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New Sociological Perspectives

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The Biopolitical Economy of Dying in Care Homes

A Theoretical Framework

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Introduction

This chapter proposes a theoretical framework to analyse the role of care homes in the care of dying people in England. Care home residents account for almost 30 per cent of all deaths in England (NEoLCIN, 2017a) and 20 per cent of all English deaths occur in a care home (PHE, 2023). Therefore, whether residents die in the care home or hospital, care homes and their staff play a strategic role in the national provision of care towards the end of life. However, sociological theories on the intersection of residential care, end-of-life care (EOLC) provisions and dying are limited. Social gerontology has mostly overlooked the question of dying, especially in relation to the residential care of older adults (Gott et al., 2008). By contrast, sociological studies of EOLC and dying have mostly focused on dying from cancer and dying in hospital, hospice or domiciliary settings (Ellis et al., 2016). Of the few sociological studies of EOLC and dying in care homes that do exist, they mostly build on the anti-institutional literature of the 1960s and 1970s (see Froggatt, 2001; Hockey, 1990; Page & Komaromy, 2005; Komaromy, 2005; Komaromy & Hockey, 2001).

The anti-institutional literature reduces the power issues which are active in the care home context to the context itself, focusing on the interactions between residents and staff and the dominance of medicine and the medical professions in shaping these interactions (Goffman, 1961; Townsend, 1964; Illich, 1982). This has produced a theoretical gap concerning the role of care homes within the provision of social and EOLC to frail and disabled adults aged 65+. To address this gap, this chapter proposes the *biopolitical economy of dying in care homes* as a theoretical framework to analyse the structural forces influencing the management of residents' dying by care home staff. Drawing on Marxist-feminist social reproduction theory (SRT) (Federici, 2012; Gonzales, 2013; Fraser, 2017) and Foucault's biopolitics (2003), the framework interrogates the normatively "caring" function of the care home sector by asking what it does for the social reproduction of English citizens. Social reproduction is defined as the totality of the biological and social processes (and institutions) which generate and regenerate the human capacity to work and/or live, such as gestation, the family, housework, childcare, eldercare and welfare provisions (see Gonzales, 2013). The framework posits a contradiction

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between the production of economic value and the reproduction of human social and biological life (social reproduction) in a capitalist economy such as England (Fraser, 2017). The *biopolitical economy of dying in care homes* also assumes that the English state has taken (some) responsibility for the survival and health of its citizens (social reproduction), independently of their capacity to achieve both through the market (Foucault, 2003). As a result, the framework explores the consequences of this contradiction between economic value production and social reproduction, and its mediation by the English state, for the care home sector. In doing so, the framework identifies three competing functions of the English care home sector. These are to keep residents alive (medico-legal function), to curtail costs to National Healthcare System (NHS) England and care home providers (economic function) and to keep residents on the care home's premises (custodial function). Although these functions are grounded in an empirical analysis of the English care home sector's laws, regulations, policies and genesis, the framework is relevant for an international readership as it captures features of the mixed economy of welfare characterising social care provisions in most developed countries (the Minority World) (see Robertson et al., 2014).

Sociological Theories of Dying and the Care Home Context

English care homes for adults aged 65+ include residential structures with or without nursing staff. They comprise more than three times as many beds as the English NHS[1] and are managed 90 per cent by private providers (LaingBuisson, 2018, p. 15). Among social care receivers aged 50 and above, those aged 80+, those with severe disabilities and those living with dementia are more likely to spend the last part of their lives in a care home as opposed to at home or in a hospice (Teggi, 2020). Further, care homes are the place of death of 20 per cent of the English population (PHE, 2023). This makes care homes *de facto* hospices for people aged 80+ dying with frailty and/or dementia (Teggi, 2020).

However, the dying of care home residents is a neglected topic in the social sciences. Sociological studies of dying have focused on palliative care in hospice, hospital or home settings (Ellis et al., 2016). In contrast, sociological studies of ageing have prioritized ageing in place and maintaining physical health and well-being in later life (see Gott et al., 2008). As a result, no theoretical synthesis has emerged concerning the role of care homes in the care of the dying. Of the few sociological studies on the topic, some adopt a staunchly empirical stance (Shemmings, 1996; Sidell et al., 1997; Katz et al., 2001; Froggatt, 2007), while others build on the anti-institutional and anti-medicalisation approaches of the 1960s and 1970s (Hockey, 1990; Froggatt, 2001; Komaromy & Hockey, 2001; Komaromy, 2005; Page & Komaromy, 2005).

The anti-institutional literature of the 1960s and 1970s was a Western-wide phenomenon, stemming from the critique of psychiatric institutions (e.g., Basaglia, 1964; Burton, 1959), to make encompassing claims about other forms of state-approved total institutions, such as the prison, the military barrack, the boarding school and so on (Goffman, 1961; Foucault, 1995). This literature's common theme was the dehumanising effect of confinement, authority and institutional routine on the lives of the inmates. Its heritage is evident in Townsend's (1964) seminal study of residential eldercare and in more recent studies of dying in care homes, from both a substantial and methodological perspective.

From a substantial perspective, the confining tendencies of residential care have resurfaced in Hockey's (1990) and Froggatt's (2001) studies. Hockey (1990) observes that care home staff separate dying residents from living residents. Similarly, Froggatt (2001) notes that staff restrict residents with deteriorating health to their rooms as a way to manage their transition from life to death. On this basis, Hockey (1990) and Froggatt (2001) argue that care homes serve to segregate people bearing the visible signs of ageing and dying from the rest of English society. From a methodological perspective, these and other studies (Komaromy & Hockey, 2001; Komaromy, 2005; Page & Komaromy, 2005) build on Goffman's symbolic interactionism (Goffman, 1959) to focus on the exchanges between staff and residents within the bounded environment of the care home setting.

The privileging of localised and interpersonal approaches to the study of power in care homes goes hand in hand with a critique of medicalisation (see Hockey, 1990; Komaromy & Hockey, 2001; Komaromy, 2005; Page & Komaromy, 2005). Medicalisation refers to the process by which non-medical issues and problems, such as the natural event of human death, are defined and treated as medical issues (Illich, 1982). Building on this, the mentioned authors argue that care home staff feel compelled to manage residents' dying from a medical perspective, even when they are not medically trained and consider dying to be the natural end of the ageing process. While evidencing important issues which still permeate the sector, the anti-institutional and medicalisation perspectives understand care homes as self-contained environments at the margins of society, failing to analyse how care home staff's EOLC decisions are affected by power structures external to the care home's context itself. The framework of the *biopolitical economy of dying in care homes* links staff's EOLC practices to issues of social reproduction and economic value production which define a capitalist economy such as England.

The Biopolitical Economy of Dying in Care Homes

The framework draws on Foucault's biopolitics (2003) and Marxist-feminist SRT (Federici, 2012; Gonzales, 2013; Fraser, 2017). Marxist-feminist SRT contends that, in capitalist societies, economic value production requires a particular type of labour (social reproduction work) and labourers (social reproduction workers) directed at the sexual reproduction and rearing of the future workforce as well as the regeneration of the current workforce's capacity to work (Federici, 2012). This includes not only the domestic work of cooking, cleaning, washing and the like but also the caring work of maintaining or reinstating health and well-being. Traditionally, this work has been provided by women, unwaged, in the household.

To facilitate the reproduction of human life as the substratum for the production of economic value, many Western capitalist states have developed systems of redistribution and social welfare (Gough, 1979). Welfare systems imply that the state assumes some responsibility for the social reproduction of its citizens. This coincides with Foucault's conceptualisation of biopolitics as a state power that concerns itself with the administration, optimisation and multiplication of human life through precise forms of knowledge, control and regulation. Medicine and the institutions for the provision of health and social care, such as the hospital and care home, are among those sciences and technologies which are typically part of welfare provision and employed by states in the biopolitical governance of populations (Foucault, 2003). The framework draws on these insights to provide an analysis of the English care home sector as a system for the survival and custody of disabled adults aged 65+ at reduced public costs.

The Medico-Legal Function: Keeping Residents Alive

Today care homes have a statutory duty to support the survival and sustenance of their residents. Safety is the first standard that the regulator, the Care and Quality Commission (CQC), uses to rate and inspect care-homes. The intention of Regulation 12 on "Safe care and Treatment" is to prevent avoidable harm to residents (CQC, 2015). It mandates the mitigation of risks involved in health and social care provision to residents, including manual handling, medicine administration and access to emergency healthcare. Regulation 14 on "Meeting nutritional and hydration needs" is intended to further ensure the life and good health of residents by reducing "the risks of malnutrition and dehydration" (Ibid., p. 51). This includes feeding residents who cannot eat or drink independently, monitoring their food and fluids intake and "taking appropriate action if people are not eating and drinking in line with their assessed needs" (Ibid., p. 53).

Although upholding residents' consent to care or treatment, Regulation 11 on "Need for consent", mandates that staff cannot provide unsafe care or treatment as defined by Regulations 12 and 14 even if residents requested it (CQC, 2015). Under the Health and Social Care Act 2008, the CQC must prosecute breaches of Regulations 12 and 14 when they result in avoidable harm to residents or risk thereof. Considered together, the duties enforced by Regulations 12 and 14 amount to the imperative for care home staff to keep residents alive by providing safe and life-supporting care. Public responsibility for the care of older adults does not, however, come without issues. From the perspective of Marxist-feminist SRT, state support of adult social care is inevitably contradictory since it reflects the tension between social reproduction and economic value production within capitalist economies.

The Economic Function: Reducing Costs to Care Providers and NHS England

Adult social care provision in England bears the signs of the contradiction between economic value production and the reproduction of human life in a capitalist economy. Care work is qualitatively different from economic value production work because it preserves and regenerates the human capacity to live directly. Being a type of social reproduction work, care work sustains human life directly regardless of whether it is waged or unwaged and its products are sold as service commodities on a market or not (Gonzales, 2013). An unwaged carer assisting a companion for free and a waged carer assisting the client of a care company are both enabling someone to complete vital daily tasks. Care work always reproduces the human capacity to live directly, regardless of the economic conditions in which it is performed. By contrast, economic production work reproduces the human capacity to live directly only when it is waged care work or care work that is sold as a service commodity on a market (namely directly market mediated) (Ibid.). Support staff employed by a care home company performs waged and directly market-mediated (DMM) care work since the service is provided in exchange for money. Whereas support staff employed by an NHS hospital performs waged and indirectly market-mediated (IMM) care work since the service is free at the point of use. When it is not waged or DMM care work, economic production work reproduces the human capacity to live only indirectly (Ibid.). It does so by providing money to individuals, either as wages or profits, so that they can use it to support their wellbeing. Arguably, the most common forms of care work are unwaged and IMM activities that individuals carry out to survive and regenerate their ability to perform economic value production work. These activities involve a labourer transforming the commodities purchased with the wage or profit (e.g., food, laundry detergent, shampoo, a house with a bed) into the capacity to live and work in a capitalist economy (e.g., a cooked meal, clean clothes, a clean body, a rested body) (Ibid.). The human capacity to live and, crucially, to work which is reproduced by care and self-care work is the substratum to all economic value production. That care work supports the capacity to live of a fellow human being, even when producing economic value for the employer (a profit) and/or the carer (a wage), has two consequences for the mixed economy of social care provision in England.

First, care work is both essential and a cost to economic value production. Unemployment, low wages and long working hours threaten individuals' ability to support themselves and others through the market. As a response to this, England, as other capitalist states, developed welfare systems, including the public provision of adult social care for those unable to purchase it on the market. This leads to the second point. Waged care work, whether IMM or DMM, cannot both meet demand and generate high returns on investment because, being essential to the lives of those needing it, there will always be more people needing waged social care provision than people who can afford it. Returns on investments in social care are low or investors, whether public or private, must accept that the service will reach only those able to purchase it, thereby producing inequalities in access to care. In England, local authorities have a statutory duty to provide social care free of charge to those meeting the eligibility criteria. However, the service is underfunded and does not reach all those needing it.

Austerity cuts led local authorities to restrict eligibility criteria in the 2010s, resulting in 1.4 million people not receiving the care they needed at the last count (Age UK, 2018). Further, local authorities' failure to meet providers' costs steered care homes to charge self-funders on average 41 per cent more for the same service (CMA, 2017, p. 14) and reduce staffing levels to maintain financial viability (Johnson, 2023). This had the effect to shorten interactions between residents and staff and lower the quality of care provided (Ibid.). Finally, the compound effect of chronic public underfunding and inflation has hit the care home sector hard in recent years, with the four biggest operators being up for sale in 2019 (Plimmer, 2019) and 42 per cent of providers closing part of their services in 2022 owing to debt and inordinate losses (Care England, 2023).

Reducing the costs of care work is not just the recent preoccupation of cash-stripped local authorities and care providers. The English welfare state has a long history of rationing of public resources to the “disabled” old. It started with the institution of a free NHS in 1946 and a paying or means-tested social care in 1948. The financial divide was accompanied by an arbitrary organisational separation between health and social care provision, with the “sick” old being placed in NHS long-term hospitals (approximately 90,000 people) and the “disabled” old in care homes (approximately 42,000) (Thane, 2009, p. 6). Drawing on this separation, English policymakers shifted long-term healthcare provision for the “disabled” old from the free NHS to the paying or means-tested care home sector by the end of the century. The privatisation of residential care in the 1980s and the closure of NHS geriatric wards in 1990 went hand in hand with changes in the balance of nursing versus residential care, in favour of the former (Johnson et al., 2010). In 1970, the ratio of nursing care beds to residential care beds was 2:17; by 2007, it was approaching 2:3 (Ibid., p. 21). This change in ratios marks the extent to which paying and means-tested social care services are increasingly providing healthcare. The issue of reducing NHS England costs by externalising healthcare services to private care home providers continues today and dovetails with the custodial function of the care home sector.

The Custodial Function: Keeping Residents on the Care Home’s Premises

The custodial function is the traditional function of the English care home sector. As outlined in “Sociological Theories of Dying and the Care Home Context”, sociology has often theorised care homes as institutions for the containment, control and separation of unproductive (and dying) bodies from the rest of society. Certainly, care homes remain enclosed environments with limitations placed on visitors’ access and residents’ freedom of movement within and outside the care home (Teggi, 2022). This framework considers the custodial function of modern care homes as subordinate to the keeping-alive and cost-reduction functions.

In England, care home staff seek to keep residents on the care home’s premises as well as monitor and influence their behaviour within the care home, to keep them safe and healthy (Ettelt et al., 2022). The Mental Capacity Act 2005, the Equality Act 2010 and the Equality Act 2014 confer legal liability onto providers to deliver safe and life-supporting care in respect of residents’ human rights. When this is not possible, the Deprivation of Liberty Safeguards procedure under the Mental Health Capacity Act 2005 allows providers to detain residents lacking capacity. The care home’s function to contain and control residents within the care home is thus subordinate to providing safe and life-supporting care which, as explained in Section 2.1, is a statutory duty of the English care home sector.

On the other hand, the care home sector plays a strategic role in relation to hospital bed capacity and the costs of providing in-hospital care by absorbing hospital discharges and creating barriers to readmission. NHS England hospitals developed internal procedures for the rapid discharge of frail and/or dying older adults to nursing homes. In response to 90 per cent bed occupancy rates (Res Publica, 2016) and £820 million spent on delayed hospital discharges in 2016 (Oliver, 2016), NHS England hospitals developed internal procedures for the rapid discharge of frail or dying adults to nursing homes (Oliver, 2016). These are the Discharge to Assess Model (NHS England, 2016) and the NHS Continuing Healthcare Fast Track (DoHSC, 2018) to move, respectively, medically optimised and dying patients from a hospital to a nursing home. As a result, Mckean (2021) found care homes to be at the receiving end of a pervasive push to discharge frail old adults from hospital as quickly as possible. She conceptualised this as "the drive to discharge conveyor belt" evidencing that it was both caused by and caused resource limitations within the NHS.

At the opposite end of the spectrum, to prevent hospital admissions from care homes, NHS England directors developed the 2020 Enhanced Health in Care Homes (EHCH) for the provision of generalist preventative and palliative care in the care home setting. The EHCH requires general practitioners to visit care homes on a weekly basis and prescribe anticipatory medication for the management of dying symptoms to residents expected to die (NHS England and NHS Improvement, 2020). There is thus congruence between care homes' function to keep residents safe on the care home's premises and the NHS long-term plan to reduce residents' hospital admissions, especially at the end of life.

Practical Implications

This section discusses how the biopolitical economy of dying in care homes allows for a rigorous analysis of staff's care provision to residents nearing the end of life. It does so by drawing primarily on an ethnographic and interview study of staff EOLC provision in five English care homes conducted by the author between May 2019 and March 2020 (Teggi, 2022; Teggi & Woodthorpe, 2024). The keeping-alive, custodial and cost-reduction functions influence staff decisions around residents' place of death and the sort of EOLC residents receive in the care home. In England, care home residents experience a high rate of hospital admission in the last month of life (34 per cent) and death (28.5 per cent) (Kinley et al., 2014, p. 376; NEoLCIN, 2017b, p. 2). This is due not only to the difficulty of predicting resident's precise time of death (Teggi, 2018) but also to staff's duty of safe care provision (Section 2.1).

Care home staff seek ambulance emergency care, often leading to a hospital admission, when residents without prescribed anticipatory medications experience a life-threatening health crisis (Teggi & Woodthorpe, 2024). This occurs even when residents have been discharged from hospital with a doctor-signed letter or Recommended Summary Plan for Emergency Care and Treatment advising against hospital readmission on clinical grounds (Teggi, 2022). Staff's default response to residents' health crisis is in line with the keeping-alive function of the care home sector and contradicts the custodial and cost-reduction functions (with respect to NHS England) since it leads to clinically inappropriate and expensive hospital admissions at the end of life and, often, deaths (see Kinley et al., 2014).

On the other hand, the presence of doctor-prescribed medications for the management of dying symptoms, that is anticipatory medications, allows staff to demonstrate safe care provision to doctors certifying the medical cause of death and, potentially, coroners when residents die (Teggi & Woodthorpe, 2024). This medico-legal function of anticipatory medications enables staff to withhold ambulance emergency care safely and facilitate a regulation-compliant EOLC in the care home (Ibid.). In doing so, staff reconcile the keeping-alive, custodial and cost-reduction functions of the care home sector with respect to NHS England. Nevertheless, contradictions between the keeping-alive and cost-reduction functions resurface when considering staff provision of EOLC within the care home.

The keeping-alive function of the care home sector, which is mandated by legislative and regulatory frameworks (Section 2.1), produces a focus on bodily care as opposed to care that encompasses the whole person. Some staff feel forced to provide bodily care, including support with food and fluids intake, three-hourly repositioning in bed, and personal hygiene care, even when competent residents refuse it (Teggi, 2022). However, the increased workload of providing this type of care to bed-bound and, at times resistant, residents is usually not met by a corresponding increase in staffing levels (Ibid.). Staff complain that the staffing levels enforced by some providers to contain costs are insufficient to provide good EOLC which, as they define it, includes spending time with residents to understand their priorities and sitting at their bedside to comfort them in the last hours of life (Ibid.). This tension between the keeping-alive and cost-reduction functions of the care home sector (with respect to providers) thus reinforces the regulatory focus on bodily care. Moreover, it limits staff's ability to negotiate and provide bodily and emotional care in line with residents' preferences about nutrition/hydration, touch and company at the end of life (Teggi, 2022).

Conclusion

Sociology has traditionally theorised care homes for adults aged 65+ as self-contained institutions where a few staff govern many residents drawing on organised routines and medical discourses. These anti-institutional and medicalisation perspectives fail to investigate how care homes operate in relation to the rest of society. To address this gap, this chapter proposed the first unified theory of the role of care homes in the management of dying adults aged 65+. The *biopolitical economy of dying in care homes* builds on Foucault's biopolitics and Marxist-feminist SRT to identify three competing functions of the English care home sector. These are to keep residents alive (medico-legal function) and curtail costs to NHS England and care home providers (economic function) while keeping residents within the care home's premises (custodial function). These functions link two power structures which are external to the care home context to the care home context itself. These are (1) the

English state's assumption of responsibility for the survival and (partial) well-being of its citizens and (2) the antagonism between economic value production and the reproduction of human social and biological life within capitalist societies in the Minority World. In doing so, the keeping-alive, cost-reduction and custodial functions of the care home sector reveal that power structures which do not stem from within the care home dictate how staff care for dying residents. Concretely, it is not just the personal views of staff that determine how staff provide EOLC but also economic and regulatory processes independent of single care homes and their staff. Insufficient economic resources and regulations mandating safe and life-supporting care restrict the options available to staff to care for dying residents. The imperative to keep staffing levels to a minimum and residents alive limits staff's ability to provide the emotional aspects of EOLC which many staff aspire to provide, namely human presence, comfort and the interpretation of residents' EOLC preferences. Therefore, the theoretical framework of the *biopolitical economy of dying in care homes* uncovers the social dimension of EOLC by shifting the focus from individual (and moral) responsibility to systemic power dynamics. The framework encourages sociologists to rethink staff's EOLC practices and interactions with residents as integral to a capitalist economic system such as England and reflecting its core contradictions. This approach echoes the one adopted by Samantha Fletcher and William McGowan in their analysis of the political economy of pre-need funerals, presented in Chapter 2 of this collection. The authors pinpoint how the financialisation of pre-death funeral arrangements has transformed not only the death-care industry but also people's desires concerning body disposal and memorialisation. Likewise, the *biopolitical economy of dying in care homes* constrains the possibilities for staff to imagine and practice individual approaches to EOLC.

Note

1 A total of 455,837 beds in the care home sector (Laing & Buisson, 2018, backcover) against 142,000 beds in the NHS (Ewbank et al., 2017).

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