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   - **How to use it**
     - Highlight a word or sentence.
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   - **How to use it**
     - Highlight the relevant section of text.
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   **How to use it**
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   **How to use it**
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   - Double click on the shape and type any text in the red box that appears.
Precarity in late life: Rethinking dementia as a ‘frailed’ old age
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Abstract Approaches to ageing that are organised around productivity, success, and active late life have contributed to views of dementia as an unsuccessful, failed or ‘frailed’ old age. Operating through dominant frameworks, socio-cultural constructs and organisational practices, the ‘frailties’ of the body and mind are often used to mark the boundaries of health and illness in late life, and shape responses accordingly. Our concern is that both the taken for granted and the ‘imagined’ can further marginalise persons who occupy the locations of dementia and disablement. This article analyses the extent to which frailty and dementia are better understood in the context of new forms of insecurity affecting the life course. Drawing on the concept of ‘precarity’, this article shifts debates on the ‘fourth age’ away from age or stage-based thinking, into a recognition of the shared vulnerability and responsibilities for care. The argument of this article is that ‘precarity’ represents a ‘new form of ageing’, notably as regards its impact on the upper extremes of the life course. The article concludes with a call for a response that is grounded in an acknowledgement of the fragility and limitations which affect human lives, this requiring grounding in inclusive forms of citizenship.

Keywords: ageing, dementia/Alzheimer’s, social care, inequalities/social inequalities in health status, life course, risk

Introduction

Ideas and assumptions about cognitive impairment, combined with approaches to ageing organised around ‘success’ and ‘activity’, have contributed to views of dementia as a ‘failed’ or ‘frailed’ old age. Alongside this, institutional and organisational practices associated with physical and mental frailties are increasingly used to mark the boundaries of health and illness in late life. For example, policies and frameworks targeted at later life tend to focus on either healthy populations (those viewed as the ‘active ageing’), or those in need of care (i.e. ‘the frail’ and/or ‘demented’), thereby sustaining distinctions between the third age as a successful lifestyle, and a ‘fourth age’ as a social position marked by decline (Gilleard and Higgs 2013,
Grenier 2012, 2015, Katz and Calasanti 2015, Lloyd 2012, Lloyd et al. 2014). Socio-cultural interpretations of late life frailties have themselves emphasised age and stage-based distinctions, these identifying the fourth age as an ‘unagentic’ social and cultural space (Gilleard and Higgs 2010). Our concern is that such approaches can further marginalise persons who occupy locations linked with dementia and disablement.

Interpretations of dementia as a ‘frailed’ and ‘failed’ late life have become highly influential in the context of health and social care practices. The construction of ‘frail’ subjects, itself takes place amidst a larger ‘decline narrative’ (Gullette 1997, 2004), one supported by the biomedicalisation of impairment and dementia. Moreover, concerns have been raised about the dominance of biomedical approaches to memory loss, and threats to ‘selfhood’ and the ‘civilised body’ (Gilleard and Higgs 2000, Katz and Peters 2008, Kontos 2005). At the same time, the medicalisation of dementia has itself raised the status and public attention afforded the condition, and sustained its position as a distinct disease (Whitehouse and George 2008).

Ideas about dementia as impairment have been reinforced in the context of the dominance of ‘the successful ageing paradigm’ (Rowe and Kahn 1997), with dementia and frailty relegated to the ‘fourth age’. Although unintended, the emphasis on successful ageing, combined with historical and medicalised trajectories of impairment, have crystallised the ‘frailities’ of physical and cognitive impairment into an ‘unsuccessful’ or ‘failed’ late life. Dementia is considered by many to represent a dreaded disease and a ‘horrible’ end to late life (Gilleard and Higgs 2010, Katz and Peters 2008). This sentiment operates in the public eye, through fundraising campaigns and policy frameworks, often meeting up with discourses about cost and the urgency of response. For example, the foreword to an official report on dementia care in England states that: ‘We are facing one of the biggest health challenges ever, a challenge as big as the fights against cancer, heart disease and HIV. Dementia steals lives. It also imposes a huge emotional and financial cost. It is time to fight back’ (Department of Health 2013: 2). One response to this has been the establishment of a ‘World Dementia Council’ together with the setting of a ‘global dementia challenge’ charged with the goal of finding ‘a cure or disease modifying therapy by 2025’.

Such responses to dementia are reinforced in conditions of economic austerity whereby longevity and the increased likelihood of a life with dementia, collide with the loss of rights and citizen entitlements to social welfare (Phillipson 2015). The resulting tension, as this article argues, is between ideals of independence and the emergence of new forms of vulnerability, or what we shall term as ‘precariousness’. The concern of this article is that current ideas and practices organised around the ‘fourth’ age – including taken for granted discourses, practices and the ‘imagined’ – risk reinforcing unequal power relations in late life, with the potential of further marginalising persons with dementia. We suggest, therefore, that the concept of precarity be used to reconsider the socio-cultural ideas and practices that operate with regards to dementia, and shift the debates into considerations of shared processes and experiences of vulnerability that occur over time. Within this frame, use of the concept of precarity can help to draw attention to a deeper problem whereby notions of dementia as a ‘frailed’ old age risk being read and interpreted as a ‘failed’ old age.

Frailty and dementia: Discourse, practice and the ‘imaginary’ of the fourth age

Frailty and dementia have both emerged as conditions which are presented as ‘opposites’ to a ‘healthy’ and ‘active’ later life. Where medical and practice perspectives consider frailty and dementia as different states or conditions, there is also a significant overlap where discourse, practices, and the ‘social imaginary’ are concerned. Impairment – whether physical or...
cognitive – is considered to mark disease, establish practice directives, and inform socio-cultural interpretations about debility and decline. While frailty and dementia are undoubtedly different, it is the construct of the ‘fourth age’ that links them together. This connection results in part from the emergence of the ‘fourth age’ as a function – or troublesome outcome – of the dominance of success-based discourses and the third age lifestyle characterised by health, personal growth and active engagement (see Lloyd 2015). This article combines frailty and dementia to illustrate how understandings of physical or cognitive impairments – the ‘frailties of the body and mind’ – can be reconsidered through contemporary writing on precarity.

In biomedical and health domains, frailty has become a major site of research efforts to define the ‘condition’, determine practice indicators, and target health and social care practices to those at ‘risk’ (Lacas and Rockwood 2012, Morley et al. 2013, Searle et al. 2008). This is equally the case for dementia, where the diagnosis provides access to specialised services and community-based programs (Brooker 2007). Where health research tends to focus on dementia as a disease or ‘frailty’ as an indicator of risk, the ‘fourth age’ refers to a construct that encapsulates ideas about the ‘frailties’ and impairments of late life – whether physical or cognitive in nature (Lloyd 2015, Pickard 2014). The ‘fourth age’ is increasingly described as a complex cultural construct, a ‘social imaginary’ that is unknowable and, once entered, from which there is no return (Gilleard and Higgs 2010). As such, the ‘fourth age’ refers both to an age or staged-based period, and a cultural construct – or ‘imaginary’ – that espouses impairment, decline and dependency in late life (see Gilleard and Higgs 2000, Laslett 1991). Whether in practice, or the socio-cultural sphere, the ‘fourth age’ becomes an important discursive and symbolic marker of the boundaries between health and impairment, the proximity to death, and by extension, the expectations of late life as a period of disableness and decline (Grenier 2012). It is viewed as a liminal space and an event horizon – a location that holds the negative or less than ideal experiences of ageing (Gilleard and Higgs 2010; Grenier 2012). Falling into the ‘fourth age’ space, frailty and dementia occupy sites laden with associations of physical and cognitive deficits, dependence and burden, pity or weakness (see Grenier 2007, 2012, Pickard 2014).

The marginalisation of those with physical and/or cognitive deficits is reinforced by the lack of agency ascribed to persons deemed to occupy the ‘fourth’ age. Gilleard and Higgs (2010: 123) argue in their paper ‘Ageing without agency’ that: ‘The fourth age . . . represents not so much a particular cohort or stage of life but [...] a kind of terminal destination – a location stripped of the social and cultural capital that is most valued and which allows for the articulation of choice, autonomy, self-expression and pleasure in later life’. However, an alternative perspective has been put forward by Grenier and Phillipson (2013) who suggest that conditions within the ‘fourth age’ can be said to challenge conventional approaches to the idea of agency. In the case of conditions such as dementia, it is possible to see how agency rather than being ‘compromised’ may simply differ from current interpretations, or be communicated or enacted differently. This suggestion makes the case for a critical approach to understanding the location of dementia within the life course. Such a perspective is supported by Jaworska (1999: 124, 126), who argues that 'the ability to value is independent of the ability to understand the narrative of one’s whole life [and] the capacity for autonomy is first and foremost the capacity to espouse values and convictions, whose translation into action may not always be fully within the agent’s mastery’. Thus, in the context of care services, the task is to value the lives, experiences and convictions of persons with dementia, even in circumstances where what is expressed seems foreign or ‘unknowable’.

Although the discourses, practices, and imaginary of the ‘fourth age’ have yet to be fully considered in relation to dementia, approaches organised around selfhood and cultural change represent parallel concerns about dementia as an ‘unagentic’ and ‘failed’ late life. Researchers
in dementia studies have stressed the importance of person-centred care and the need to challenge dominant approaches to thinking about the condition (O’Dwyer 2013). George and Whitehouse (2010: 351), among others, have argued: ‘for the need to challenge the tyranny of the scientifically uncertain and socially stigmatising AD [Alzheimer Dementia] story to make both cultural understandings and social institutions more responsive, and so that persons with memory challenges and their families may tell their own stories about brain ageing rather than succumbing to the generality of a vague, imprecise, and stigmatising disease label that emphasises only decline’. Similarly, Kontos (2004) has questioned the idea that cognitive deficiencies lead to the loss of selfhood and advocated for arts-based approaches that bridge differences in communication (Kontos and Naglie 2007). Yet, the contemporary discourses and practices, including the ‘social imaginary’ can run counter to these ideas, and reinforce the view that people with dementia have ‘less’ or are without agency, with the implication that their lives are both marginal to society and less valued.

To explore this issue, the next section of this article analyses the extent to which frailty and dementia are better understood in the context of new forms of insecurity that affect the life course, as expressed through ideas associated with the concepts of precariousness and risk.

Precarity as a means to reconsider experiences of dementia

The concept of precarity has been used in a number of contexts in order to draw attention to rising insecurities in the context of global economic and social change. In articulating a perspective from critical geography, Waite (2009: 426) refers to precarity as ‘life worlds characterised by uncertainty and insecurity’, and a concept that implies ‘both a condition and a possible rallying point for resistance’. Although precarity has been widely used in other fields, in particular with regards to changes in the labour market (Standing 2010), its application to ageing and late life is relatively new. To date the concept has been applied in discussions around ageing and employment (Bohle et al. 2010), financial insecurity and/or exclusion of older people (Craciun and Flick 2014), disability and citizenship (Knight 2014), and trends towards inequality in the G20 countries (Biggs 2014). In all cases, the use of precarity in gerontology and allied disciplines echo the broad application to issues of exploitation and insecurity in the labour market. The dominance of discourses of success and declining social protection, however, point to the need to consider older people outside the labour force, including those considered ‘frail’ by means of their cognitive and/or physical impairments.

Drawing on the concept of precarity to understand the structured and existential vulnerabilities experienced across the life-course and into late life may help reconfigure ideas and practices about physical and cognitive impairment. The insights of researchers such as Standing (2010, 2012) and Butler (2006, 2009, Butler and Athanasiou 2013) are particularly helpful in advancing our reconsideration of dementia as a ‘frailed’ and ‘failed’ late life. Although representing different theoretical standpoints, both draw attention to the vulnerabilities in which people are placed. Likewise, they ground their analysis in dependency and the need for change through a response based on a shared interdependence. Where Standing focuses on a dependency structured by the labour market, Butler emphasises shared cultural frameworks about physical and mental frailties and the ‘fourth age’.

Uncertainty, insecurity and vulnerability may be viewed as produced by shifting global, economic, social and cultural relations, as well as the choices and decisions made in such contexts. Standing’s (2010, 2012) analysis draws attention to the insecurity, unwanted risks, and
costly hazards of contemporary life that have resulted from globalisation, neo-liberalisation, and declining social protection. He focuses primarily on the implications of flexible labour relations and the rollback of public pensions in creating new uncertainties in late life. Drawing older people into precarious work raises issues for social care as well as labour relations. According to Standing (2010), older people can get caught in a ‘precarity trap’, forced to remain or re-enter the workforce in flexible and lower-income status positions. Older people with limited financial resources may themselves rely upon precarious workers as carers, and family networks may be reduced or drained by means of their own precarity.

Standing’s (2010) approach draws attention to the way in which structural inequalities are reinforced through differential ‘options’ and ‘choices’ about work and care in later life. While his argument has primarily been applied to the operation of the labour market, the thrust of his critique can be extended to later life more generally. Taking a long view of the life course, it is precisely the ‘cumulative effects’ of precarity that shape late life, in particular where social and economic inequalities are concerned. Further, the contemporary economic conditions and austerity measures that are central to Standing’s critique do not cease at retirement or in later life. This is particularly the case for groups of older people who are poorly served by traditional programmes such as pension schemes (i.e., immigrants, casual employees, women, people with disabilities, etc.) as well as carers, who may themselves be precarious by means of migration, low wages and labour market conditions. In fact, the precariousness that Standing outlines may become exemplified in late life in a context whereby reduced public support intersects with an ever-expanding for-profit market of homecare. Vulnerabilities may thus be considered to shift from labour, income and status, to ‘dependence’, the need for care, and the struggle to have these needs met by residual public services and private care schemes. As such, Standing’s notion of the ‘precarity trap’ may in effect continue to snare older people as they move into late life, and most notably at the very moment that they require care.

Butler’s (2009) argument is that we all experience ‘precariousness’ at different points in our lives, that ‘interdependence’ is a feature of the human condition, and that this precariousness is political. Butler’s work on precariousness is chiefly concerned with the construction of subjects and the ontological questions of what it means to have a life. According to Butler (2009: 25): ‘Precarity’ is a ‘politically induced condition in which certain populations suffer from failing social and economic networks of support and become differentially exposed to injury, violence, and death’. Her analysis draws attention to the importance of the differential construction of subjects, and how mutually held frameworks create and sustain particular responses, especially with regards to independence and dependence. Butler’s interpretations of precarity shed light on the politics of ageing, whereby older people can suffer from ‘unequal access to material goods, and diminished social networks, resulting in a potential vulnerability to neglect, abuse and violence’. Her approach raises questions about both life and care, and points to concerns about how the construction of a devalued ‘fourth age’, in the context of declining social protection, may place older people at risk of abandonment or ill-treatment.

The processes of de-subjectivation and ‘othering’ that lead into ‘precarity’ highlight the potential problems of a devalued ‘fourth age’. For Standing (2010), a precarious life characterised by a chronic state of uncertainty and instability can lead to a ‘truncated status’ where many become ‘denizens’ as oppose to citizens, defined as lacking at least one group of basic rights (civil, political, economic, social and cultural). Similarly, Butler outlines a shared experience of vulnerability, and a collective de-humanisation that is used to justify the devaluation of particular lives. Butler highlights that life, and the decisions made about life, are not self-evident, but constituted by structures of recognition, and discursive power. That is, they are contingent upon mutually-held epistemological and normative frameworks that depict collectives as ‘having or not having a life’, and enacted through decisions and social practices. Such
perceptions play a central role in accessing networks of protection and care, and are thus directly relevant to the construction and response to the ‘fourth age’. She illustrates her point through the need for intensive forms of care: ‘when decisions are made about providing life extending machine support to patients, or extended nursing care to the elderly, they are made, at some level, by considering the quality and conditions of life. To say that life is precarious is to say that the possibility of it being sustained relies fundamentally on social and political conditions, and not only on a postulated internal drive to live’ (Butler 2009: 21). A shared schema of ‘fourth age dependence’ as a social and cultural burden can thus play a central role in configuring responses and sustaining power organised around a devalued notion of decline.

At the same time, a critical reading of precarity draws our attention beyond the immediate horizon of decisions about care, to recognise and confront the risks of life. Precarity underlines the fact that life is essentially ‘risky’. Unlike previous social divisions organised around class, gender, geography, or ‘racial’ lines, precarity represents a universal form of insecurity, vulnerability, and potential suffering. Standing (2010) argues that contemporary conditions have created a ‘class-in-the-making’ (italics in original) – a membership that is open to virtually every member of society whose social, economic and political relationships are destabilised by neoliberal commodification. Butler’s (2009) thinking here is that our lives are, and always have been, defined as a state of precarity, based on an interdependent web of social support and obligations. She argues that: ‘precariousness implies living socially, that is, the fact that one’s life is always in some sense in the hands of the other’ (Butler 2009: 14). This is reinforced by Turner’s (1993) point that individuals may be viewed as ontologically frail rather than autonomous human beings, this arising partly through the effects of ageing and decay, but also because life itself is inherently risky.

All of these authors draw attention to an inherently shared, but unequally experienced, ‘precariousness’. So, while risks or insecurities are part of the human experience, certain locations or lives are more susceptible to the hazards than others, and even more so in a context characterised by precarious work and declining social benefits. Older people increasingly find themselves as linked with precarious work, ever-shrinking social protections and safety nets, and in need of care in later life. Such conditions are then carried into late life, affecting experiences that occur in ‘frailty’ or dementia. Conditions of care also shape precarity and underline human inter-relatedness, as can be seen in the accounts of families and carers of people with dementia, who describe a sense of abandonment. Similarly, precarity is evident in the conditions of workers in health and social services where low pay and poor conditions of employment match precisely Standing’s description of the precarious worker (Cangiano et al. 2009). Realities of ageing and decline combined with contemporary age and care-relations, create a greater risk of precarity, as both structured and experienced – risks that are carried across the life course and into late life.

Finally, the experience of precarity underscores the need for change. Whether drawing on the works of Butler or Standing, the concept of precarity can be employed to stress the need for a response based on interdependence as part of the human condition. Although Standing ignores the way in which labour force insecurities may be carried into late life, he calls for a progressive vision that contains the potential to influence new perspectives on late life. Standing (2010: 157) argues: ‘The precariat’s foremost need is economic security, to give some control over life’s prospects and a sense that shocks and hazards can be managed. This can be achieved only if income security is assured. However, vulnerable groups also need ‘agency’, the collective and individual capacity to represent their interests’. Butler’s emphasis on change is rooted in a response that is intrinsically tied to the relational nature of our existence – our interdependence. Highly relevant to the question of dementia and impairment in late life, she states ‘the question is not whether a given being is living or not, nor whether the being in
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question has the status of a “person”; it is, rather, whether the social conditions of persistence and flourishing are or are not possible’ (Butler 2009: 20). Here, Butler’s (2009; Butler and Athanasiou 2013) thinking presents a serious challenge to existing approaches to the ‘fourth age’, outlining both that our response to late life should develop from an acknowledgement of fragility and limitation, and not a denial or distinction from it, and that such conditions will not naturally emerge, but must be fostered.

**Shifting the discussion from the ‘fourth age’ as debility and decline: Unhinging age and stage-based assumptions**

Precarity draws attention to the risks and inequalities across the life course and into late life, underscoring the importance of unburdening ourselves from the age and stage-based fixations that are implicit in notions of the ‘fourth age’. Considering late life frailties as precarious deepens our understanding of the ideological power inherent within constructs, practices and the ‘social imaginary of the fourth age’. Using precarity to understand late life illuminates the ‘fourth age’ as a location distinguished from youth and adulthood, and one where the devaluation of life is based on impairment and the associated costs of dependency. This assists our understanding of the multiple layers that structure deep old age as disadvantage, whereby older people with physical or cognitive frailties become ‘othered’ by means of the contradiction between autonomy and dependence. As such, it highlights how these ideological notions are culturally mediated and sustained through institutions and practices. Despite attempts to distinguish ageing from a negative period of the life course, the mutually reinforcing constructs of the ‘third’ and ‘fourth age’ draw us back to deeply held notions of age as impairment, dependence and decline. Arguably, the ‘fourth age’ is becoming constructed as old age *per se*. As such, there is a growing realisation that the concept of successful ageing may operate to the disadvantage of older persons with physical and cognitive impairments. Looking back, it may be the case that the pendulum has swung back to the notions Rowe and Kahn (1997), and Laslett (1991), were challenging – the view of ageing as a largely negative experience. It might also be argued that over time, understandings and approaches to late life have shifted in line with patterns of mortality, with the burdens of the ‘fourth age’ unequally distributed to those without resources or care networks, and where declining social protection fail to compensate for their needs.

Drawing on interpretations of precarity to understand the ‘fourth age’ accentuates the need for agency and the provision of care as a shared responsibility. Butler’s (2009) work on precarity can be employed to underscore how the ‘fourth age’ is created and reinforced as devalued, through cultural priorities and practices, social structures, and care systems. Thinking about precarity with regards to late life, therefore, helps shift the focus to the conditions within which people live. Chronological age – or any proxy such as the ‘third’ or ‘fourth age’ – and the ways in which we ‘imagine’ or respond to these categories, can create and sustain inequalities, many of which are a result of contemporary decisions and priorities about care. The suggestion is therefore, that altering the constitution of subjects, and the responses that take place through social structures and care practices, can create change. Admittedly, 20th century patterns of extended longevity have redistributed death from a more equal distribution across the life course to one in which it is overwhelmingly associated with old age. A long life has become so commonly expected – assumed to be a right – that a ‘premature’ death has to be explained. While the cultural impacts of associations between age and death, and similarly dementia and old age, cannot be overlooked, the same may not be true of our understandings and responses to late life. Precarity calls attention to the construction and conditions of...
vulnerability, including how even the right to a long life is unequally distributed, through for example, differential mortality rates of privileged and disadvantaged groups (Marmot 2015).

Recognising vulnerability: Fostering the conditions for a sustainable life

Drawing attention to precarity emphasises the importance of responding to vulnerability and fostering the conditions for a sustainable life. An analysis of precarity can offer new insights, first, into existing critiques in the field of dementia studies; second, into how ideas about care and the accompanying care relations can naturalise and sustain inequality and disadvantage (Holstein 2015, Tronto 1993). In the context of increased longevity, late life is often accompanied by what is termed ‘co-morbidity’ and extended periods of ‘chronic impairment’, creating a new dimension to discussions about ageing and the need for care. What precarity brings to light is how the need for care, combined with potential of impairment in late life, can conflict with declining support from the welfare state. Our concern is that the relegation of people with dementia to a devalued category of the ‘fourth age’ can become a further rationale for poorly resourced services and threaten standards of care for older people in late life.

Recognising precarity and the inherent risks of late life could form the basis for reconfiguring understandings and care practices towards frailty and dementia (see, also, Gawande 2015). Standing and Butler argue for the need to foster conditions that make life sustainable in situations of vulnerability and insecurity. Where Standing’s suggestions would mitigate the inequalities that accumulate across the life course, Butler recognises the roots of suffering as the foundation for an ethical and just response. According to Butler (2010), the response to precarity should develop from an acknowledgement of fragility and limitation. She articulates that a response capable of improving lives will not naturally occur, but must be created, arguing: ‘Simply put, life requires support and enabling conditions in order to be a livable life’ (Butler 2009: 21). And later, ‘To sustain life as sustainable requires putting those conditions in place and militating for their renewal and strengthening. Where a life stands no chance of flourishing … one must attend to ameliorating the negative conditions of life’ (Butler 2009: 23). Here, Butler’s point may resonate in some ways with approaches (Barnes 2012, Sevenhuijsen 1998, Tronto 1993) which view the need for care as a political issue, and is not confined to ‘abnormal’ situations, nor grounded in moral and ethical duty. However, where Butler, and Tronto (1993) both focus on vulnerability as a universal human characteristic, their positions are different. Where the ethics of care tends to remain grounded in a ‘moral imperative to care’ and a ‘knowable other’, Butler focuses on relationality, the social and political conditions which give rise to precarity and precariousness, and the ‘processes that render ‘them’ [the other] unintelligible’ (see Chambers and Carver, 2008: 107).

In the context of this article, the social and political conditions which shape a devaluing of subjects by means of their physical or cognitive impairments, can serve to reinforce precarity, and deflect attention from the disadvantages that accumulate and affect late life, the experiences of living with dementia, and the practices of providing and receiving care. As such, the associations embedded in the constructs, practices, and ‘imaginary’ of the ‘fourth age’ may lend strength to decisions and programmes that provide only minimal public care as a form of compensation for a lack of personal or family resources, rather than universal vulnerability and the need to foster care. With few available care ‘choices’, and in particular accessible and affordable options, notions of the ‘fourth age’ which are formed, and become activated over time in line with the conditions of a life, and in the current political context, can serve to limit agency, as well as reinforce notions that agency is limited in situations of physical and/or mental frailties. The trajectories into care and the foundations for effective communication with
people with dementia are thus ignored, and the potential for people living with dementia to shape the conditions within which they live go unrecognised.

**Discussion: Citizenship and vulnerability in late life**

The argument of this article has been that concepts such as ‘precarity’ can contribute to better understandings of frailty and dementia, especially when placed in the context of new forms of insecurity influencing the life course. This approach also helps shift ‘fourth age’ debates away from age or stage-based thinking that risk reinforcing unequal power relations and marginalising older people with physical or cognitive impairments. It does so by rendering visible how current approaches to the ‘fourth age’ as a ‘failed’ late life mask universal suffering, structures of inequality, and processes of precarity. Rooted in the idea of instability and enhanced vulnerability, precarity provides a foundation from which to more closely consider care priorities and the experiences of living with impairment. A key issue concerns how best to protect people subject to the vulnerabilities associated with late life. Whilst these conditions may be shared across a large section of the population, they are experienced by individuals – often living alone and with limited community support. The key issue which arises is how to incorporate the recognition of the vulnerabilities associated with ageing and dementia into frameworks which translate into an acceptable response that gives scope for agency (or some variant thereof) and the maintenance of human dignity.

One response is to link the analysis of precarity with an inclusive form of citizenship that challenges the responses to older people with physical and cognitive impairments. This may be illustrated through what Delanty (2000) refers to as ‘cosmopolitan citizenship’. Challenging a ‘deep moral contradiction at the heart of the modern state’, Linklater (1998: 24) argues that cosmopolitan citizenship is used to ‘remind citizens of the unfinished moral business of the sovereign state and to draw their attention to the higher ethical aspirations which have yet to be embedded in political life’. In this sense, cosmopolitan citizenship can provide a crucial bridge from our analysis of precarity in late life into pathways for enacting change. A framework that is capable of responding to precarity in late life requires attention to both shared vulnerabilities, and the unequal experiences of such conditions. Linklater (1998) cites Beitz’s view that political communities should widen their ethical horizons until the point is reached where no individual or group interest is systematically excluded from moral consideration.

Such an approach challenges the construction of old age as a form of ‘otherness’ – a central feature of approaches to dementia and ‘frailty’. Insisting on the political component of cosmopolitan citizenship, Linklater (1998: 28) states: ‘The argument is that, if it is to have real meaning, cosmopolitan citizenship must involve rather more than moral commitments not to exploit the weaknesses of others – more than the ethical resolution to treat all other human beings with care and compassion. It requires political action to build communication communities in which outsiders, and especially the most vulnerable among them, have the power to ‘refuse and renegotiate offers’ and to contest unjust social structures’ (Linklater 1998: 28). As such, cosmopolitan citizenship represents an important framework when considering how to move beyond a ‘precarious’ old age.

This model of citizenship underscores the importance of inclusion, agency and negotiation that is fostered in part through communication, in this case, even in circumstances where agency is considered to be reduced. A critical analysis drawing on precarity, when combined with an inclusive notion of citizenship, holds the potential to recognise and respond to the needs of older people with dementia. Precarity highlights the severity of the problems that exist for a large number of older people. This leads us to argue that it is ‘precarity’ rather than

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‘activity’ and ‘success’ that may be a more realistic model for understanding late life, and especially the lives of older people with physical and cognitive impairments. A careful consideration of the ‘fourth age’ as a form of symbolic exclusion can create the space to reconsider the foundations of constructs and care practices, and ‘what it means to live in a ‘frail’ state’.

In some ways, insights from dementia studies have pioneered a reconsideration of late life care. Discussions framed around ‘personhood’, ‘selfhood’ and ‘othering’ have drawn attention to the need to change medical and social practices, particularly the interactions between professionals and people living with dementia, and the reconfiguration of care spaces (see George and Whitehouse 2010, Kontos 2004). Models such as The Eden Alternative (2012) or other dementia-friendly spaces (Mitchell et al. 2004) reflect alternative notions of what care ‘should look like’. Such responses have played an important role in reconfiguring dementia, but we also need perspectives that address the socio-cultural and political challenges to interpretations of dementia as a ‘frailed’ and ‘failed’ late life. Dementia is by its nature one of the most challenging areas in which to argue against age and stage-based thinking given that it is a chronic, physiologically based condition, leading to death, mostly occurring in old age. Yet, it is a site where constructs, practices, and the ‘social imaginary’ of the ‘fourth age’ reinforce negative valuations of dependence as a problem, and sustain notions of living with dementia – or other end of life stage conditions – as void of agency and potential. Dementia and other ‘frailities’ that fall within the ‘fourth age’ signify that mastery over the body cannot be won, that death is inevitable, and simply a question of time (see Lloyd 2000). Such devaluations are, of course, worsened in a context where political notions of dependence interpreted as costly burden can result in non-existent or poor levels of care for older people.

Shifting the focus from constructs that reinforce the negative valuations of age, to a recognised shared vulnerability, acceptance of the limitations of life and death, and shared political responsibility can help to unhang dementia and impairment from a ‘frailed’ and ‘failed’ late life into a foundation from which to develop new types of care relationships. To do so however, relies on a critical analysis of the constructs, practices, relations, and contexts within which care for people with dementia takes place. Relocating dementia to a more ‘normalised’ life course space however, must not become another rationale for neoliberal care models to relegate care onto families, individuals, or the lowest cost service provider. Change must also be accompanied by a social and cultural ethos of care, the prevention of inequalities, the alleviation of suffering, and the opportunity to flourish throughout the life course and into late life. Understandings and practices for older people with physical and/or cognitive impairments must, therefore, be repositioned in a space where it is possible to recognise and address vulnerability, inequalities, suffering, as well as the moments of pleasure and joy that can exist in deep old age. We must create structures and programs where ‘care’, and the alleviation of suffering, is both important and possible, and begin to more closely consider and respond to the relationship between cultural, social and biological life, and death.

Conclusion

In conclusion, the contemporary response to dementia in the context of longevity and austerity creates a need to examine the inequalities of late life, the failures of the system with regards to care, and to develop new cultural narratives of deep old age (Phillipson 2015). This will involve a willingness to normalise late life and frailties that occur over time, and recognition that communication and agency may look different in later life, and be as much socio-cultural as biological. Turning to an analysis of precarity throughout the life course and in late life outlines the differences that exist, including how late life contains the vulnerabilities of the human...
condition, the accumulation of structured inequalities, and the socio-cultural assumptions and notions of ‘failure’ that are associated with impairment. Precarity makes two contributions to the discussion: first, it moves thinking away from the dominance of individualised age or stage-based frameworks that are rooted in success, and by consequence, position dementia as a ‘frailed old age’. Second, it renders visible a shared vulnerability, as well as the desire for control, and the inability, or the lack of political will, to address dependency, interdependence and human suffering. Our suggestion is, therefore, to pair the analysis of precarity with a response that balances an inclusive form of citizenship, recognition, and shared responsibility to vulnerability. Only from this point, can we alter current understandings of late life, structures and relations of care, and attempt to alleviate rather than sustain the suffering that may exist in late life. Such approaches would create responses to older people with dementia not because they are pitied or sick, but because they are valued, and because a clearer understanding of their experiences prevails.

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Notes

2 In the feminist ethics of care, care is a political issue that should be brought out of the private and into the public, and debated, not only in terms of cost and organization, but the potential to respond to need and support human flourishing (see Barnes 2012, Sevenhuijsen 1998, Tronto, 1993). Tronto, for example, argues that ‘all humans are extremely vulnerable at some points in their lives’ (Tronto 2011:164), and it is this vulnerability that underscores both the political nature of care ethics and the need for care. However, in Tronto’s work, the primary focus is on the moral imperative to provide care.
3 The differences between these positions are the subject of philosophical debate and in particular, that of ontology. Chambers and Carver (2008: 107) state the following: ‘even in the case of Joan Tronto’s deft articulation of an ethic of care, her understanding of “relationality” bears little or no resemblance to Butler’s. In Tronto’s understanding of caring, the “other” is always a concrete, knowable and intelligible other. She writes: “that “others” matter is the most difficult moral quality to establish in practice’ (Tronto 1993: 130). Butler, however, does not focus her attention on intelligible others (those who would then be cared for, be granted rights, be recognised), but on the very processes that render “them” unintelligible . . . Tronto’s account concerns itself solely with actual “beings” and not with the Being of those beings. Butler’s “relationality” not only precedes but also undoes any so-called “ethic of care”. Thus, in describing Butler’s political ontology by way of highlighting the “primacy of relationality”, we are at the same time, and in no uncertain terms, rejecting any variant of individualised ontology’.  
4 It also links with arguments from the ethics of care. The political dimension of the ethic of care can, for example, be linked to the concept of citizenship and the possibility of changing conventional responses to people with physical and cognitive impairments. Sevenhuijsen (1998) for example,
articulates a view of citizenship that is grounded in an ethics of care, and inclusive of a range of voices. She argues that: ‘citizenship is not conceptualized exclusively in terms of a liberal rights model but first and foremost as an activity and a normative approach which can lead to a search for the best course of action in public contexts’ (Sevenhuijsen 1998: 148). In models of citizenship based on the ethics of care, conflicts of interests are recognised and discussed through processes that ensure that weaker voices are included.

References


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