9 RESPONSIBILIZATION OF AGING?

An Ethical Analysis of the Moral Economy of Prevention

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Introduction

"Our main message is that we can have a dramatic impact on our own success or failure in aging," John Rowe and Robert Kahn (1998: 18) stated in their seminal contribution to the gerontological debate on "successful aging." For them, the answer to the question of maintaining health, activity, and performance in old age is "surprisingly simple": "good old-fashioned hard work" (Rowe and Kahn 1998: 17). As both explain, "To succeed . . . means having desired it, planned it, worked for it" (37). Phrased in biological and biomedical terms, the anti-aging movement starting in the 1990s has raised similar claims. Thus, according to Ronald Klatz and Robert Goldman (2003: 16), the founders of the American Academy for Anti-Aging Medicine (A4M), "if you're willing to make some simple lifestyle changes, to work with a doctor who can prescribe appropriate anti-aging treatments, and to commit yourself to a longer and healthier life, you too can stop the clock." In this perspective, "you, yourself, are your most important tool—you, your mind, and your body" (Klatz and Goldman 2003: 16).

These examples indicate that the debate on dementia prevention has to be contextualized in overarching contemporary discourses. They show how the rise of the paradigm of prevention (Petersen and Lupton 1996) has begun to transform images and expectations regarding aging and old age in at least two crucial respects. From a *prospective* perspective, later life is turning into a projection screen for individual and social predictions, prognoses, scenarios, and plans. Aging no longer appears as a matter of unalterable fate or unfathomable luck but as a process that must be actively shaped and prudently modeled by means of circumspect decisions and determined preventative actions (Schweda et al. 2017). Accordingly, from a

retrospective point of view, looking back upon the course of an individual life, old age is becoming the decisive litmus test for the seriousness, intensity, and effectivity of the preventative efforts invested in previous phases of life. It appears as the final moment of truth and justice, the ultimate moral payoff of a life of caution, planning, discipline and self-management—or neglect, indulgence, and carelessness. As the author of *God's Anti-Aging Plan* explains, "What we sow is what we reap" (King 2017).

In critical gerontology and the sociology of aging, this development has been described and criticized as a symptom of a general "responsibilization of aging" in the present era (Cardona 2008; Moulaert and Biggs 2013). According to this theoretical perspective, pervasive policy shifts in the traditional allocation of roles and functions between the individual and society are increasingly redefining aging and old age in terms of individual responsibility. Political strategies of safeguarding public welfare and social security are transformed, and individuals are called upon to act as active citizens who are personally in charge of looking after their own health, wellbeing, and socioeconomic subsistence in later life (Lessenich 2008). This development apparently also implies a new "will to health" and an expanding obligation to monitor and manage one's own health: "Every citizen must now become an active partner in the drive for health, accepting their responsibility for securing their own well-being" (Rose 2001: 6). As a consequence, the last stage of life—which was once mainly seen in the light of well-earned retirement, social disengagement, and biological decline—is now assigned with attributes such as "health" (WHO 2015), "activity" (Walker 2002), "productivity" (Butler and Gleason 1985), and "success" (Rowe and Kahn 1987, 1998; Baltes and Carstensen 1996).

From an ethical point of view, it is important to acknowledge that assigning responsibilities is not, per se, problematic. Instead, what is needed is a differentiated analysis and discussion of responsibility ascriptions. Hence, the present chapter is aimed at an ethical analysis of the "responsibilization of aging" in the age of prevention. We focus on the two pertinent expert discourses already mentioned above: the first one, the gerontological discourse on "successful aging," challenges previous deficit-oriented models of aging by emphasizing the resources and potentials of older people; the second one, the biomedical "anti-aging" discourse, addresses the lifestyle of self-caring subjects and relays medical advice for combatting senescence and leading a healthy and long life. Starting from an explorative analysis of these two discourses and their entanglements and similarities, we first give an overview of current trends toward a responsibilization of aging and of the main lines of their academic sociological and gerontological critique. Against this backdrop, we provide an ethical elaboration of the concept of responsibility itself and the criteria of justified responsibility ascriptions.

On this basis, we discuss the legitimate scope and limits of responsibility in the context of aging and old age. Contextualizing the topic of dementia prevention within these larger discourses, we finally draw conclusions for a differentiated discussion of responsibilization of aging and the moral economy of prevention in contemporary society.

Successful Aging, Anti-Aging, and the Paradigm of Prevention

Although the programs of successful aging and the anti-aging movement are based on different scientific foundations and pursue different practical approaches, both can be considered symptomatic for the (re-)negotiation of aging under the paradigm of prevention (e.g., van Dyk 2014). Of course, the relation between mainstream (bio-)gerontology and anti-aging medicine is often characterized by intensive disciplinary "boundary work" (Binstock 2003: 5; Fishman, Binstock, and Lambrix 2008: 299) and global antagonisms (Flatt et al. 2013: 944). However, while the science and technology may differ, the spirit and goals of successful aging and anti-aging medicine converge in the idea of prevention of age-associated diseases and syndromes such as frailty or dementia, and in the vision of healthy, active, and productive old age (Flatt et al. 2013: 944).

From a historical point of view, both endeavors are rooted in the same sociocultural contexts. Thus, Flatt and colleagues (2013) interpret the emergence of anti-aging medicine as the outcome of a lively successful aging discourse that contributes to a general positive redefinition of aging. In their understanding, the "successful aging" paradigm eventually spread into other domains, also infusing medicine and culture (Flatt et al. 2013: 951). Cardona also locates the origins of the anti-aging movement in Western societies' powerful narrative of successful aging (Cardona 2008: 478). Both paradigms fit into the cultural ideals of personal autonomy and responsibility, which present the life course as modifiable and controllable through individual decisions (Flatt et al. 2013: 944). Thus, successful aging and anti-aging medicine both share and reproduce the same narratives of Western societies on the significance of health (Cardona 2008: 478) and the preventability of aging (Kaufman, Shim, and Russ 2004). In these respects, successful aging and anti-aging appear as "two sides of the same coin" (Flatt et al. 2013).

Successful aging is not only seen as a "dominant construct" (Martinson and Berridge 2015: 65) but as "one of the most vibrant intellectual traditions" (Flatt et al. 2013: 944) and "almost ubiquitous" (Dillaway and Byrnes 2009: 703) in contemporary gerontology. The concept can be traced back to the 1940s when Georg Lawton published *Aging Successfully*

(1946). Robert J. Havighurst (1961) prominently presented the concept in the inaugural issue of the *Gerontologist*. The idea was further popularized in the late 1980s by Rowe and Kahn (1987), and, since then, it is mainly associated with their names. There have been a growing number of publications on successful aging, and over a hundred variations of the model can be identified (Rowe and Kahn 2015: 593). The Rowe and Kahn model defines three components of successful aging: avoiding disease and disability, maintaining high cognitive and physical functioning, and continuing engagement with life (Rowe and Kahn 1997). Another prominent approach of successful aging was established by Baltes and Baltes (1990b). Their so-called SOC-model (Baltes and Baltes 1990a; Baltes and Carstensen 1996) conceptualizes successful aging as an individual adaption to the aging process that leads to the maximization of gains and the minimization of losses through selective optimization with compensation (SOC). Until today, the intensive academic debate on successful aging continues. Rowe and Kahn have updated their model as "successful aging 2.0" (Rowe and Kahn 2015), and two special issues of prominent gerontology journals were dedicated to the topic in recent years ("Successful Aging" 2015; "Successful Aging" 2017), thus confirming its status as a discursive leitmotif.

By comparison, the anti-aging movement is younger. Of course, there is a long-standing tradition of medical approaches to rejuvenation and life extension that dates back to antiquity (e.g., Haycock 2008). However, the neologism "anti-aging," as well as the corresponding project of a biomedical fight against human senescence, are phenomena of the twentieth century.[1] The A4M was one of the first institutions whose public relations activities contributed to the dissemination of the idea in the 1990s (Mykytyn 2009). The domain of anti-aging medicine is commonly characterized as a "contested field" (Settersten, Flatt, and Ponsaran 2008) with a "complicated cartography" (Mykytyn 2006). Different actors represent different approaches, and there is disagreement between the professions involved regarding the definition and the objectives of anti-aging. All of them have in common a view of aging as a medical problem, a meta-disease, or a major risk factor for diseases and thus a process that needs to be fought, slowed down, or stopped (Mykytyn 2006). At least three main types of goals addressed by anti-aging medicine can be reconstructed: the preservation of a youthful appearance, the maintenance of high levels of physical and cognitive functioning, and the extension of life expectancy or even life span (Schweda and Pfaller 2017). The methods used to achieve these goals also comprise a wide range of largely preventative medical measures, from dietary supplements and lifestyle adaptations to antioxidants, hormone replacement, or caloric restriction, to more radical biomedical interventions involving gene therapy or regenerative medicine (Stuckelberger 2008). In the meantime, the label

"anti-aging" has also gained worldwide prominence as a marketing strategy for the cosmetics and health industry (BCC Research 2013).

As indicated, both successful aging and anti-aging appear symptomatic for the contemporary paradigm of prevention in several respects. It is not the primary aim of prevention to achieve a particular positive state but to avoid the occurrence of negative states (Bröckling 2008: 39). Accordingly, the idea of successful aging is mainly characterized by "avoiding" disease and disability and "maintaining" cognitive and physical functioning and social engagement (Rowe and Kahn 1997). The same holds true in the context of anti-aging. The wording already conveys the defensive orientation. Global players such as the SENSE Foundation frame their mission as a "war on aging" (de Grey 2004; see also sense.org). The promotional slogan of Google's daughter Calico (California Life Company) reads "We're tackling aging" (calicolabs.com). Furthermore, prevention is always directed toward the future and the control of its contingencies and thus always refers to risks connected to one's own decisions and actions (Bröckling 2008: 40). Indeed, successful aging sets out to control the risks of disease and physical or cognitive dysfunctions in old age. And anti-aging medicine involves manifold forecasts, promises, and interventions regarding the individual future and future biomedical developments (Schweda and Pfaller 2017). It frames old age as a major risk factor for diseases and public health burdens and presents itself as a strategy of medical risk prevention and risk management (Spindler 2014). However, in order to prevent something, one must know the conditions and probabilities under which it occurs (Bröckling 2008: 43). In this context, experts and expert knowledge play a crucial role. Thus, in his landmark article, Havighurst (1961: 8) explains the role of the concept of successful aging with regard to gerontology's aim "to provide society and individuals with advice." Protagonists of the anti-aging movement even describe their endeavor as the "vanguard of biomedicine" (Fishman, Settersten, and Flatt 2010) committed to cutting-edge research. Finally, prevention is also linked to cost-benefit calculations (Bröckling 2008: 46). Especially in the field of health prevention, it is deemed an irrefutable fact that prevention is better than cure. Above all, prevention—from a health economy point of view—appears simply cheaper than the treatment of diseases that have already occurred. Thus, successful aging paradigms and corresponding active aging policies are presented in terms of a "win-win situation" (van Dyk 2014: 94). Individuals can maximize their health in old age and therefore their quality of life, while society can avoid costs associated with early retirement, illness, and care (Walker 2002: 137). In a similar vein, Klatz and Goldman (2003: 13) promote anti-aging medicine not only by reference to individual functioning and quality of life but also with regard to its socioeconomic benefits and

"great dividends": "When anti-aging medicine is able to delay admission to nursing homes by just one month, the US health care system will see $3 billion in savings a year!"

Responsibilization and Its Critiques: The Moral Economy of Prevention

Both successful aging and anti-aging have come into the focus of critical gerontology and sociology of aging (Katz and Calasanti 2015). In the respective approaches, special attention is paid to the problem of "responsibilization" that seems to be entangled with prevention (Cardona 2008; Moulaert and Biggs 2013). Responsibilization is not necessarily understood to mean the general process of ascribing responsibility, but rather the shifting of responsibilities—and thus the corresponding risks—to individual subjects (Lemke 2002: 59). In this vein, Moulaert and Biggs define responsibilization as "the transfer of responsibilities from a group or society to an individual" (Moulaert and Biggs 2013: 33).

At the same time, the significance of personal responsibility (Flatt et al. 2013: 952; Holstein and Minkler 2003) in successful aging and anti-aging is interpreted in the context of larger social and cultural developments in contemporary Western societies. Regardless of variations due to different national settings and frames of reference, especially two general theoretical paradigms and lines of critique play an important role: the idea of an increasing activation and disciplining of older people under regimes of activating social policies or neoliberal governmentalities (van Dyk 2014; Leedham and Hendricks 2006; Powell and Biggs 2000; Katz 2000) and the theorem of a (bio-)medicalization of aging (Larkin 2011; Kaufman, Shim and Russ 2004; Estes and Binney 1989). Both frameworks serve to analyze and discuss the effects of cultural norms shaping the experience of aging and the identities of older people today (Holstein and Minkler 2003: 791). They help explore how the "ethos of responsibility" (Cardona 2008: 482) is producing a corresponding "responsible self" (Cardona 2008: 478).

For the purposes of an ethical evaluation, it is particularly important to specify in more detail what exactly the respective approaches in critical gerontology and the sociology of aging consider problematic with regard to the "responsibilization of aging" and for what reasons. Thus, at closer inspection, it becomes clear that the commentators usually do not criticize the mere fact that the question of responsibility is raised at all. Instead, they rather problematize the *moral economy* (Hendricks and Leedham 1992) within which responsibility is discussed and attributed—that is, the system of "normative ideas of reciprocity, justice and obligations [that] influence

the way people understand their rights and responsibilities as members of a political community" (Nilsson 2017: 79). In this perspective, at least four interwoven lines of critique can be distinguished, referring to (1) an *individualization*, (2) *overexpansion*, (3) *instrumentalization* and *ideologization*, and (4) *stigmatization* of responsibility.

The first concern is *individualization*—that is, the reduction of "social phenomena to the aggregate of individual actions" (Rose 2001: 2). The prominent models of successful aging focus on individual characteristics (Rowe and Kahn 1997) or competences (Baltes and Baltes 1990a), classifying health, as well as physical and cognitive functioning, as a capacity and achievement of the individual. The same holds true for anti-aging medicine. The concrete practice focuses on individual bodies and attributed risk factors and accordingly offers highly individualized tailor-made options and interventions (Fishman, Settersten, and Flatt 2010). For both, the most significant determinant influencing the aging process is individual lifestyle. As a consequence, successful aging and anti-aging have drawn criticism for reducing complex social interrelations to individual actions and choices (Katz and Calasanti 2015: 28; Katz 2013). Relevant political and organizational structures, social contexts, and social inequalities that permeate biographies and have an increasing impact as one grows older are being trivialized or ignored (e.g., Holstein and Minkler 2003). Also environmental conditions and social relations of power in terms of "biopolitics" fail to be acknowledged (Katz and Calasanti 2015: 28). This narrow focus on individuals is characterized as "hegemonic" (Holstein and Minkler 2003: 794). Here, successful aging and anti-aging discourses not only reduce the two-faced nature of old age as a source of risks as well as a chance for liberation, but also the conception of responsibility (Cardona 2008: 480). By hiding socioeconomic factors and not providing adequate resources for managing related threats, responsibilization in the context of successful aging and anti-aging therefore seems one-dimensional. It can "burden rather than liberate older people" (Holstein and Minkler 2003: 794) and lead to a feeling of "obligation" (Cardona 2008: 481) to stay healthy. In effect, the attribution of responsibility is not associated with more agency and empowerment (Emirbayer and Mische 1998), but only with bearing the consequences of respective risks.

The second line of argument focusing on the *overexpansion* of responsibility contends that many ascriptions of individual responsibility in the context of health and aging are not sufficiently covered by reliable empirical evidence. According to this critique, it is not even clear to what extent interventions in the aging process are empirically founded and practically feasible. Thus, the scientific empirical and methodological foundations of the paradigm of successful aging are frequently challenged within geron-

tology (Katz and Calasanti 2015). In a similar way, biomedical anti-aging research is faced with criticism. At the turn of the millennium, the academic debates evolving around the anti-aging movement were even perceived as a "war on anti-aging medicine" (Binstock 2003). Prominent US (bio-)gerontologists attacked the A4M with harsh arguments regarding the effectiveness of the anti-aging methods they marketed. Since there was no sufficient empirical evidence for the efficacy (or at least innocuousness) of the measures offered, the protagonists of anti-aging medicine were denounced as "swindlers, hucksters and snake oil salesmen" (Butler et al. 2002; Olshansky, Hayflick, and Carnes 2002a, 2002b). Against this backdrop, the attribution of a responsibility to intervene in the aging process appears not only unjustified but also dangerous: "Treatments that practitioners might portray as 'cutting edge' may be unproven, ineffective, and even harmful" (Flatt et al. 2013: 925). This is all the more problematic as the ethos of responsibility pushes aging people into the traps of anti-aging medicine, i.e., the "tyranny of youth-preserving technologies and lifestyles" (Holstein and Minkler 2003: 794). As a consequence, the attribution of responsibility seems to be less based on empirical knowledge than driven by social ideas and standards, especially "an ethos of management and control over the aging process" (Flatt et al. 2013: 944).

The third line of argument addressing the economic *instrumentalization* and political *ideologization* of responsibility focuses on the "political economy" (Estes 1979) of responsibilization—that is, the interrelations of power and knowledge in the assignment of responsibility. Thus, Cardona (2008) highlights the interdependence of political (healthy aging), scientific (successful aging), and economic (anti-aging) complexes and the resulting regimes of knowledge. In order to understand the "successful aging" discourse, it is important to identify the inventors of the concept and the political and historical settings (Dillaway and Byrnes 2009). Therefore, some authors reconstruct the personal ties between the proponents and their political and economic entanglements. An important factor in this context is the influence of the MacArthur Foundation with their ten-million-dollar *Study on Successful Aging*, in which the conception of Rowe and Kahn was established (Holstein and Minkler 2003: 787). The authors themselves eventually call their model the "MacArthur model" (Rowe and Kahn 2015: 594). In the context of anti-aging medicine, the interdependence of science and industry appears even more obvious. Petersen and Seear (2009) identify the main players in the field and explain the (commercial) success of anti-aging medicine by exploring the political-economic forces behind it. In a political perspective, the emphasis on personal responsibility has also been challenged as an ideological manifestation of a global shift in aging policies. According to this line of thought,

activating social policies or neoliberal governance dismantle traditional welfare systems and at the same time identify retired people as a social resource to be activated and exploited (van Dyk 2014). Framing this renegotiation of aging as a "win-win situation" (van Dyk 2014: 94)—with benefits for both individuals and society—is debunked as an "empty rhetoric" (Boudiny 2013). The emphasis on personal responsibility appears as a mere cover-up of social welfare cuts and shifting risks and costs to the individual. Thus, while "new gerontology" may present its own standpoint as purely scientific and therefore neutral (Holstein and Minkler 2003: 788), it actually turns out to be highly *ideological* (Cardona 2008). In the context of anti-aging, the ideological mechanisms appear similarly problematic as the underlying commercial and political interests are masked in terms of objective biomedical facts (Petersen and Seear 2009).

Finally, the related *stigmatization* line of critique addresses the evaluative and "affective economies" (Ahmed 2004) of responsibilization processes. In particular, evoking a normative and emotional setting can be understood as a strong instrument of power and governance. As already indicated, successful aging models and anti-aging approaches are not "neutral" but hold a "normative vision" (Holstein and Minkler 2003: 787). In this normativity, the authors see the threat of new forms of ageism since it goes hand in hand with the valuation of certain behaviors and personal characteristics that are not based on the free choice of individuals but are attributable to structural conditions (class, race, gender) (Holstein and Minkler 2003: 787; Katz and Calasanti 2015). Cardona reconstructs that by simultaneously confronting individuals with risks and making them responsible for their consequences, the "ethos of responsibility" makes use of the widespread "anxieties of growing old in Western societies" (Cardona 2008: 475). The popular discourse around "aging societies" is based on an "alarmist" (Katz 1992) or "apocalyptic" (Gee and Gutman 2000) demography (see also Katz and Whitehouse 2017). Thus, as critical gerontology points out, ideas of active, productive, or successful aging promote new positive images of later life but at the same time also intensify the devaluation of aging and old age (van Dyk 2014: 96). Anti-aging practitioners are faced with the same accusation of exploiting cultural fears of aging (Flatt et al. 2013: 944; Vincent, Tulle, and Bond 2008). Thus, Cardona (2018) speaks of "three main anxieties" addressed in anti-aging discourses: the loss of functionality and attractiveness, unemployment, and poverty (Cardona 2008: 480). Kemp and Denton also highlight that the desire to be independent corresponds with morally laden fears of becoming—or being perceived as—a burden (Kemp and Denton 2003: 756). Gilleard and Higgs point out that it is specifically the abject nature of the fourth age characterized by frailty and dementia that fuels the fear of old age. This fear is related

to the loss of agency and the horrifying feeling of social death (Gilleard and Higgs 2010: 125). Thus, the imaginary of the fourth age and especially the risk of cognitive decline stand for everything that does not fit in the paradigm of successful aging. It represents the opposite of the autonomous, active, and responsible self. Eventually, shifting responsibility is accompanied by the blaming of those who did not "age successfully" (Cardona 2008). Moreover, those who do not meet the criteria of successful aging engage in self-blame (Kemp and Denton 2003: 756). Fear, shame, and guilt are the emotions accompanying the corresponding cultural imaginary of old age.

Toward an Ethical Analysis of Responsibility Claims

Under the buzz phrase "responsibilization of aging," sociology of aging and critical gerontology discuss trends toward individualization, overexpansion, instrumentalization and ideologization, and stigmatization of responsibility ascriptions in the contexts of successful aging and anti-aging discourses. This critique makes important points regarding the contemporary culture of aging. At the same time, its moral underpinnings often remain almost as unclear as those of the criticized discourses themselves. From an ethical point of view, assigning responsibilities is not per se problematic. On the contrary, it constitutes a necessary precondition for ethical judgments and discussions. An ethical analysis of responsibility ascriptions and their moral implications can help clarify the debate and sharpen and substantiate the arguments of critical gerontology. We have to be able to assess and discuss to what extent claims about responsibility are justified or not. To this purpose, we need a systematic reflection on the concept of responsibility.

There are various theoretical models of responsibility (e.g., Baier 1991; French 1991a,b). They all conceptualize "responsibility" as a relational concept. This means that talking about responsibility always implies a relation between several different entities. At least three relata are required: a subject, an object, and an instance. Someone (the subject of responsibility) is responsible for someone or something (the object) against someone (the instance). However, on closer inspection, more relata are necessary in order to reconstruct and analyze common uses of the concept "responsibility." For the subsequent analysis of its role in the context of prevention and aging, we rely on a conception developed by Schicktanz and Schweda (2012) involving seven relata: someone (*subject*) is responsible for something/someone (*object*) against someone (norm-proofing *instance*) on the basis of certain standards (*norms*) in a particular time frame (*time*) retrospectively/prospectively (*temporal direction*) with certain consequences (*sanctions or rewards*) (see figure 9.1).

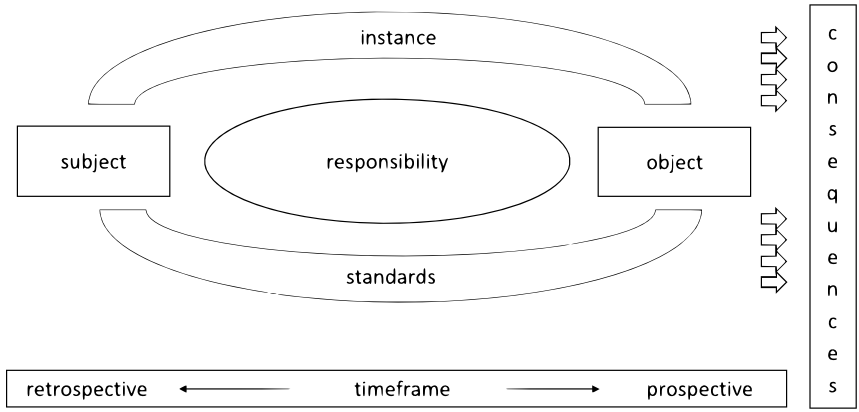

FIGURE 9.1. Relational structure of responsibility based on the concept of Schicktanz and Schweda (2012).

Each relatum involves complex questions.[2] Thus, it is debated whether only individuals or also collectives (e.g., families, corporations, states, etc.) can be *subjects* of responsibility (French 1991a,b). With regard to *objects*, there are also different candidates: one can be responsible for people, animals, plants; for tasks such as cleaning the dishes or providing for a family; and for abstract issues such as population health or world peace. The *instance* is the authority that judges whether a responsibility has been fulfilled. Thus, courts count as instances for legal responsibility. In the moral domain, there are other authorities, such as God, individual conscience, or the community. *Standards* refers to the norms on which responsibilities are based. These can be general (e.g., to respect others, avoid harm, etc.) or concrete and context-specific (e.g., professional virtues such as confidentiality, or institutional rules such as efficiency). The *time frame* and *temporal direction* are important, too. In the legal context, responsibility is primarily discussed from a *retrospective* point of view as guilt. In a prospective sense, being responsible means being in charge of or taking care of future events. Finally, *consequences* result from meeting one's responsibilities or not—that is, reward or punishment, social recognition or exclusion, pride or shame.

Against this backdrop, the analysis of notions of responsibility allows and at the same time requires a careful examination of the relationship between different actors and their tasks and capacities, the instance and its power, and the underlying moral standards and their validity and binding character. Depending on the context, "being responsible" can also be defined in terms of duty, obligation, right, or virtue. While "responsibility" as such is a relational term, these moral concepts refer to entitlements to

treat or to be treated in a particular way. However, especially in modern, functionally differentiated and therefore complex societies, they cannot define the whole social, relational context of application and consequences. Therefore, the proper use of "responsibility" or "being responsible" always requires a thorough definition and analysis of the relata—and if relata are undefined or under-determined, this calls for an in-depth inquiry.

As we have already seen, the first and foremost objection in the social gerontological critique of the "responsibilization of aging" is concerned with the adequate allocation of the *subject* and *object* position of responsibility. The accusation of *individualization* refers to the fact that individuals and maybe their families and closer social relations are more and more in the focus of responsibility ascriptions regarding aging and old age, while other potential moral agents, such as the health-care system, the solidary community, or the welfare state, are increasingly eliminated from the picture. However, while this may arguably be an appropriate description of the respective social processes addressed by political and sociological diagnoses, it does not per se explain what is ethically problematic with these processes. After all, one could argue that the traditional welfare state had wrongfully usurped many individual competences and responsibilities, thus ignoring individual agency and effectively patronizing, disempowering, and incapacitating its citizens (Wikler 1987). From this perspective, it would appear perfectly reasonable and justified to shift the individual back to the center of the discussion.

Thus, in order to explain what may be wrong with the individualization of the responsibility for aging and old age, we have to take a closer look at the criteria and preconditions of individual responsibility. Under what conditions are we justified in ascribing responsibility to a single person? In the tradition of philosophical ethics, at least three interrelated criteria are usually mentioned: knowledge, intention, and causal control (French 1991a,b). First, in order to be able to assume responsibility for something, a person has to be aware of the relevant facts and interrelations. Thus, if I do not know (and could not be reasonably expected to know) that a decision or course of behavior could have certain problematic consequences, I cannot be held morally responsible for these consequences. This requirement of knowledge is closely linked to the second aspect of intention: if I caused something inadvertently and accidentally—for example, because of an unfortunate and unforeseeable coincidence of events—I prima facie cannot be held morally responsible for the effect (leaving aside the important but complicated issues of negligence or recklessness). Finally, the criterion of control refers to the possibility of actually influencing a given process and its outcomes. Thus, while I may be well aware of the causal mechanisms leading to a particular event, and even may have the wish to interfere and

stop the process, I may still lack the ability or power to actually do so. In this case, it would not be fair to hold me morally responsible.

It appears obvious how these criteria apply to the "responsibilization of aging" and especially to the problem of an *overextension* of responsibility claims. First, in light of fundamental knowledge gaps and controversies in the state of scientific research on the biological and physiological mechanisms of aging, it is unclear to what extent we can really claim to have the relevant knowledge to fully understand what causes aging and age-associated diseases and physical or cognitive impairments. Of course, most of us are aware that excessive smoking and drinking puts our future health in jeopardy. Apart from such rather generic knowledge, however, the concrete causal mechanisms of biological senescence or age-associated processes like frailty or dementia are still not sufficiently understood. Many of the things we do or do not do may influence our aging process without our knowledge. Nevertheless, successful aging as well as anti-aging discourses provide a plethora of examples for dubious bits of alleged "knowledge" on aging and respective recommendations for its prevention, which are constantly circulated and revoked—for example, from disengagement to activity (Achenbaum and Bengtson 1994), from sex hormones to antioxidants (Olshansky, Hayflick, and Carnes 2002a), or from "brain jogging" to nootropic medication (Lawless and Augoustinos 2017). Furthermore, it is unclear how the individual person can actually identify, access, and utilize reliable knowledge that becomes available. Here, the individual is clearly dependent on the provision of suitable health education (health literacy) and authoritative and trustworthy knowledge resources, but also on economic and technical framework conditions (Estes 1979). Finally, although there may be some knowledge or at least statistical information on factors involved in the aging process, this does not mean that the individual is able to effectively control this process. While we know that senescence and accompanying conditions such as dementia are associated with certain risk factors, these are not necessarily a matter of choice or lifestyle but are often beyond our control. In the case of dementia, for example, potentially modifiable risk factors are believed to amount to 35 percent (Livingston et al. 2017). In addition, the individual will frequently depend on other actors—for example, the family, the community, or the state—to exert an influence on relevant processes. This includes technical and financial support for health prevention, such as medical expertise and financial subventions for checkups and effective preventive measures, but also broader framework conditions, for example, the social living situation or environmental circumstances.

These considerations on knowledge and control are also of high relevance for the question of the temporal dimension and consequences of responsi-

bility for aging involved in the objections against the *stigmatization* and the "blaming and shaming" at work in responsibility ascriptions. Prima facie, retrospective and prospective responsibility seem to be categorically different. Retrospective responsibility requires that something went badly or a consequence is assessed as morally wrong, while prospective responsibility focuses on doing morally right or at least avoiding doing wrongs. However, moral actions must be understood in a temporal continuum, in which backward and future-oriented views often complement each other. Indeed, there is usually a fairly direct moral connection between prospective and retrospective responsibility: if I am prospectively in charge of something, then I am also retrospectively blameworthy for failing to fulfill the pertinent tasks. In this sense, prospective responsibilities for preventive practices and lifestyles can result over time in retrospective liabilities if a person did not do enough to prevent a disease. Thus, according to Veatch (1980), new health care choices and technical opportunities always bear the risk that disease is seen as a personal fault because someone failed to do something against it. However, in light of the problematic scope of scientific knowledge on, and practical control of, aging and old age, prospective responsibility cannot be automatically turned into retrospective blaming. Prevention may be a good and advisable thing, but its failure usually cannot be definitely traced back to causal factors of individual mistake or misconduct. For Yoder (2002), the crucial and problematic part of dealing with responsibility is that information and risks, the epistemic dimension of assessing consequences and exerting control, are usually considered a matter of objectives facts. However, much of the information we actually do have from aging research has a rather problematic epistemic status. It refers to statistical correlations that do not permit a deterministic interpretation in terms of a direct relation between cause and effect but only allow for probabilistic conclusions in terms of chances and risks. We have to acknowledge that there are limits to our knowledge of outcomes and also limits to causal explanations and interventions. Thus, while there may be a justified expectation for people to make reasonable efforts to stay healthy—for example, to behave and live in a healthy way (within certain limits of acceptability)—there can hardly be a moral duty to stay healthy because achieving or maintaining the state of health is simply beyond our causal control.

The aspect of the reasonable acceptability of the "costs" of preventive measures already points to the decisive importance of relevant instances and standards for the discussion of responsibility claims. To counteract the problematic *instrumentalization* and *ideologization* of responsibility, these aspects need to be made explicit, discussed, and justified (or criticized). Thus, there is the evaluative question of the adequate weighing and prioritization of health prevention compared to other important things in life. In ethi-

cal terms, this is a eudemonistic question addressing the conditions and ingredients of a good life in the double sense of subjective happiness and objective accomplishment and flourishing. From this point of view, especially the profound ageism and the ideology of "healthism"—the presumed status of health as an ultimate and absolute goal in life—underlying the responsibilization of aging have to be called into question and put into perspective (Crawford 1980). This is especially true when the epistemic status of the relevant knowledge and the prospects of the corresponding preventive practices and interventions are rather doubtful. Most of us would not find it reasonable to subordinate one's whole life to the prevention of diseases and dysfunction in old age—that is, to renounce any pleasures, invest a fortune, or even take serious risks (e.g., of hormone treatment). All the more so if the best outcome to hope for is a fairly dubious and remote chance of better health in later life. Health may have great value or even be a "transcendental good." However, it is definitely not the only or even most important thing in life. In fact, we may be willing and even justified to put our health at risk for the sake of greater goods—for example, dangerous activities involving joy and pleasure, a great professional or artistic achievement that promises enduring honor and glory, or simply raising children and taking care of old parents (Pfaller and Schweda 2019).

Furthermore, the acceptability of responsibility claims also depends on underlying normative standards determining the system, allocation, and balance of moral roles and expectations between different actors and parties. From an ethical point of view, these standards are centered on ideas of justice and fairness—for example, between individuals, communities, and the state, or toward future generations. In the case of successful aging and anti-aging medicine, it has to be questioned whether the underlying distribution of responsibilities to the individual is really fair and balanced given the limitations of individual knowledge and control and the crucial role of other moral agents at the interpersonal, community, and policy level, let alone the significance of economic and political interests. Another dimension of normative standards pertains to ideas of intergenerational relations and the respective balances and transfers between generations. Thus, underlying conceptions of intergenerational justice determine what members of different generations morally owe each other, not only in terms of financial and other resources, but also in terms of responsibilities for prevention and care. From a perspective of sustainability of social security systems, these intergenerational responsibilities can even extend to future generations (Tremmel 2009). However, in many of the ongoing debates, more or less subtle forms of ageism seem to be at work. This is the case when demographic aging is framed as a kind of unavoidable natural catastrophe and older people are singled out as the obvious scapegoats for the resulting so-

cial problems (Minkler 1997). This not only perpetuates negative images of aging and old age as an individual disaster and a social burden, but also ignores that there is no direct causal impact between demographic aging and social problems but rather a complex field comprising manifold factors and switch points for individual and policy decisions (Binney and Estes 1988).

Conclusions: Analyzing the Moral Economy of Prevention

Discourses of successful aging and anti-aging express and promote a comprehensive change of perspectives on later life in contemporary Western societies. In particular, they are aimed to overcome traditional deficit-oriented models of aging in terms of decline and degeneration by highlighting the resources and potentials of later life. Yet, paradoxically, this renewed outlook is often accompanied by particularly negative images and interpretations of old age (Katz 2001). It seems to be the primary task of the individual to prevent all the diseases, disabilities, and physical and cognitive impairments often associated with the fourth age. Dementia in particular frequently appears as a worst-case scenario of later life, the ultimate demise of the rationally planning, autonomous, and accountable self—a process that needs to be prevented by any means (Latimer 2018).

In the sociology of aging and critical gerontology, this development is critically discussed in terms of a comprehensive "responsibilization of aging." According to our analysis, this discussion involves at least four different lines of argument addressing issues of *individualization*, *overextension*, *instrumentalization* and *ideologization*, and *stigmatization*. Furthermore, we have argued that these lines of critique can benefit from a theoretical elaboration of the concept of responsibility itself and a differentiated ethical perspective on the relevant moral questions and difficulties. Introducing a relational conception, we have pointed out that the subject, object, instance, timeframe, and consequences involved in the ascription of responsibilities deserve closer examination. Last but not least, the underlying evaluative and normative standards also require explicit reflection and discussion in ethical terms. In particular, this calls for an ethical reflection on the value of prevention and health in the perspective of a good life, as well as for a deliberation on the fair distribution of roles and claims between individuals, communities, and the state.

In addition, a combination of ethical considerations with sociological perspectives can further contribute to the analysis by uncovering the social positions, interrelations, and constellations presupposed by these standards of responsibility and discussing their plausibility and legitimacy. Thus, a closer investigation focusing on these "moral economies" of pre-

vention can help to sensitize normative ethical reflection for the complex interplay of individual interests and social interrelations, functions, and power structures permeating the field of morality. At the same time, it makes clear that the moral standards and social constellations influencing our discussions of responsibilities can vary strongly with different national contexts and their specific traditions and sociopolitical framework conditions. In a largely privatized health-care system, for example, insufficient health prevention for old age may simply appear as an expression of personal imprudence and carelessness that deserves pity or reproach. By contrast, in a public health-care system, the same behavior can also be judged as a serious moral misconduct involving a problematic degree of recklessness and an illegitimate lack of social solidarity.

In the public health debate, a more differentiated perspective on responsibility for health is supported by ecological approaches to health prevention that neither focus on "the individual" nor concentrate on "the society" alone but rather try to analyze and utilize the complex interaction of the different individual, communal, social, and political actors and factors influencing health and old age (McLeroy et al. 1988). In a corresponding vein, Minkler (1999) and Holstein and Minkler (2003) propose the concept of individual "response-ability" as an alternative to address the role of the manifold actors and (inter-)dependencies that have to be taken into account when the concept of individual responsibility is used. "Response-ability" can be understood as "the capacity of individuals for building on their strengths and meeting the challenges posed by the environment" (Minkler 1999: 124). As this capacity is embedded in and dependent on a complex web of other individuals, the community, and state policies, "response-abilization" would mean a truly empowering approach engaging all these actors in order to strengthen and support individuals' response-ability and thus enable them to accept and exert their fair share of responsibility.

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Notes

1. The historical origins of the expression "anti-aging" have not yet been systematically clarified. It is well known that the US osteopath Ronald Klatz describes himself as the creator of the term "anti-aging medicine" (drklatz.net) in the early 1990s (Schweda and Pfaller 2017). However, we already find earlier publications that explicitly use the word and associate it with medical questions. The first one dates back to 1948 and is dedicated to "effects of vitamins as anti-aging factors" (Gardner 1948).
2. For a more detailed discussion, see Schicktanz and Schweda 2012.

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