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Stigmatised, marginalised and overlooked: health, later life and gender in India and the United Kingdom.

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Introduction

Dominant discourses and conceptual frameworks tend towards stereotypical understandings of what 'the issues' are for older people. This forces research, policy framing and everyday discourse down predictable pathways. In neoliberal Britain, where a discourse of 'austerity' is being used to reduce social protection, that pathway mainly consists in defining older people as an unaffordable social burden and in constituting later life as an object for intense statistical analysis. In neoliberal India, where social provision for older people is negligible, the dominant discourse classes older people as the responsibility of families and of limited research interest, especially by comparison to women and children. In both contexts, stereotypical discourses on frailty, disability, dependence, isolation and family neglect marginalise other perspectives, with the result that research into old age rights (or their lack) and into later life activity, participation, independence, contribution, productivity and mutual interdependence across generations tend to be framed as policy objectives ('active ageing') rather than empirical realities. These stereotypical discourses on old age locate health in the body, in access to health practitioners and in being cared for. This chapter will challenge these stereotypes by demonstrating how a focus on what older people do, that is not pre-determined by ageist thinking, produces a broader understanding of what determines health in later life.

Health and Wellbeing in Later Life

Research on older people tends to take descriptive population measures, especially average life expectancy at birth, as proxies for health and wellbeing (Higgs et al, 2003) and it is a commonly, though erroneously, thought that it is

only in the 20th century and in developed countries that life spans have extended beyond middle age (Thane, 2005; Bloom et al 2015). The main population descriptor, life expectancy at birth, provides an average heavily distorted by deaths in the first five years of life, and cannot be taken as a proxy for longevity or later life health. For example, in India in 1960 the average life expectancy at birth was 42 years, which rose to 66 years in 2013 (World Bank). This would suggest that living into late old age would not be widespread in India and certainly would be less likely to occur amongst those at the lower end of the social hierarchy. However, photographs from the late 19th century and water-colours from the early 19th century demonstrate otherwise: they depict many aged people at work, as agricultural labourers, as potters, scribes, stone workers, servants, weavers and spinners and so on.

The underused average life expectancy at 60 provides a better comparative measure of average longevity. In the UK the average life expectancy at birth was 81 years in 2013 but at age 60 it was 25 years for women and 22 years for men, meaning that if women reached the age of 60 then, on average, they will live to age 85 (GHO, 2015). Healthy average life expectancy (HALE) at age 60 provides the number of years a person can expect to live in full health, defined as not suffering from disease and injury, from the calculation point - in this case age 60. In 2002, the UK HALEs at age 60 were 18 years for women and 15 years for men (WHO, 2004). In India, in 2013, while average life expectancy at birth is 68 years for women and 65 years for men, at age 60 it was 18 years for women and 16 years for men (GHO, 2015) and HALEs at age 60 were approximately 11 years for both men and women in 2002 (WHO, 2004). This means that women that reach the age of 60 will, on average, live to 78, but, as it is an average, may live much longer, and approximately 11 of those years are likely to be in good health. For men reaching 60 they would, on average, live till aged 76, but once again, about 11 of those years are likely to be in good health. In both countries the main killers are no longer the communicable diseases that kill children but the non-communicable diseases of middle and later life. India also has high rates of death from suicide, road traffic accidents, diarrhea and tuberculosis, demonstrating the need to broaden the analysis of what constitutes a health issue well beyond the body and take a broader focus on well-being. However, in relation to older people health is treated as a proxy

for well-being which reinforces the negative view of ageing as decline and older people as dependent, ignoring their capacity to adapt and compensate for changes in health and mobility (Higgs et al, 2003).

The World Health Organisation recognises this need to broaden the concept of health and health outcomes by promoting an active ageing agenda to 'realise (older people's) potential for physical, social and mental well-being... to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance' (WHO, 2002:12). The main determinants of active ageing identified by WHO are culture and gender, health and social services, behavioural determinants, the physical and social environments, economic determinants and individual determinants (genetics and psychology) (WHO, 2002) and these require linkage to health, social and economic policy (Walker, 2014) and to infrastructural provision in developing countries. In 2002 the United Nations adopted the Madrid International Plan of Action on Ageing (MIPAA) which defined the policy agenda to secure active ageing. Priority 1 is that older people must be 'full participants in the process of development and also share in its benefits' (UN, 2002:cl 16). Priority 2 is that older people are 'fully entitled to have access to preventative and curative care' (cl 58) and Priority 3 is 'ensuring an enabling and supportive environment' in order to 'empower older persons and support their contribution to society' (cl 94). India and the United Kingdom are both signatories to MIPAA.

Older's people's right to participate in and benefit from development was overlooked by the Millennium Development Goals (MDGs) and marginalised by their focus on maternal health, on children's health and education and on women's empowerment; in practice older women fall out of the frame in conceptualisations of 'women' as a category unmarked by age. The Sustainable Development Goals, which include developed and developing countries, where the MDGs did not, are also likely to be detrimental to older people. The current version of Goal 3 is to 'ensure healthy lives and promote well-being for all at all ages' and Target 3.4, which will be the key measure of attainment of the goal, reads: 'By 2030 reduce by one third premature mortality from non-

communicable diseases.' Death before the age of 70 is described as 'premature' - yet in the UK the average life expectancy at age 60 for women would suggest they can expect to live to 85 and for women in India until they are 78 and many will live much longer. It is highly unlikely that India and the UK will be adding sufficient new resources to meet this goal and are much more likely to refocus resources on people aged below 70. Not only would this formulation of 'premature', rather than 'preventable', deaths increase the likelihood of those most at risk from non-communicable diseases being denied health services, but it sends the message that at age 70 death is to be expected and preventative, curative and care services are not warranted by comparison to other's needs. Clearly this negates MIPAA and the fundamental human rights that older people have as *people* and reinforces the stereotypical discourse of frailty, decline and dependence. For a global institution, with its aura of rationality, objectivity, and authority, to underscore an ageist discourse with an implicit 'expiry date' exposes all older people to further stigmatisation and discrimination and especially older women who live longer, whose unremunerated work for family and society is disregarded and who have accumulated less resources over a life course marked by gender discrimination in relation to education, incomes, pensions and assets.¹

Confronting Stereotypical Discourse in the United Kingdom

In the UK health and health-related research on older people typically focuses on mental health, in terms of loneliness and isolation, on care needs, in terms of disability and dementia, on non-contagious diseases, on food and fuel poverty and disability-appropriate housing. This narrow scope reflects and drives policy, deepening ageist stereotyping (Vincent, 2006) and generating social divisions by constructing older people as 'other' (Katz, 1996) and as a burden on younger generations (Quafagno, 1989; Vincent, 1999, Walker, 1990). Yet, barring dementia, none of these health needs can be remotely described as primarily 'old age issues', but can affect people at any stage in the life course.

¹ See Vera-Sanso (2010) on gender and the accumulation of advantage and disadvantage over the life course.

Even to describe dementia as characteristic of old age is a significant distortion. In the United Kingdom the research, political and media discourses on dementia are increasingly alarmist. In December 2013 David Cameron, the then Prime Minister of the United Kingdom, called dementia a '21st century plague' and a 'global challenge' at the first G8 Dementia Summit held in London (Dobson and Dobson, 2014). Disturbing absolute figures of dementia cases and highly questionable costs to the economy are regularly trotted out by a wide range of experts and opinion-shapers; demonstrating the dangers of trying to raise the profile of a cause in a neo-liberal context where costs to the economy will draw attention but can also stigmatise and further deepen the stereotyping of particular social groups. While Cameron backed his calls to life science companies' investment in UK research and to G8 countries to share knowledge by claiming that dementia will affect one in three persons and that it costs the world \$600 billion per year, more reliable sources also feed into this stigmatising discourse.

The Alzheimer's Society commissioned researchers at the London School of Economics and Kings College, London, to undertake a meta-analysis of the cost and prevalence of dementia in the UK (Prince et al, 2014). If we invert the presentation of their results, by presenting proportions of people *without* dementia, rather than focusing on those who have dementia, we can see that dementia is more associated with old age than earlier life stages, but by no means is it characteristic of old age. In absolute terms the number of people with dementia, irrespective of age, might appear large, estimated at 850,000 in the UK, in fact this represents a tiny percentage (1.3%) of the entire UK population. Bearing in mind that according to the 2011 Census 16% of the UK population is aged 65+ (Office for National Statistics 2011), it becomes clear that while 95% of people who have dementia are aged 65+, 93% of people aged 65+ do *not* have dementia.² Similarly, Prince et al (2014) report that 29% of people aged 90-94 have dementia, meaning that over 70% do not and nearly 60% of people aged over 95 do not either.

² Five percent of people with dementia are aged under 65 and 7% of people aged 65 and over have dementia (Prince et al, 2014).

The report devotes 26 pages, a quarter of its text, to estimating the cost of dementia to the UK. After exploring how to estimate health care, housing, social care, unpaid care, police costs, fire service costs, research costs, advocacy costs and £20,000 per lost year of life (from premature mortality of, on average, 18 months for men to 2 years for women), much of which was unsuccessful, it produced an annual estimate of £26.3 billion. To achieve this figure for such a tiny percentage of the population (1.3%), the report builds in £11.6 billion in *unpaid* care costs, setting values for this unpaid care that ranged from commercial replacement costs (£19 per hour), the national average wage (£15.50 per hour) and the National Minimum Wage for the carers's age bands. Carers aged 65+, being presumed to be retired, were allocated £6 per hour - demonstrating that even in the imagined world of hypothetical research older people are not thought to deserve equal pay for equal work.³ When we consider the lack of policy recognition to other unpaid care, including the care of children and workers (to make them fit and presentable for the next day's work) and the UK's Carer's Allowance for carer's of people with 'substantial caring needs' (£62 per week), it is difficult to see the justification for putting forward a figure of £11.6 billion on unpaid care for people with dementia.

The inconsistency in approach demonstrates that estimated costs need to be examined not in terms of their methodological shortcomings as a piece of research but as an intervention in the public perception of older people. By defining unpaid care of dementia care as an unaffordable cost to the UK, when it is not defined as such in relation to ill-health, children, workers and (slightly less aggressively) to disabled people, there is no alternative to the judgement that 'data' is being constructed. While it is unlikely that the Alzheimer's Society intended such, the alarmist presentation of the prevalence and costs of dementia can only fuel ageist stereotypes, stigmatising all older people as a potential social burden, and in an 'austerity' policy context fueling the view that older people are soaking up social resources (pensions, National Health Services), at younger people's expense.

³ When the Report was published, 2014, the National Minimum Wage required that those aged 21 and over be paid £6.50 per hour.

The credibility and effectiveness of such research, as an intervention in the public perception of older people, lies in its confirmation of ageist stereotypes; the view that older people are frail, dependent and disengaged from society and that it is younger generations who are socially and economically active and on whom society and economy depend. Yet nearly a quarter of people aged 16-64 in England and Wales are not 'economically active', meaning neither working nor seeking work (Office for National Statistics, 2015a). Whereas nearly a million people in England and Wales aged 65+ are in work, comprising about 10% of people aged 65 and over, and representing 3.5% of the work force (Office for National Statistics, 2015b). Sara Arber's analysis of University of Essex's Understanding Society Survey interview data of with over 11,000 men and women aged 60-79 finds that 21% of women and 18% of men aged 65-69 years are working (Arber, 2015). In the UK as a whole, 20% of unpaid carers are over 65, amounting to 1.3 million carers, and this is the fastest growing group of carers, growing three times faster than any other age group (Carers UK, 2014). The fastest growing group is aged 85 and over, 60% of whom are men and over half of carers aged 85 or more provide 50 or more hours of care per week (Carers UK & Age UK, 2015) . By age 59, half of women and by age 75 half of men are carers (Carers UK, 2014), caring for spouses, children, grandchild and friends. In terms of childcare alone, informal care plays a larger role in most families than does market-based care and grandparents, particularly the mother's parents, are the most important providers of informal childcare (Wheelock et al 2003); the importance of grandparents' care work extends to filling the 'parenting gap' between working parents and adolescents (Tan et al, 2010). The most frequent formal volunteers in the UK are aged 65-74 and nearly 30% of people aged 75+ are involved in formal volunteering through a group, club or organization (NCVO, 2015). These figures do not include informal volunteering to help cover social needs not, or inadequately, met by the State, including childcare, volunteering in schools, hospitals, hospices and out of school activities.

A number of studies recently undertaken in the UK have placed older people's experiences at the centre of research and this approach has demonstrated that

older people are socially connected and contribute significantly to their communities and families but that their participation is hampered, unacknowledged or undervalued (Vera-Sanso et al, 2014). Cumulatively the conclusion from these studies is that widespread negative stereotypes and prejudicial discourses about older people's needs, wants and capacities drives the overlooking of their social and economic contributions and marginalisation of their rights and leaves these factors out of the equation in investigating older people's health and wellbeing. Failing to address the structural obstacles to participation can only deepen inequalities between older people and these inequalities reflect a lifetime of inequalities based on gender and class.⁴ Until there is a shift from focusing on needs and social costs to researching what older people *do*, studies of the intersections of age and gender that do not reproduce age-and-gender stereotypes will remain scarce. It is only by analyzing how gender and class shapes what older people are enabled to *do*, under what circumstances and with what consequences for themselves and others, can research go beyond discourses that contribute to the stigmatization of older people.⁵

Confronting Stereotypical Discourse in India

In India health and health related research on old age also typically focuses on mental health, frailty and disability, food poverty and more recently on non-contagious diseases. The similarity of concerns with research on later life in Britain is not surprising as the social scientists who gained prominence in India were trained in the United States in the 1940-50s and attempted to relocate theories in sociology, psychology and social work to an India facing the effects of rural to urban migration, the fragmentation of refugee families resulting

⁴ See, for example, the Office for National Statistics (2014) on the social gradient in morbidities; for example taking two boroughs in London, Richmond, noted for its privileged residents, and Newham, noted for its disadvantaged residents the men and women in Richmond on average enjoy over 12% more of their life disability-free by comparison to men and women in Newham. In both areas men spend 2% more of their life disability free by comparison to women. Similarly national evidence on income gaps in later life show men's incomes to be 70% higher than women's (Arber, 2015).

⁵ For a sample of the few examples of a gender analysis of what older people do in the United Kingdom, see Arber and Ginn (1990), Arber and Timonen (2012) and Gray (2009).

from the Partition of India (into India and Pakistan) at Independence, and industrial employment practices (Sivaramakrishnan, 2014).⁶ Applying their expertise they defined these experiences as generators of 'psychosocial' tensions that could bring on and accelerate symptoms of ageing and senility. Just prior to Independence, key texts by Indian experts in disciplines new to India produced foundational myths of traditional India, three of which stand out for their impact on contemporary approaches to old age. First, a debate about labour reform and welfare provision for industrial workers resulted in the colonial appointment of the Labour Investigation Committee led by the economist B.P. Adarkar who continued to advise government on social insurance after Independence. Adarkar observed that the economically active age groups in Indian industry to be between 15-55 years and that older workers could fall back on extended family support in the villages when no longer able to work. He defined premature death as a more serious policy issue than old age and asserted that old age pensions were not a priority because 'every contingency could not be addressed' (Sivaramakrishnan, 2014:974). Second is J.M. Kumarappa, who later headed the Bombay School of Social Work and was influential with Indian nationalist leaders. He wrote movingly on the 'new poor' dependent on beggary in India's towns and cities. He posited the cause lay in broken working class families due to rapid changes in social life, rural-urban migration and the erosion of family networks that resulted in the new social evils of family neglect and immorality, leaving mothers vulnerable, children delinquent and the old destitute. The third is Jawaharlal Nehru, India first Prime Minister, who when enumerating the social groups comprising the country's social priorities identified children as having a 'first claim on us, because they represent the India of Tomorrow' and women were associated with an 'inspiring' history and tradition who needed to play a full part in the life of the nation: on older people he was silent (Sivaramakrishnan, 2014:974).

⁶ I am grateful to Sivaramakrishnan's work for making visible the historical roots to much contemporary discourse on formal sector retirement which, until recently, started at age 55, as well as discourses on senility and the traditionality of family support.

The legacy of this period has been the virtual total exclusion of older people from state provision and purview. It was only in 1995 the Government of India began to provide old age pensions for 'the destitute', that is those below the poverty line without any means of support, including no surviving adult son. The meanness of the sum allocated and the coverage of only 50% of those eligible for a pension (Alam 2006:230) continues the Nehruvian view that older people are irrelevant to India's development.⁷ This exclusion of older people from state purview is also visible in the National Family Health Surveys (NFHS) that inform health and social policy. The NFHS have age cut offs of 49 for women and 54 for men. The thrust of India's policy towards older people is also visible in the national policy on older people, the first of which was launched in 1999 in response to a United Nations General Assembly Resolution, and later versions that were also in response to further UN adoptions, including MIPAA. These policies have produced little beyond some concessions to middle class older people in terms of bank interest, tax and travel concessions. The main outcome of the policy has been the Maintenance and Welfare of Parents and Senior Citizens Act, 2007, that brought together under one Act extant provisions in prior acts requiring adult sons to support their parents. The new development was to extend this to all adult children and pre-mortem heirs, to enable older people to take cases to local level courts and to enable the courts to commit those who fail to support older people for up to three months imprisonment. The point, and certainly the main achievement of this act, coming as it did after 12 years of the social pension, was to reassert that families and heirs are responsible for older people, not the state.

⁷ The national social pension was launched under the Ministry of Rural Development in 1995 for those aged 65 and over, living below the poverty line, who have no means of support, do not beg and have no surviving adult son. Budget allocations did not support every older person eligible, so in 2000 those not covered by the pension became eligible for the Annapurna Yojana scheme of 10 kgs of free rice. In 2007 the surviving son bar was removed and the pension raised from Rs75 to Rs200 a month and has not since been raised despite an average inflation rate of 10%. In 2011 the eligibility age dropped to 60 years and pensions for people aged over 80 was raised to Rs500 per month. In 2015, in the State of Tamil Nadu, the surviving son bar was re-introduced.

In contrast to this discourse of a tradition of family support are watercolours and photographs from the early and late 19th century that depict people working into late old age, some in multi-generational contexts, some not. Similarly, survey data from the 19th century demonstrates that joint families, in which older parents live together with younger married children, were not more prevalent in the past (Shah, 1996). The degree to which the discourse of traditional filial support has been bracketed off from the known realities of waves of conquest and of class and caste relations (Habib, 2002) is striking; the poverty endured by those lower down the social hierarchy would not have allowed unproductive dependents. However, this creation of a mythical past is not new, as Shah (1996) and Sivaramakrishnan note 'the device of judging and reforming the present by making up a singular, traditional past when Indian family ties and social relations had been untouched by the onset of modernity was not new. It had already been the subject of middle class writings in the colonial period' (Sivaramakrishnan, 2014:978). The dominance of this discourse of the traditional past in contemporary discussions of older people's health and wellbeing is amply demonstrated by the work of one of India's leading social gerontologists, Irudaya Rajan. Together with Sanjay Kumar, in 2003, Rajan wrote an article, entitled 'Living Arrangements among Indian Elderly', for the peer-reviewed journal *Economic and Political Weekly* which is a key source for anyone researching India and for Indian policy makers. The six page article was based on an analysis of the 1992-3 National Family Health Survey, examining the extent to which older people are co-residing with their children; the argument being that older people's economic security is a 'major issue' if they are not co-resident. Setting aside the authors' presumption of economic dependence, this article produced the valuable finding that 88% of older people co-reside with children and grandchildren, 9% of older people live alone or as a couple, many households accommodate more distant elderly relatives (in-laws, aunts and uncles), 2.4% of older people live alone and 3.5% of older women live alone. The conclusion to the article was that the evidence 'reinforces the conventional notion that the family is still taking care of the elderly in a big way' (2003:80). This is conventional as it is the argument put forward for not providing a universal state pension: families support the old.

For our purposes this article is significant in two respects. First, it shows that the often repeated public discourse of failing family values is *not* supported by patterns of co-residence. Second, that peer reviewed articles on Indian gerontology end up reproducing dominant discourse on failing family values, despite the article's evidence and main argument – whether that is the outcome of peer review is not possible to determine. The article begins with a lengthy paragraph stating that the 'caring of the elderly by family members... has been a practice down the ages' (2003:75) and that rising longevity, lowered fertility, increasing female labour force participation, age selective rural-urban migration, 'the spread of western culture and lifestyle, and growing individualism, among other factors have had their impact on the traditional family system' (2003:75). The overall policy conclusion is 'a suitable policy measure needs to be framed towards *restoring* familial care for the elderly in the *unavoidable* circumstances of *drastic* society changes in the wake of modernisation' (2003:80), despite the lack of direct evidence on care in the data set to support such a conclusion. And while the authors do make a one-sentence statement that pensions are required (2003: 80) and co-residence is no guarantee of care and financial support (2003:75), the effect of the more extensive framing of the analysis within a discourse that goes back at least to the 1940s, just prior to Independence, is to let India off the social-welfare hook; older people *are* living with relatives and those that are not should be.⁸

By relegating the support of older people to the family in a context of 93% of people working in low-paid insecure work and between 30-70% of people below the poverty line,⁹ it is clear that the State is placing them in competition with other generations for very limited household resources. As stated earlier, there is little direct evidence of older people's health in India as the country only regularly samples the health of children, women to the age of 49 and men to the age of 54. However, as a country with more stunted children than the

⁸ By comparison to the low-income countries of Bangladesh and Nepal which put 0.08% and 0.32% of GDP into social pension India, a lower-middle income country, only puts 0.03% into social pensions (pension-watch.net).

⁹ The official government poverty-line produces 29% below the poverty line; the World Bank definition of less than US1.25 purchasing power parity places 42% below the poverty line; a Multi-dimensional Poverty Index includes 55% of people (Horton and Das, 2011). A \$2 a day poverty line would include 70% of people.

whole of sub-Saharan Africa and with high rates of anaemia amongst women up to age 49 women (56% in 2005/6), which is positively correlated with lower wealth status (Balarajan et al, 2013), it is extremely likely that a large proportion of people aged 60 endure a significant degree of poverty related health outcomes, as well as the non-communicable diseases widely understood to be age-related. Research on inequalities in food consumption undertaken in rural India in 2009-10 found that the bottom 20% of the monthly per capita expenditure quintiles ate an average 33 kg of food (all food groups) while the top quintile ate an average of 50kg (Gupta and Mishra, 2014) and that suggests the likelihood of poor nutritional status of older people. This extrapolation is supported by a small study of active middle aged and older villagers in northern India that found 40% had a BMI as low as 18.5% (Prasad, 2013), a four-village study in South India of villagers aged 60 and over found nearly 50% had a BMI of 18% and 53% had anaemia (Purty et al, 2005) and a further rural study in South India that found 63% of people aged 60 or more were malnourished or at risk of malnourishment and 60% had deficient protein energy intake (Vedantam et al, 2010). Taken together this data demonstrates that for a large section of the population families cannot provide adequate support for anybody, irrespective of age and gender. In terms of gender differentials, there is evidence from the Census of India's National Sample Survey (NSS) data for 2007-8 that reveals differences: men over 60 do receive more food than do women over 60, but the most significant difference is to be found in health expenditure where, in a country with one of the highest rates for out of pocket expenses, 85% of household expenditure on people over 60 is spent on men, though the expenditure on elderly health care is not even 1% of the total household expenditure (Maharana and Ladusingh, 2014). This research found that older people received less than one-tenth of total household food expenditure and that household expenditure on education had risen from 0.3% to 6% between 1999-2000 and 2007-8. This evidence on family resource distribution suggests that the central issue for older people is not so much gender differentials but inadequate social provision, which families are trying to compensate for in the context of a vicious labour market, including by directing family resources towards the youngest generation in the hope of better futures.

In such a context it is necessary to explore not just what older people receive from families but how *they* support families. The 2004-5 NSS revealed that 38% of people aged 60 and over are working and that they represent 7% of the workforce which, at the time was approximately their percentage in the population (Selvaraj et al, 2011). However, as many older women are not recognised as workers in family businesses, despite putting in many hours of work (being categorised, instead, as ‘passing time’ or merely ‘helping out’) it is unlikely that they would have been enumerated as working – making the figure of 38% working an underestimate. Research undertaken in five of Chennai’s slum settlements between 2007-10 and 2012-13 with an 800 household survey and 179 household semi-structured interviews and observation of street vendors in one busy street market revealed older people were engaged in over forty occupations, reflecting the specificities of local economic opportunities.¹⁰ Yet this did not represent the wide range of activities older people could be seen engaged in across Chennai so we undertook what might be called a convenience-based photo survey of older people’s that the research team came across in the city over the life of the project. This research revealed that the older urban poor are engaged in every sector of the urban economy, including financial services, manufacturing, construction, transport, retail, and services, as well as the delivery of international development initiatives (Vera-Sanso 2012). It found that older people play an essential economic role as a reserve army of labour, filling the economic niches no longer filled by younger people, due to lowering child labour/raising school enrolments or the movement of young people into more modern work contexts. The result is an age and sex-segregated labour force where, for instance, older people are concentrated in street vending and younger people work in shopping malls and department stores, where cycle rickshaw pullers are old men and taxi drivers are young men – where young

¹⁰ The 2007-2011, project *Ageing, Poverty and Neoliberalism in Urban South India* (RES-352-25-0027), was part of the AHRC/ BBSRC/ EPSRC/ ESRC/ MRC New Dynamics of Ageing research programme (2005-13). The research team were: P Vera-Sanso (PI), V Suresh, M Hussain, H Joe, A George, and B Harriss-White. The 2012-13 *Ageing and poverty: the working lives of older people in India* ESRC Follow-on Funding (ES/J020788/1). The research team were: Penny Vera-Sanso (PI), V Suresh, M Hussain, S. Priya and J Longina.

men earn 50% more than older men and where men aged over forty find it increasingly difficult to secure work because of a large youth population (to age 29) seeking work.¹¹

In this context of age discrimination in male employment, households have to push more people into the workforce. In the 800 households surveyed only 2% of children aged 10-14 were working, reflecting the widespread acceptance of education in this part of India. Consequently, women began to take up work from the age of 30, in response to the declining incomes of their older spouses. These women relied on older women to take on their care and domestic work. While most relied on relatives, including relatives not living in their household, others paid older women to cover time consuming tasks such as waiting in line to collect water from water lorries. Once drawn into work women tend to stay in work, though that work may change: some older women took on more domestic and caring roles, some work in family businesses, though often defined as 'passing time' or 'helping' and some went into paid or own-account work. The outcome of age discrimination in male employment was a switch to increasing involvement in work for younger women, the extending of paid and

¹¹ In order to demonstrate the wider relevance of research in the context of negligible research on older workers and in order to garner a better idea of the extent of older people's work across India we launched a national photo competition with *The Hindu*, one of India's most widely read newspapers. This produced nearly 3,000 photographs of older people working across the country, virtually all in the informal economy (The Hindu, 2013). The photographic competition demonstrated that older people are engaged in a huge range of work from farming, salt-panning, brick making, cotton-picking, carpentry, vending and guiding Himalayan tourists, to railway track inspecting. The research project's approach has been to trace the forward and backward linkages of older people's work. If we apply that approach to the work of the older track inspectors whose dangerous, arduous and isolated work younger people are unwilling to take up, we cannot avoid seeing how critical older people's work is. The Indian Railway, whose revenue in 2013-14 was \$23bn, as India's largest employer and biggest consumer and transporter is absolutely critical to India's economy – all dependent on men inspecting railway tracks at ages well beyond retirement age in order to ensure the continued functioning and safety of the network.

unpaid work for older women, often into deep old age and a declining capacity to earn for middle aged and older men.

It is the inter-section between the informal economy and the huge shortfalls in state provision of social and physical infrastructure that determines older people's health in India. Caught in the informal economy, without job or income security, holiday or sickness pay and no social pension worthy of the name, the vast majority of people living on low-incomes are forced to work as much as they can. The Chennai research found that most people, including older people, work 6-7 days a week. In some trades, such as vending, older women could be working 78 hours a week, setting out for the wholesale market at 4am and finishing work after 9pm. Low incomes, lack of work security and welfare provision, under-resourced and often distant and poor quality public medical services and poor education provision (which forces families into low-quality private education) all work to ensure that older people cannot afford to take time off to access state health provision or to convalesce.¹² As one 72 year old female vendor, who supports her widowed and disabled son and his children, succinctly put it 'if I have the cataract operation I need a month to recover – who will feed my grandchildren and pay for their school fees?'. Consequently older workers have the choice of private health care or doing without the care they need, many merely describing their symptoms at a pharmacy. Medicines that are not obtained from public institutions are unaffordable, giving people the choice of repeated loss of income, as hospitals dole out medicines on a per diem basis (Ergler et al, 2011), or selecting the cheaper elements from a prescription, or pharmacy recommendation, which will allow them to continue working. The outcome is reliance on painkillers and the sporadic use of anti-biotics and other medicines.

It is not just paid older workers who are not having their health needs met. Anyone in low-income households who needs to be cared for at home or in public hospitals (where nursing and food are not provided) jeopardises the livelihoods of family members working in the informal economy as they have

¹² See Ergler et al (2011) for the factors determining whether Chennai's poorer residents select private health over public health services.

no right to time off. This level of precariousness forces family members, particularly older people, to forego necessary medical care and medication on the basis of direct costs and potential livelihood impacts. For example, a study of all older people in one of Chennai's slums found that 40% of older people's illnesses were not treated despite the proximity of public and private health facilities (Balagopal, 2009).

Economic precariousness exposes older people to the health impacts of long term poverty and of global economic turbulence. Surveys of household income undertaken in the five Chennai slums studied, covering November 2007 to May 2009, found that the global financial crisis, global food price hikes and climate shocks had cascaded down to the settlements studied, forcing families to cut steeply into their food consumption, shedding protein and vegetables and in some cases dropping to one meal a day, while increasing their hours of work (Harriss-White et al, 2013).¹³ By May 2009 people reported some improving food consumption. In autumn 2012, we returned to the settlements to uncover what advantage a pension increase from Rs400 per month to Rs1,000 per month (\$7.50 to \$18.80) had for the people lucky enough to have secured a pension. We found that the increased pension had not released older people from the need to work but they did report an easing of uncertainty. They knew that there would be enough rice for two-thirds of the month, or they could buy more of the medicines they needed, and the self-employed could take a day or two per month off work when sick.. . However, it did not extend to enabling them to access public health facilities if sick enough, or distant enough, to require help from a working relative. The reason why the sizeable pension increase of 2011 (in percentage terms) did not do more for older people is that the pension, which had last been raised in 2007, had been allowed to depreciate significantly. Unfortunately, at the time of writing, in summer of 2015, the pension in Tamil Nadu, which is one of the most generous in the country, remains unchanged since April 2011 at Rs1,000 per month.

¹³ Research undertaken in Delhi slums between 2011-12 identified similar strategies to cope with food insecurity (Gupta et al, 2015).

Far from confronting significant hardship, in India the contemporary thrust in social provision and urban planning is sharply against reducing inequalities in livelihoods and access to state resources. Instead welfare measures, such as the non-contributory pension, food security provisions and workfare programmes are being reduced, stalled or poorly implemented. Urban planning has progressed from the 'Slum Free Cities' programme of slum demolition and resettlement at significant distances from the city (30km in Chennai's case) with deeply inadequate infrastructure, transport, educational, medical provision or work opportunities (Coelho et al, 2012), to the '100 Smart Cities' programme, the promotion of which is notably silent on poverty and inequality, is producing yet again 'islands of California in a sea of sub-Saharan Africa' (Dreze and Sen, 2013:ix). Plans to double public spending on health from 1% of GDP to 2% were put on hold in 2015. New contributory schemes for pensions for people in the unorganized sector and for farmers are now being introduced, as are disability insurance and life insurance. These measures will not help the vast number of people, who are not earning enough to eat regular meals, who are not employed regularly and with sufficiently generous incomes to make contributions to pension and insurance schemes. They are less likely to be taken up by women and especially middle aged women who face age and gender discrimination and may well be the only or main income earner in the household. Nor do these measures recognise the importance of preventive medicine and health promotion over curative medical care; the importance of food, water, shelter, sanitation, education and other basic needs (Narayan, 2011). As Sengupta and Prasad argue: 'the current framework of economic growth is not designed to address the concerns of very large sections of the population, for whom it has directly perpetuated the situation of ill health and inadequate health care' (2011:15).

This brings the discourse on filial support of older people into perspective. By framing Indian tradition as one of family support for frail, old, dependent persons within an undifferentiated past the discourse de-legitimizes questions regarding social inequality and the *capacity* of all families to support or look after older people now (or in the past). By overlooking the necessity of older people to undertake paid and unpaid work to support their families, the discourse enables India to turn a blind eye to older people working long hours

into deep old age while benefiting from an enlarged, low-cost labour force. By defining care and support as happening within the family, the need for social infrastructure becomes secondary to stigmatizing families that cannot support older people and pulls the inadequacies of physical infrastructure out of the frame.

Conclusion

This chapter has made four arguments. First, public pronouncements on what older people are, do and need should be examined as discourses, as attempts to structure ways of thinking. In the United Kingdom the Alzheimer's Society's presentation of data on older people, which was aimed at raising the profile of the disease served to erroneously heighten the association of old age with dementia and presented older people as an unaffordable burden on society. Defining older people's care as publically insupportable or inter-generationally unjust is a necessary step in legitimating a reduction in public support. In India the discourse of traditional filial support for older people and of children as having the first call on national resources has enabled the government to avoid getting caught in provision for older people beyond a thin tokenism. Second, these discourses present older people as frail, dependent and vulnerable, overlooking the significant contributions older people make to family, community and economy through their volunteering, unpaid family work and paid work. Third, that the evidence base of what older people do, rather than what they need, remains under-developed and until we shake off stereotypical assumptions of what should be studied in relation to older people we cannot provide an adequate analysis of the intersection of age, gender and class. Fourth, health and access to health care need to be understood from a much wider perspective than health care provision; determining factors range from vulnerabilities in the labour market to social and physical infrastructure provision and this is as true for older people as younger ones.

Despite the unlikely comparison of older people in the United Kingdom and in India's slums, we can see that older people in both contexts are vital, yet widely over-looked, contributors to national economies through both their

paid and unpaid work. Most face ageism and age discrimination to some degree but those whose situation is most difficult, older people living in India's slums, suffer the multiple deprivations of income insecurity and inadequate state provision of social infrastructure (health, pensions and education) and physical infrastructure (water, sanitation, storm water drainage). Their families, who are caught in equally precarious arrangements that bear down on their health and survival, are as likely to need older people's help, both financial and physical, as they are to provide it. The solution to a poverty that combines stigmatisation, marginalization and being overlooked with economic insecurity and health deficits lies in recognising that 'poverty persists because the concerns of poor people are (kept) invisible and their needs unpoliticized' (Mosse, 2010:1165), thereby enabling poverty and its consequences to appear unexceptional, even normal (Gupta, 2012). We need to recognise that ageist assumptions regarding older people's dependency and the younger generation's capacity, not only misconstrues the reality, and mutuality, of lives (especially those lived in precarious conditions) but also entirely misses the degree to which national economies are dependent on the paid and unpaid labour of older people, a realization that would help upend stigmatizing discourses. If we fail to tackle ageism in research design, studies of the intersection of age and gender can only serve to reinforce the stigmatizing discourse of burdensome, vulnerable and isolated elderly women and men.

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