CHAPTER 6

The Value of Care

Abstract  During the coronavirus pandemic in the UK, attention increasingly focused on the death rate of elderly and disabled residents in care homes, as well as the staff. On 29 April, 2020, the news came that deaths the previous week in these institutions – far more dispersed and numerous than those of the NHS – had exceeded those in the latter’s hospitals. Although it had been clear from the first stages of the pandemic that older people with established preconditions were far more vulnerable to its impact than young, physically fit people, it was shocking that those who could do nothing to safeguard themselves through isolation were supplying the virus with concentrations of easy victims in this way. Furthermore, the high proportions of Black, Asian and minority ethnic staff in these homes, and their lack of personal protective equipment, made them doubly vulnerable to the virus.

Keywords  Vulnerability • Older people • Residential care • Black Lives Matter

The care home residents were from the generation which had fought, suffered and survived the Second World War, yet they were now being exposed once more to the highest risks in the face of a new deadly hazard. Furthermore, residential care, and services for elderly and disabled people in the community, represented the longest-running unresolved policy
issue in the social services in the UK. It was a reproach to the democratic process that, despite repeated pledges by the political parties, and the availability of examples of the same issues being eventually negotiated and resolved in other European countries, the evidence of the harm to this generation’s well-being due to these failures was now clear in grim statistics.

There were many reasons why this situation had been allowed to develop. Perhaps the most fundamental was that the historical mode of care for those older people who survived past pandemics and the hazards of working life involved women’s roles in extended family households. For instance, at the time of the Spanish Flu of 1919, women’s participation rate was around 35 per cent, and during the peace that followed until 1939 it remained roughly stable. Overall, service jobs (including domestic service, which made up around a third of their employment) grew by 33 per cent, as manufacturing work, mainly by men, fell by 3 per cent between 1920 and 1938 (Feinstein 1976, Table 59, p. 129). Women played a crucial role during the Second World War, but then resumed household roles in large numbers when peace came. In the 1960s, they were catching up with developments in Sweden, but ahead of those in Germany; between 1951 and 2018, the total figures for economically active women increased from seven to over 15 million (Office for National Statistics, Labour Force Survey, 2019).

The contraction in industrial employment and the growth in service work were key factors, but many of the new employments were part-time, and women’s earnings were supplementary to those of their partners (Pahl 1984). The political parties were slow to recognise that, as life expectancy increased, women were bearing the heaviest burdens, as carers for their parents as well as their children, in addition to their roles as contributors to household earnings. In Britain in 1983, 5 per cent of all men and 15 per cent of all women over 80 were being looked after in their children’s households (OPCS, General Household Survey, 1983, Table 3.7, p. 15). But the supply of family carers was declining; at that time it was already forecast that the average couple in their 80s, which had 40 surviving female relatives, would have only 11 when reaching that age in 2000 (Ermisch 1983, p. 283).

This prospect was recognised by the political parties, but other priorities always supervened. Following the White Paper ‘Caring for People’ (1989) and the NHS and Community Care Act (1990), local authority care services had been re-organised and contracted out to private
companies. But also because of the low status of work in care homes, and the fact that most of the electorate had little contact with this sector except at the end of their elders’ lives, the issue did not command much priority. The establishment of a truly national system of care, on a par with the NHS, and directly funded from taxation or social insurance contributions, in line with Continental developments, was seen as unlikely to pay electoral dividends.

The coronavirus pandemic exposed the weaknesses in care systems in a tragic way. By 29 April, 2020, deaths in UK residential homes exceeded those in NHS hospitals (Channel 4 TV, ‘News’). There was too little testing for the virus, and too little PPE, and what there was came too late, as staff and residents succumbed. The huge number of homes, dispersed all over the country, many in isolated rural locations, made them less accessible for these protective measures than they were for the virus.

Looking back on these tragedies two months later, the Chief Executive of one group, Goldcare Homes, where 169 residents had died, said that there would have to be closures of some of his facilities, because of low occupancy, a fall in admissions and loss of income – numbers of self-funding residents in particular had fallen. One report said that county councils were building their own homes for the first time since the 1980s. The government was giving £3.2 billion in support for the sector, and £600 million for measures to prevent infection. The report recommended higher minimum wages for care workers, and better training and status, in recognition of their heroism and sacrifices during the pandemic (BBC Radio 4, ‘You and Yours’, presented by Winifred Robinson, 18 June, 2020).

These tragedies were not confined to the UK. At the end of April, 2020, it was reported that there had been 20,000 deaths in Spain’s residential homes since early March, over half their populations. The loss of life was initially covered up by the government, but broke in the press because of disclosures by relatives of residents at the Montermoso home, a four-storey 120-bed facility on the outskirts of Madrid, which also provided day care for the district’s needs. The home stopped responding to relatives’ telephone calls on 17 March, when the national lock-down had just started, by which time 46 were dead. Ambulances refused to visit the home, and the funeral company was causing delays in collecting the bodies. When the military arrived, there were many dead bodies in the rooms which they had been sent to disinfect.

In one case, an elderly couple had gone on sharing a room for six days after the wife became ill; she died on 16 March, after having been refused
admission to the local hospital. An Alzheimer’s Disease sufferer, her husband was holding her hand at the moment of her death. By then some 65 residents had symptoms of the virus, as attention of politicians and the media focused on hospitals; care staff and residents in homes lacked PPE. The virus was rumoured to have come to Spain through a man who had been skiing in the Alps, and the delay in publicity about the plight of care home staff and residents (in contrast to hospital patients) was attributed to the insecurity of the non-unionised status of the former workers and the power of private home-owners (BBC Radio 4, ‘Crossing Continents’, ‘Spain’s Care Home Nightmare’, presented by Linda Presley, 30 April).

One of the surprising features of statistics on SWB is the fact that – in the advanced capitalist democracies – older people have the highest levels of well-being. This may reflect the fact that their citizenship status and rights are the least contested in the age groups. Retirement pensions – historically the first to be granted in liberal democracies, and the least conditional – have tended to be more generous than benefits for other age groups, as well as largely unconditional. If media stereotypes of older people are often insultingly patronising, at least they do not present them as dangerous deviants. The popular press and TV channels are constantly on the lookout for old people who – like the Second World War veteran Captain Tom Moore – are courageously battling ill-health to perform unlikely feats such as walking for many miles to raise money for charities, even on their hundredth birthday (BBC Radio 4, ‘Today’, 30 April, 2020).

So, whereas the public provision of care for children raises a whole series of hotly disputed issues (over the state’s capacities and duties to support and police parenting, to socialise young people, and to supply substitute families for those who lack suitable ones in which to grow up), both income maintenance and care for older citizens have historically been much less disputed fields for policy. But there are still important questions about how services can bestow the highest levels of social value on their ways of life.

For instance, as work (including much service work) becomes more automated, should this allow earlier ‘retirement’ from the labour market, or should people work fewer hours per week over a longer period? Should we see residential care as a ‘last resort’, or could it be transformed into a way of life with more social value than a potentially isolated experience at home? And if the UBI becomes available for people of working age, should there be a different system of income maintenance beyond a certain age, or should older people be part of the same tax-benefit regime as younger ones? These questions will be explored in the final two chapters.
The Genesis of the Problems

The underlying issue for this field in social policy was the growth in the numbers and proportion of the UK population aged 70 and over. Between 2008–9 and 2018–19, those in England aged 65–74 increased by 21 per cent, aged 75–85 by 14 per cent, and aged over 85 by 20 per cent. Of all those over 80, 44 per cent needed some kind of help with daily life. Meanwhile policies for de-institutionalisation in the fields of mental illness and mental handicap had led to the establishment of large numbers of small-to-medium-sized units in communities, some run by local authorities, others by private providers. Many residents were older people.

Under New Labour, a White Paper on services for adults (Department of Health 1998) had criticised local authorities for failing to support people with disabilities and chronic illnesses in their homes. The personal social services had for some time been shown to have difficulties in meshing with family and neighbourhood networks of support for older people (Finch and Groves 1984). Research by Challis and Davies (1985) had shown that lack of flexible and intensive packages of home care had caused unnecessary admissions to residential homes – an experience which the sociologists Miller and Gwynne (1972) had characterised as ‘social death’.

However, it took a number of scandals and deaths of care residents for the system to be reformed. Under the 1990 Act, 90 per cent of care provision was to be in privately owned homes, rather than ones owned by local authorities. Between 1980 and 2001 the proportion of residents in private homes rose from 18 to 85 per cent; by 2005 it was 90 per cent (Johnson et al. 2010, p. 236). A number of companies owning such homes went bankrupt in the financial crash of 2008–9, but by far the most notorious such collapse was that of Southern Cross in 2011.

At the start of that year, Southern Cross owned 750 care homes all over Britain, employing 44,000 staff and accommodating 31,000 residents, of whom about 70 per cent were funded by local authorities. In the North East of England they were providing 30 per cent of all care home beds (House of Commons Public Accounts Committee 2011). But this situation represented the outcome of a frenzied round of transactions which had little to do with the well-being of frail elderly people, and a great deal to do with financial capitalism.
In September, 2004, the New York-based equity giant Blackstone had acquired Darlington-based Southern Cross Healthcare, a company with New Zealand origins, for £162 million, which had previously been owned by a similar firm, West Private Equity, for two years (Drakeford 2006; Scourfield 2007). Then Blackstone sold off the freeholds of these homes, partly to help finance the purchase of another huge group of private nursing homes, NHP, based in Surrey, which also managed another 165 homes through its subsidiary company, Highfield Care.

These transactions were motivated entirely by profit; Blackstone simultaneously bought a German chemicals company, the Dutch telephone directory supplier VNU, and a French cinema group. By this stage, care homes had become commodities to be traded, with little regard for the well-being of their residents. Because Southern Cross had sold the freeholds of its homes, it was vulnerable at the onset of the 2008–9 financial crash, because it was paying rents for the land on which they stood, which by 2011 had risen by 18.6 per cent in a period when property values were falling; these totalled £250 million a year, to 80 different landlords, including two banks which had been nationalised during the crash. Southern Cross posted half-year losses of £311 million in May, 2011, and a month later it ceased to exist (Jordan and Drakeford 2012, pp. 88–91).

This was by no means an isolated example. In the wake of these events, it emerged that Qatari Investment Authority, one of the largest owners of that group’s freeholds, was a company registered in the Cayman Islands, a tax haven. One of the largest new owners of Southern Cross’s chain was a new company, NHP, whose founder, Dr Chai Patel, had been chief executive of Westminster Healthcare when a resident of one of its homes, Lynde House, had been neglected and mistreated, a scandal exposed by the London Evening Standard. Another set of questionable financial transactions surrounded the Four Seasons group of homes, where suspiciously high rates of profit appeared in their accounts of October, 2011 (GMB 2011).

What all the cases illustrated was that ‘care’ – nominally a set of relationships through which the social value is expressed in looking after the most vulnerable and dependent members of the population – had become detached from the task of maximising their well-being, and was instead organised around gains through financial trading. Once again, the tensions between relationships appropriate for emotional flourishing (or at very least, a life without emotional suffering), and the competition for material wealth, had put at risk the former for the sake of the latter.
Furthermore, and of even more concern in many ways, it became clear in mid-May that the NHS had looked after its own professional and institutional interests at the expense of the care system. By the second week of April, 40 per cent of deaths in England had been in care homes. Advice had been given by government, which remained uncontradicted between mid-February and mid-March, that there was no risk of a coronavirus outbreak in care homes, in spite of warnings in previous years to local authorities that the sector was vulnerable to such infections; the new evidence was that 10,000 more deaths than in previous years occurred during this month. A payment of £600 million for infection control to the care sector was very belated; local council finances were in crisis, with a £10 billion gap in their funds (BBC Radio 4, ‘Today’, 14 May, 2020).

As the low priority given to this sector received critical attention in the media, the fact that many care staff, especially in London, were from ethnic minority backgrounds, and that they seemed more vulnerable to the fatal effects of the coronavirus, was also made more prominent. This connected with the outrage about the police killing of George Floyd in the USA, and the rise of the Black Lives Matter movement in the UK also, to form the focus of protest mobilisations (see Chap. 7).

**Revaluing Older People and Their Care**

Older people are a group in societies whose well-being is most fragile; they are vulnerable to illnesses and accidents at the best of times, and the coronavirus pandemic made them doubly so. Under normal circumstances in the UK, they could expect to receive domiciliary support, especially if they lived alone, both during illnesses and after a period in hospital, and as their mobility declined.

But the residential care (which normally marked their transition to dependence on a more intensive form of practical assistance) was usually seen as supplying a form of security, after a process of growing risk (from falls, or the loss of sight, for instance). Suddenly, being in a care home meant exposure to the highest risk to health and life itself, with the onset of the pandemic.

Furthermore, hospitals now had incentives to discharge such patients as fast as possible, to keep their own rates of infection from Covid-19 down. This added to the vulnerability of the residents of care homes.

The real reason, surely, why social care had not been integrated within the NHS in the UK was that the medical profession was unwilling to be
seen to accept as a full partner something as unprestigious as practical help for people with Alzheimer’s disease or mental or physical disabilities. Care continued to be seen as an adjunct to medicine which was concerned with residual tasks, once every remedial procedure had been performed.

The price for these hierarchical assumptions was paid during the coronavirus pandemic. There continued to be thousands of dispersed care homes, owned by private firms, many with only a few establishments; they were underfunded, and some were understaffed. As the hospitals filled up with victims of the pandemic, there was soon a drastic shortage of places for those older patients cured of it to be discharged for the further care they needed. There is now evidence that patients (both those with other conditions and those who had been suffering with coronavirus symptoms) were discharged to care homes before they had been adequately tested (BBC Radio 4, ‘PM’, 13 May, 2020). Soon deaths in care homes exceeded those in hospitals; the number of deaths in care homes from mid-April to early May was three times the average number of previous years, while those in hospitals were lower than the average for that time of year (ibid.).

Then the virus itself began to infect the homes; once it penetrated them, it spread like wild-fire among residents and staff. In this emergency, some homes resorted to a system by which the staff decided to lock down with the residents, to avoid bringing in the virus or taking it home (BBC Radio 4, ‘Today’, 30 April). This decision indicated a dedication and commitment by staff which did much to expunge the notoriety associated with the homes during the financial manipulation at the start of the decade.

As nothing else in the long and indecisive debate about the future status of care had done, the pandemic focused on the need for a fundamental overhaul of the system. It was a national scandal that care homes had become the most unsafe environments in the UK for citizens to find themselves; but it indicated the consequences of decades of indecision and postponement in this field of social policy.

As I have argued throughout this book, interpersonal relationships involve the creation and exchange of social value, but these processes are vulnerable to the corrosive effects of economic, power and criminal forces. Services such as the care of elderly, chronically ill and disabled people are especially vulnerable to these influences, because the decision to enter residential facilities usually follows a long and painful chain of events, in which family or other informal care has broken down. Very often this arises from the illness of the person most involved in care-giving, and it can happen
even after much support from domiciliary services has been received over a prolonged period (Jordan with Jordan 2000, pp. 89–95).

Although the finance of care has been an unresolved problem for many decades (Dilnot Commission 2011), the machinations of the very large care home owners who use them as a source for various kinds of international property deals and tax-avoidance scams should not obscure the vital role of this work in an age of increased life expectancy. As the coronavirus pandemic has reminded everyone, some of the citizens who have been losing their lives to the Covid-19 virus are the people who defended liberal democracy against totalitarianism in their early adult lives, and who surely deserve better.

Currently, life expectancy for men of working age in the USA is falling. The causes of death which are bringing this about include obesity, alcohol and drug abuse and suicide; the highest rates are in rustbelt former industrial areas with high unemployment (BBC Radio 4, ‘News’, 27 November, 2019). In the UK, it is the life expectancy of working-class women that is falling. In each case, this seems to be one of the consequences of greater inequalities in their societies.

The insurance industry has high-status lawyers and economists concerned with placing a financial value on human lives. This became the focus of attention as a result of the random deaths of victims of terrorism, such as the 9/11 attack in New York. Some of these were stockbrokers and bankers, others maintenance workers or passers-by in the street below. In a radio broadcast (BBC Radio 4, ‘How to Value a Human Life’, 6 May, 2020), the lawyer Ken Feinberg said that the estimate of what one person could earn in a lifetime varied between $750 million for a stockbroker and $850 thousand for an undocumented immigrant waiter. Emotional loss was measured in standard amounts – $250 thousand for a spouse, $150 thousand for each surviving child. But survivors reported that the process of claiming for physical and psychological suffering and the costs of treatment felt like begging, not a right.

Parallel with this, the UK committee evaluating whether the NHS should purchase a new drug, NICE, used the concept of QUALYs (Quality-Adjusted Life-Years) to reach their decisions. Thus they applied a trade-off to their decisions: length of life versus pain and suffering. But the value of relationships was not included (Institute of Government 2019). The coronavirus is a new challenge, since millions of lives, and possibly even the ‘fate of humanity’, appeared to be at stake – more like climate change than a normal illness or accident, though perhaps comparable with the impact of a typhoon or tsunami.
On 29 April, 2020, cancer experts predicted an extra 18,000 extra deaths from this disease being untreated in the UK because of the priority for pandemic victims, but in reality the power of the medical profession ensured a very different outcome. In the second week of April, 40 per cent of all coronavirus deaths were in care homes. By the middle of May, the death rate in care homes in the UK was greater than that in hospitals.

It had become clear that the government had mishandled the issue from the start. Questions in the House of Commons in mid-May revealed that for a month from mid-February, the government had advised that there was no risk of an outbreak in the care sector. Hospital patients were not tested for Covid-19 before being transferred to care homes. In the event, care home deaths were 10,000 more than the average for previous years during these months. The care sector had just been given a belated extra £600 million for emergency measures (BBC Radio 4, ‘Today’, 14 May).

**Conclusions**

The neglect of the sector over decades was reflected in these appalling statistics, in which care workers as well as elderly and disabled residents were victims. The Chair of the National Care Association said in retrospect that the sector had been used to protect the NHS, and staff felt completely abandoned; the government had been badly advised. Visitors were allowed long after this was obviously risky (BBC Radio 4, ‘Today’, 14 May, 2020). It was in this sector that the impact of Covid-19 most closely resembled a major natural disaster; the post-pandemic policy landscape, already crowded with urgent issues, should surely include this one as a high priority in the aftermath.

Meanwhile, the NHS was struggling to balance its response to the coronavirus with its other main priorities. Partly because of fears by patients about self-referral in a period of pandemic, investigations of suspected cancer fell sharply, along with those for suspected heart and lung problems. Numbers of patients arriving at Accident and Emergency Departments of hospitals fell to half the usual figures. While some of this was due to the fall in traffic accidents on the much emptier roads, it also indicated some concern by citizens not to overtax the services in this period of crisis (BBC Radio 4, ‘World at One’, 14 May, 2020).

Solidarity, expressed in applause for the NHS each Thursday evening, was transferred to the care sector as the extent of mortality in residential
care was revealed, and a time to express support was allotted. But it was symbolic of the differentiation of status between cure and care that this was far less widely observed.

The tragic toll of deaths in care homes has reminded the UK electorate of how long a period has elapsed since their re-organisation and upgrading was first mooted. But these more fundamental issues of social value in services have not all been made explicit. The origins of some of these and other omissions will be considered in the next chapter.

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