute a ‘‘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, p. 191). They systematize networks of ideas about the ‘‘nature’’ of individuals, their perfectibility, the reasons for their behavior, and the ways they may be classified, selected, and controlled. Social work became an instrument with which to manage individuals by the manipulation of their qualities and attributes, depending on applied social-scientific knowledge and professional expertise.

Under particular social circumstances and as history changed, discourses emerged that both lead to the creation of new professions that in turn simultaneously reinforced the discourse itself. In so doing, the development of a new type of knowledge about older people emerged, and new sites in which to grow old were created.

A Genealogy of the Post-Second World War Consensus of Care and Aging

In the era following the Second World War, which saw the consolidation of care systems in much of the occidental world, old age also came to be seen as problematic in a certain way. Williams Beveridge (1942, cited in Wilson, 1991), for example, whom some credit as being the architect of the British welfare state, says of older people:

*It is dangerous to be in any way lavish to old age until adequate provision has been assured for all other vital needs, such as the prevention of disease and the adequate nutrition of the young. (*Beveridge, quoted in Wilson, 1991, p. 39)

The quote is clear. Children were to be the priority despite the universalism that the Welfare State would be there from the cradle to the grave irrespective of age – which was demolished as mythical. Worse, while on the one hand the older person was portrayed as a stoical and heroic survivor in the immediate post-war period, this representation was contingent on an absence of demand on the rest of society. This ambivalence was reinforced by the difficulty of reconciling old age with the rhetoric of progress and investment for the future that characterized the growth and ideological justification of children. Nor did older people fit narratives of care but add production, work, and usefulness to capitalist production, used to justify welfare in terms of maintaining the current workforce (Phillipson 2013).

When older people came to the attention of social work in this period intervention was allowed when the conduct of an older person was judged to be a danger to him or herself or to others, most notably as a “health-hazard”. In fact, associating social work with the future, social investment, and protection from social hazards had contributed to a deep embedding of the coupling of later life as a stereotypical burden on society.

Here, this social work discourse of aging and its positioning as a medicalized yet mythical story of decline and maintenance that dominates much of the Western literature on aging. In the post-war consensus on health and social care, old age took on a double and somewhat contradictory character: the pension-worthy survivor of the War and the burdensome hazard to society.

The new welfare state, and its associated ''welfare gaze,'' simply did not see them as people. In both senses, Social Welfare came to colonize the meaning given to old age in the public imagination, and the Welfare State and its care professions came to characterize the place, the discourse, in relationship to which aging identities have come to be formed: decline and stigma of lost personal control (Powell 2017).

The next section illuminates the technologies embedded in social work practice that exemplify this phase of care: psycho-casework with older people.

Psycho-Casework with Older People

Since the 1960s, the new human sciences had as their central aim the prediction of future behavior (Ignatieff, 1978), which fit well with social work's professional mission and what emerged as its chosen method: psychoanalysis (Lubove, 1966). Psychoanalysis supplied a language and way of thinking, which served to pathologize older age and also happened to suit the needs of social production. The negative stance taken by psycho-analysis to older age has been catalogued elsewhere (Biggs, 1999). The point here is that this negative stance, coupled with the need for a discourse that both reinforced professional power and the marginal positioning of older people, found each other in the early use of psychodynamic language by social workers on both sides of the Atlantic. Thus, the ''caring'' profession tended to draw upon psychoanalytic discourse to socially construct an image of older clients as ''greedy and demanding, always clamoring for material help, always complaining of unfair treatment or deprivation; this attitude shades into paranoid imagining'' (Irvine, 1954, p. 27). This psychologized view of failing independence closely parallels an economic discourse that old age constitutes a drain on resources that could be used more ''productively.'' As another powerful discourse, the conceptualization of age as burden has developed an enduring presence. In a survey of Social Service Departments twenty years later, Satyamurti (1974, p. 9) observed:

The language that social workers use about their clients, often jokingly, seems often still to be based on an image of them as good or naughty . . . It seemed, too, that when social workers referred to a 'difficult case' they did not mean that the client presented problems that were difficult to solve, but that he was demanding and time-consuming.

Discourses of ''dependency'' formed the foundations of practice development in modern society in relation to older people. The notion of dependency was articulated in terms of policy through the state provision of care services and via social work through the practice of care. Rather than valuing older people, they were devalued. Rather than empowering older people, they were disempowered.

This positioning was reinforced as knowledge was collected on older populations throughout such agencies and remedies channelled through their offices. Psychoanalytic thinking, rather than an occasion for individual liberation, became the language and the technique through which the identities of professionals and their older clients were shaped. This seeped into society and created further ambivalence to older people.

Health, Care, Market Forces and Aging

With the marketization of welfare, this psychological point has itself been significantly eroded, and with it the traditional role of social worker as provider and counselor. Not only do new discourses provide a ''swarming'' of professional power/knowledge, they can also take away. And in the Reagan and Thatcher years of the late 1980s and early 1990s, social work had to reinvent itself–and its construal of older people–in order to survive.

Controversially, old age became, in this period, increasingly associated with risk, both personal and structural, and at the same time, was subject to a privatization of that risk and a withdrawal or rolling back of supports, previously taken as stable and enduring. It is not by chance that an increased focus on risk in social work has coincided with the decline in trust in social workers' expertise, decision-making through psycho-analytical insights, and a growing reliance on increasingly complex systems of managerialism with older people themselves as ''consumers'' (not all) of services. Such a growth has constituted a conducive framework based on the language of the market and its pragmatic management as opposed to trust in applied social scientific discourse, al-though preceding emphases on the psychoanalytic can be brought in from time to time to reinforce an individualized notion of personal responsibility. New policy priorities require new technologies if they are to influence the control of resources of their subjects and objects. The new technique introduced to United Kingdom and Australasian welfare was care management (Powell 2005). However, rather than being an attempt to co-ordinate an already privatized and fragmented welfare system as existed in the United States, care management United Kingdom-style was used as a mechanism to deconstruct the existing state-run system and introduce a marketized care economy. It privatised care.

AGING AND CARE MANAGEMENT

The role of the care manager in the United Kingdom over the past thirty years to the present marked a fundamental shift in social work from a practice-based to a managerial role and identity. As a result, the management and delivery of care has become increasingly indirect. It has become indirect in two ways: first, the pivotal function of the case manager is seen as the co-ordination of packages of care that draw on services provided by private and not-for-profit agencies; second, there is an increased emphasis on assessment and the monitoring of standards of those services supplied by others. Indeed, in this regard, one can cite Howe's (1994) view that the managerial role highlights a shift from social welfare to surveillance and control. In emergent managerialized regimes, judgment is increasingly bound up with managerial necessities concerning corporate objectives and resource ‘‘control’’ (Flynn, 1992). The devolution of managerial responsibilities is intended to turn clients into consumers and to constrain professional autonomy by having such managers internalize budgetary disciplines. A result is that managerial processes and categories of assessment are compounded with other categories of ‘‘risk’’ (Beck, 1992) and in some cases supplant them almost entirely (Phillipson 2013).

Care management makes sense as part of a discourse that displaces and reduces the financial ‘‘burden’’ of age on the state and onto the families of vulnerable older people. Economic privatization is accompanied by a wish to see those same older people as active consumers, making choices between services and changing services or residence if they are found wanting – from their own resources – some without hardly any. Hence, there has been little consideration, however, of the financial costs, the costs to well-being, or the ability of such vulnerable groups to act in accordance within a discourse based on consumption.

While care management has proved an effective technology for transforming welfare economies, it has made little sense in terms of the preceding social work ethos of counseling and direct care. It is here that the second ‘‘surveillance’’ aspect of case management technology has come to the fore as a source of professional power/knowledge. Social workers are now the risk-assessors and enforcers of a mixed care economy, a discourse that leaves older people who use services on the contradictory and risky ground of being simultaneously consumers and potential victims being in poverty. It is this contradiction that the Thatcher/Reagan turn in political discourse had given its social democratic governmental successors.

THE EMBEDDED MARKET OF CARE AND AGING

An unwillingness to increase public finance for older people has lead both the Blair and Clinton administrations to leave the market-welfare systems of both countries relatively untouched. However, it is possible, at least in the United Kingdom, to observe a change in the rhetoric, and by association the policy discourse, legitimizing the place of older users within welfare services.

Using communities to engage older people changed the discourse of care management yet again. It has become a priority on the one hand to ‘‘include’’ older people back into the wider social fabric as ‘active’ participants, and on the other, to protect those who are sufficiently infirm not to be able to participate. This contradictory inheritance had led to two parallel and independent policy initiatives. First, government-sponsored initiatives such as ‘‘Better Government for Older People’’ (1998) have been used to promote short-term partnerships with service providers. Second, a debate on the nature of mental incapacity (in other words, when older citizens are judged no longer capable of existing under the rubric of partnership) has resulted in policy guidance entitled, ‘‘No Secrets: The Protection of Vulnerable Adults.’’ which draws on an increasingly inquisitive version of care management a version of professional social work not old age as a legitimate voice (Powell 2005).

CONCLUSION

The recognition of partnership in communities appears could mark a shift away from the traditional role of policy as facilitating progressive disengagement and dependency. It also links policy with changes in the lifestyles and self-governance adopted by older people themselves; listening to them and acting on their experiences. This is essential as much of the focus is on the legitimacy and reconstruction of professional services in health and social care rather than listening to the real experts – older people themselves. This impacts on risk.

However, these developments have their dark side, and the ethics of using such social work technologies to deny the force of aging as a human experience have been subject to less scrutiny as espoused by the article. Indeed, it is perhaps emblematic of contemporary occidental culture that each of the shifting social work identities identified above and different ways to "manage" the care of older people offers the promise of escape from, rather than a deepened understanding of, aging experiences (Powell 2017). Those who do not conform to the social work framework appear to have been shunted into a non-participative discourse, bounded by professional surveillance, or the more edible yet closely related discourse of ''monitoring.'' In both cases, it could be suggested that a discourse on dependency driven by the post second world war has been accompanied, and in some cases replaced by, a discourse on risk. This stretches to the present and post BREXIT (Powell 2017). The risk of giving in to an aging body, the risk of thereby being excluded from one's retirement community, the risk of being too poor to maintain a consumer lifestyle, the risk of being excluded from participation through incapacity that has been externally assessed by social workers, the risk of being abused, the risk of control being taken out of one's hands, the risk of tokenism in partnership, and worse of all, the risk of being ignored – especially when care is crucial for older people as individuals and as populations.

A final yet crucial point, and one that links a Foucauldian assessment with contemporary trends in understanding modern aging in health and social care, is to suggest that a Foucauldian analyses of discourse and power explicate what it means to speak of narratives of aging. It suggests that narratives are not personal fictions by which older people choose to live by, but are discourses subject to social, economic and historical influence by external forces and powerful biomedical assumptions. Narratives of aging are personal in so far as older people apply techniques to themselves, while the professional technologies and the knowledge base on which they are legitimized imply particular power differentials that will determine the way and the what of the storyline of how society treats older people who may require health and social care services and how they are managed.

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Citation: **Jason L. Powell.** *Aging, Discourse and Subject Positioning: The Case of Health and Social Care – A Foucauldian Excursion. Open Journal of Geriatrics. 2019; 2(2): 1-11.*