# Transformation of Research into Policies for the Aged Population: the “failed” Case of the Uk’s Guidance for the Care Sector During the Covid-19 Pandemic

**Jimena Vázquez García and Konstantinos Roussos**

**Abstract** The unfolding of the Covid-19 pandemic proved to be a critical moment for healthcare systems worldwide. Decisions about scarce resources were rapidly justified based on, allegedly, neutral, and objective research-informed guidelines. Within this scenario, older adults and the care sector were disregarded and deemed expendable. In this chapter, we draw from Political Discourse Theory to argue that research informing policy for older adults, while often deemed neutral, has a social and political drive. By operationalizing this approach in doing aging research, we analyse two policies specific to the UK context in 2020 and unpack the effects of ageist discourses and norms in shaping public health policy guidance at the start of the pandemic. Ultimately, we highlight how the problem of care for older adults has been constructed as one of limitations and scarcity of resources, enabled through a logic of expendable risk. We conclude that if we strive for research on older adults to be translated into dignity driven policies, we need to centre the matter of care.

**Keywords** Older adults · Political Discourse Theory · Covid-19 · Policy · Risk · Care

## Introduction

The unfolding of the Covid-19 pandemic evidenced that governments and politicians around the world were vastly underprepared to tackle what would become the biggest (global) public health emergency in decades. Scarcity of resources at the beginning of the pandemic quickly meant decision making was centered around prioritizing certain lives over others. In many parts of the world, if not all, older adults found themselves at the bottom of the list in terms of receiving care and attention. When decisions regarding the allocation of resources, such as the use of ventilators, had to be made, Covid-19 was already framed by many, including healthcare advisers and policy experts, as an 'older adult' problem [1] who are fighting an already lost battle [2], justifying in this way the exclusion of this part of the population. Governments would claim that their guidance and policies were being informed by the latest scientific rigor, and given the urgency of the matter, there was very little questioning in the care pathways and treatment offered to people over the age of 65. On the contrary, there was an underlying logic, in much of the public and medical discourse, that older people are disposable or expendable; their lives had already been lived, and thus they were understandably put last [3].

In this chapter we will unpack this discourse which sought to frame older adults as expendable. We are not simply aiming for a normative argument judging the decisions made. Rather, in this chapter we will attempt to account for the political veil present in much of medical decision making, which most of the time goes unaccounted for. When discussing or analysing research transformed into policies in the medical field, we often assume that their perceived scientific drive signifies neutrality and objectivity. It this assumption that often shields medical research and policy from criticism. However, in this chapter, we will propose a different reading of research and policy. Our focus will be key policies set in place during the Covid-19 pandemic with regards to adults over the age of 65 in the UK. We will emphasize two policy guidance documents published in March and April 2020 by the National Institute for Health and Care Excellence (NICE), and the Department of Health and Social Care (DHSC), Public Health England and the NHS Care Quality Commission. The first document is the 'COVID-19 rapid guideline: critical care in adults' [4], and the second document is the 'Admission and Care of Residents during COVID-19 Incident in a Care Home' [5].

The UK government claimed to have placed a "protective ring" around the care sector. However, the reality was extremely contradictory to this statement, where the care sector, both residents and workers, were left exposed to the outmost risk. In the next section we outline our theory and methods that draw on Political Discourse Theory. We then move to present the context with an emphasis on the care sector and the policy and discourse of the UK government in the first months of the pandemic. Following from the context, we present the analysis of the two documents to understand how certain decisions were shaped by the utilization of a logic of risk as a form of biopolitics. We conclude the chapter with a discussion on centring care within research and policy development. Ultimately, in this chapter we aim to unpack the effects of ageist discourses in shaping policy guidance at the start of the pandemic in the UK.

## Discourse Analysis, the Framework

For this chapter we draw from Post-Marxist (or Political) Discourse Theory (PDT). PDT has, in the past couple of decades, seen a particular surge in its application towards policy-oriented fields [6–8]. PDT analysis has served to underscore the political, normative and ideological dimensions of policy making, including health-care policy. A growingly popular methodological approach to operationalise PDT in conducting discourse analysis in the field of policy is "The Logics Approach". While it is beyond the scope of this chapter to offer a fully fleshed account of the logics approach, we offer below a very brief introduction that will allow for clarity in the argument that will follow.

First, crucially, in this approach the category of discourse is not simply about meaning, language and text. Discourses are articulatory practices that connect and signify the meaning associated with objects, social relations, identities, and norms [9]. Such elements are articulated together producing relational systems of practice and meaning. However, such systems are always incomplete. Their fixity, a result of the articulatory practice, is established (only partially) through the exercise of power, defining the inclusion of certain elements and the exclusion of others. In this picture, any existing practice is understood as a product of hegemonic struggles in which normative, political and ideological dimensions are always in play. Let us offer an example. Think of the experience of madness, which at a first glance we might take as demarcating an objectively observed phenomenon, and one that has been so throughout time. However, if we trace its historicity, one finds that madness has been understood and approached differently in time. It is not that treatments and diagnosis evolve, but that, at different points in time, the experience of the "mad person" was understood differently, for example, deemed to be living closer to the truth and, in consequence, allowed to live freely within society. At later moments, madness became understood as an irrational suffering which needed to be cured. A discourse analysis of the experience of madness uncovers these mutations, and critically explains them by bringing to the fore the interplay of power mechanisms which enabled such different experiences. Another, more tangible, example is to think about how most of medical research has been outlined with a male white body as an exemplar, disregarding the implications this has had in diagnosing and treating women and black and global majority people. This is not to simply say that the medical field is wrong, but that the knowledge and meaning that structure it and the knowledge and meaning it produces are in accordance to the dominant worldview.

In PDT then, it is not enough to say that something has meaning. Rather, the role of the researcher is to discern the conditions and conventions that govern the production of such systems of meaning and practice. By operationalizing PDT, we investigate and characterize the rules and objects that govern a discourse, aiming to discern the logics that sustain and maintain dominant practices. To put it more fully, the logic of a practice allows us to capture the rules that structure it and norms that make it work (social logics), as well as the objects and types of relations that make the operation of such rules possible and vulnerable to change (political and fantasmatic logics). In this view, our task is to critically understand how discourse structures, maintains, and transforms social practices, related to health for the purposes of this chapter, and vice versa. If we were to unpack the example of madness, as researchers we would need to analyze not only that madness shifts in its meaning but, we would also need to grapple with the conditions and conventions that govern and partially fix the meanings, and the breaking points that allow for the shifts.

As already noted, a logics approach to critical policy analysis allows us to examine the emergence, reproduction, and transformation of discourses, practices and social relations as those are set out in certain policy documents, elucidating how they shape certain identities, interests, and understandings of what is at stake. In doing so, the analysis is routed within a cycle of five "moments": problematization, retroduction, logics, articulation, and critique. Our analysis starts with problematization, in which the analyst has to construct the object of study or 'the constitution of a problem—or an explanandum to use more traditional terms—which invariably results in the transformation of our initial perceptions and understandings' [9, 10] which therefore turns a "given into a question" [10]. So, from our madness example, we can see that a historical tracing shows that madness has not always been experienced in the same way—we trace here the establishment of what we think is objective—and that each of the historical moments of madness are not arbitrary, but they actually respond to particular power plays and needs, and so, we turn them into a question, where we ask why? Why is madness thought of as ahistorical?

Problematization, thus, works on two levels. On the one hand we problematize, we turn into a question, that which as researchers we are observing. And, on the other hand, we are tending to the power mechanisms that constructed that given in the first place, i.e. the making of a problem according to a certain rationality that prescribes specific needs and solutions. In addressing the historicity of the experience of madness, and underscoring that it is mutable and contextual, we also tend to each of the partially fixed meanings it had at moments in time, the different ways in which it has been constructed depending on the needs. For the purposes of the present chapter, we aim to problematize the dominant problematization of older age during COVID-19, within policy guidance centering care pathways for older adults in the first stages of the pandemic in England. We aim not only to show that the discourse regarding older age is contextual and partially fixed, but in doing so, we bring to the fore the government's attempt at concealing a particular understanding of older age through a guise of scientific objectivity. Simply put, we aim to underscore not only that the discourse on older adults is contextual, but that government hides this aspect through supposedly neutral policies.

In particular, we highlight how the problem of care for older adults has been constructed as one of limitations and scarcity of resources and framed by a certain understanding of risk in relation to healthy and well managed bodies or frail and dependent bodies, generating very specific questions and responses about opportunities of care and treatment. The moment of retroduction involves the furnishing of a hypothesis attempting to render the problematized phenomenon more intelligible. In our case, the puzzling phenomenon is the impact of Covid-19 on older adults in care homes, and our research question can be summarized as the following: Why did the UK Government, despite knowing that older adults could face higher risk from COVID-19 than other parts of the population, and in spite of the claims that it has thrown a 'protective ring' around care homes, failed to mitigate the effect of COVID-19 on English care home residents and staff? Our hypothesis is that their guidance was informed by a logic of expandable risk. Exemplified by an understanding of older adults as being *a* risk and *at* risk, this logic is animated by ideas and norms that see the process of aging as a passage to decline; on the one hand, as the exit of older body's from any form of productive activity (older age as burden for the rest of the productive population and the public purse), and on the other aging as a disease (older age as a state of morbidity, frailty, decrepitude, and disability - older bodies closer to death than life - with certain assumptions around the goals and effectiveness of care treatments).

We will argue that articulating together the experience of older age and risk within the Covid-19 context renders the experience of older bodies irrelevant and thus makes the need to offer critical care for older age unnecessary. In the following sections we problematize the government's problematization showing that is rooted in a notion of biopolitics. As mentioned, we are not claiming that this view of older age originated with the pandemic; rather, the pandemic intensified it pushing it to a critical juncture. By masking its political and ideological dimension, risk became a nodal point of the techno-scientific objectivity that shaped decision making during Covid-19. In this way, as our analysis highlights, a body of knowledge emerged that both disciplined aging individuals and prescribed a set of administrative practices governing their care (or lack thereof). Drawing (once more) from, Foucault, we understand the notion of biopolitics as an ensemble of governmental mechanisms and techniques that regulate and manage life itself. Biopolitics stems from the concept of biopower, a form of power that functions through a politics aimed at the disciplining and governing of populations' bodies. For now, consider the consequences that the Covid-19 conjuncture entailed, the fact that governments had the justified means to dictate our movements while at the same time viewing older age as expendable.

## Covid-19 and the Care Home Tragedy in the UK

The first recorded case of coronavirus in the UK was on the 31st of January 2020. The response of the government was amongst the slowest within the European context, insisting on a "herd immunity" strategy. A national lockdown was not implemented until the 23rd of March of 2020. Prior to the tardy lockdown, during official communications on the 12th of March, the government simply affirmed that, many more people will lose loved ones before their time, schools would not close, and the advice offered for people over 70 was, merely, to not go on cruises [11]. In the same communication, the lack of social distancing measures was explained by the claim that it was not yet the right moment of the pandemic to introduce them. Nine days later the prime minister issued a national lockdown. Such measure however, most scientists and experts agree, had been taken too late, and, crucially, did not attend to the needs of the care sector. Those living in care homes were, by all extents, forgotten or, even worse, deemed expendable.

## Guidance and Policies Particular to the Care Sector

Published on the 20th of March, the NICE 'COVID-19 rapid guideline: critical care in adults' [4] offered a tool to assist decision-making about the admission of patients over 65 to critical care. In this strongly criticised guideline, professionals were advised to assess all adults for frailty (irrespective of COVID symptoms) at the time of their admission to hospital. The critical care referral algorithm would help professionals to determine the relevant care pathway. Patients aged under 65 (or of any age with long term disabilities or learning disabilities) would undergo an individualised assessment. Patients over 65 had to be assessed with the use of the Clinical Frailty Scale (CFS). On the basis of this assessment and the CFS score, a certain care pathway was recommended for all adults of 65 years of age and above: for those with a CFS of 5 and above treatment outside critical care was suggested, with end-of-life care as the option if their condition deteriorated; for those with a CFS of less than 5, whilst initial treatment was also recommended outside critical care, they were to be moved to critical care if their condition worsened.

Almost at the same time, another piece of guidance was published playing an important role in the treatment pathways of older adults. The March Discharge Policy, consisted of 'Next Steps on NHS Response to COVID19' and 'COVID-19 Hospital Discharge Service Requirements', described how teams across the NHS, local authorities and social care had to maintain rapid discharge from hospital to home, or residential or nursing home settings. Annex A of The Discharge to Assess Model predicted that a 5% of all discharges will require the second option, including people who might be identified being in the last days or weeks of their life (p. 27). On April 2nd 2020, DHSC [5] published a guidance on the admission and care of people discharged by hospitals in care home

> As part of the national effort, the care sector also plays a vital role in accepting patients as they are discharged from hospital – both because recuperation is better in non-acute settings, and because hospitals need to have enough beds to treat acutely sick patients. Residents may also be admitted to a care home from a home setting. Some of these patients may have COVID-19, whether symptomatic or asymptomatic […] If an individual has no COVID-19 symptoms or has tested positive for COVID-19 but is no longer showing symptoms and has completed their isolation period, then care should be provided as normal […] Negative tests are not required prior to transfers / admissions into the care home (p.4).

Urgent discharge to community health providers and care home settings was predicted to free up to 15,000 hospital beds [12]. The combined effects of the above public health guidelines resulted in a rapid discharge of large numbers of patients to care homes. The National Audit Office reported that between 17 March and 15 April 2020 approximately 25,000 people, not all of them tested, were discharged into care comes. In many cases then, people that could have still been infected and infectious were moved into enclosed settings already hosting a part of the population that was identified as one of the most vulnerable groups to COVID-19. The Office for National Statistics (ONS) [13] reported an approximately 79% increase in total deaths in care homes in England and Wales from 2 March to 12 June 2020 compared to 2015–2019.

The guidance outlined until now does not comprise a specific plan of support for the care sector, it merely outlines that the government had set for the care sector to receive massive discharges of hospital patients. It was not until April 15th when a plan specific for the care sector was announced. In this document, the government claimed to offer the care sector four pillars in aid: (i) controlling the spread of infection, (ii) supporting the workforce, (iii) supporting independence, supporting people at the end of their lives, and responding to individual needs and (iv) supporting local authorities and the providers of care [14]. The discourse that the government attempted to articulate regarding the care sector was cliaming to have succesfully implemented a "protective ring around care homes". However, according to Amnesty International [15], between March 2nd and June 12th 18,562 residents of care homes in England died with Covid-19. Of these deaths, 18,163 were of people aged 65 and over, and 76% of these deaths happened within care homes. Amnesty International concluded that six key governmental errors resulted in the death and suffering of care home residents and workers: (i) the order of mass discharges from hospitals into care homes of patients infected or possibly infected with Covid-19, (ii) personal protective equipment (PPE) was not required for care home workers if workers and residents were not symptomatic, (iii) failure to ensure adequate provision of PPE to care homes, (iv) there was no assessment done in regards to the care home's capability to isolate infected or possibly infected patients, (v) failure to ensure regular testing of care home workers and residents, and (vi) misuse of 'Do Not Attempt Resuscitation' (DNAR) forms on residents of many care homes.

These are two features of the Covid-19 responses in England that are striking and puzzling. First, the UK government was one of the last to implement a national lockdown. Guided by the 'herd immunity' assumption, UK government's experts suggested that society will be shielded once the virus had run its course; that is, once most of the population would have gotten infected and recovered then they would subsequently be immune to the virus. Explicit in the government's discourse at the time was that the lockdown solution to protect the most vulnerable could not outweigh the greater socioeconomic cost. This contradiction was enabled through an underlying logic that sees older adults as both *a* risk and *at* risk. This argument does not suggest that ageist discourses are new; however, it asserts that the pandemic amplified their consequences to a new extreme.

## Logic of Expendable Risk

When discharging mass number of patients into care homes, the government stated:

> Care homes have a vital role to play in the UK, especially during the response to the COVID 19 pandemic. We want to make sure you and your staff can continue to care for some of the most vulnerable in our society. With your help, we can help keep them safe and cared for. [12]

This vital role, allegedly guarded by a protective ring, was instrumentalized differently in reality. We have outlined some key contradictions of the Covid-19 policy response that shaped the reality of care homes, their residents, and workers, and we now turn to show how this reality was reinforced by norms and ideas that frame older adults (and not only) as expendable. The NICE guideline shows how certain practices and tools work to categorise people on bodies that can be included or excluded from certain medical treatments and spaces. In the first instance, the NICE guideline creates a division between younger and older bodies. As a second step, it creates another division between older bodies that 'manage well' and the older bodies that are 'dependant'. Treatment and resources will be better spent if they are to be used first in younger bodies, and then in those older but 'managing well' bodies. What is the norm that informs such practices and decisions? This is something that researchers had signalled to, prior to the pandemic, concerned with the overuse of frailty as a guiding norm in aging policy. It has been argued that the vagueness and openness of "frailty" as a term has been instrumentalized as a norm which gives "permission" through its use to demarcate lives worth living [16, 17]. These aspects become even more concerning when we consider that this norm, which is at the center of aging guidance and policy, actually lacks a universally accepted definition [16]. What is it then that drives the dividing line justified by frailty? What underlies this vague concept as a justifying norm?

When juxtaposing the NICE guidance with the March Discharge Policy, we might not find the guiding idea of frailty to be as prominent. However, we can still highlight that the decision to provide treatment within a hospital or even more so the decision of who will be given access to critical care is not made by executive power. Rather, it is at the discretionary judgment of health and social care administrators and professionals in different levels to decide how to act within the space of such policy guidelines. As such, medical decision making is not primarily based on the promotion of health and wellbeing but it becomes an issue of scarcity of resources. Within a context of emergency, there is no space or time to think about the political and ideological underpinning of the deregulation and defunding of public health and social care systems and institutions. Risk and responsibility devolves to healthcare professionals and the public. It is the responsibility of healthcare professionals to make sure that the system will not break, and, similarly, it is the responsibility of the public to make sure that they will not get sick. Within this field a sovereign power emerges in deciding whose lives are worth saving, as the 'dependent' and 'frail' bodies of older adults are subjected to distinct (limited) opportunities of care and treatment, rendering them subordinate to the 'healthy' and 'well-managing' bodies.

Considering the deployment of sovereign power in such public health guidelines to protect the general population at the first peak of the pandemic in the UK—how can we understand so much death and suffering among some of the most vulnerable groups within care homes? Public health guidance and policy during the pandemic, not only for the older population, but the population in general followed a state of exception, which enabled the government to deploy its power in an almost totalitarian manner. It is in this scenario that the already dominant discourse on older age reached its climax, evidencing the workings of biopolitics. Think, for example, how during the pandemic we saw governments implementing specific and targeted strategies that interfered in the privacy of our lives and demarcated our liveable space in the name of a public health emergency. However, when juxtaposing the older adults to this state of emergency, this goes a step further. In this scenario, older age was used and employed as a truth-discourse [16] which allowed for the classification of liveable and expandable lives. This was enabled by a logic that frames older age as being "simultaneously a risk and at risk" [16]. This logic of expandable risk has played a key role in the construction of older age as one in constant need of care and, given this, as one perpetually posing risks (e.g. for the health system, their careers, public finance, and thus society as a whole), within the pandemic the material consequences of this logic led to further marginalization and ultimately the segregation of older adults.

## Care, the Lack Thereof

Drawing on Political Discourse Theory, we have offered an account of the early guidance and policy the UK government employed to, allegedly, take care of the older adults during the Covid-19 pandemic. We have unpacked that several of its contradictions were concealed through a guise of the objectivity of research that specified certain care pathways for the population over 65. We have argued that such decisions and practices were sustained and justified through a logic of expendable risk. Given that the dominant narrative around older adults frames them as being both a risk and at risk, the seclusion of older adults into the 'protective ring' of care homes was justified as means of care and protection. We have also attempted to underscore that research informing policy is neither neutral nor objective. This is not to say that the field of medicine is subjective, nor are we trying to negate that science enables important advancements and the bettering of our lives. Rather, we have aimed to draw attention to the discourses, norms and values that have shaped a specific understanding of older age, emphasizing their function within the Covid-19 context particularly in enabling and justifying certain translations of research into policy with devastating consequences for older adults and care workers in care homes in the UK.

As a conclusion we would like to draw attention to the absence of care in this particular case. While, supposedly, at the core of government policy and guideline was the purpose of caring for the older adults, we have seen, that, firstly, care is instrumentalized by risk, and, secondly, there is not actual discussion of care means, nor how we should strive for it. Government policy repeats a pivotal term without addressing it. Instinctually, we know that care is a fundamental part of human life [18], we know we will all care for someone and be cared for during our lives. We know that this will be amplified in old age. So, maybe, an avenue to be able to construct a different discourse about age, one that does not center the experience on risk and, thus, justifies the expendability of older adults, is to bring care to the forefront. Let us begin to draft policies informed by research that does not equate care with risk and a negative connotation of dependency; care not as a burden. Let us be driven by care as a commitment towards the possibility to nurture and, thus, to produce different discourses on age. Imagine how different our world would be through such a lens.

## References

1. Fraser S, Lagacé M, Bongué B et al (2020) Ageism and COVID-19: what does our society's response say about us? Age Ageing 49:692–695. https://doi.org/10.1093/ageing/afaa097
2. Lichtenstein B (2021) From "Coffin Dodger" to "Boomer Remover": outbreaks of ageism in three countries with divergent approaches to coronavirus control. J Gerontol B Psychol Sci Soc Sci 76:e206–e212. https://doi.org/10.1093/geronb/gbaa102
3. Ayalon L, Chasteen A, Diehl M et al (2021) Aging in times of the COVID-19 Pandemic: avoiding ageism and fostering intergenerational solidarity. J Gerontol B Psychol Sci Soc Sci 76:e49–e52. https://doi.org/10.1093/geronb/gbaa051
4. NICE (2020) COVID-19 rapid guideline: critical care in adults. Available via www.nice.org.uk/guidance/ng159. Accessed 23 Mar 2024
5. DHSC (2020) Admission and care of residents during COVID-19 incident in a care home. Published 2 April 2020, Version 1. Accessed through https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes
6. Glynos J, Speed E, West K (2015) Logics of marginalisation in health and social care reform: integration, choice, and provider-blind provision. Crit Soc Policy 35:45–68. https://doi.org/10.1177/0261018314545599
7. Barnett N, Griggs S, Hall S et al (2022) Local agency for the public purpose? Dissecting and evaluating the emerging discourses of municipal entrepreneurship in the UK. Local Gov Stud 48:907–928. https://doi.org/10.1080/03003930.2021.1988935
8. Glynos J, West K, Hagger B et al (2014) Narrative, fantasy and mourning. A critical exploration of life and loss in assisted living environments. In: Kenny K, Fotaki M (eds) The psychosocial and organization studies. Affect at work. Palgrave Macmillan, London, pp 185–214
9. Glynos J, Howarth D (2007) Logics of critical explanation in social and political theory. Epub ahead of print 2007. https://doi.org/10.4324/9780203934753
10. Foucault M (1997) Polemics, politics, and problematizations. In: Rabinow P (ed) Ethics: subjectivity and truth by Michel Foucault. The New Press, New York, pp 111–120
11. Johnson B. Press conference on the 12th of March. Available via https://www.gov.uk/government/speeches/pm-statement-on-coronavirus-12-march-2020. Accessed 23 Mar 2024
12. DHSC (2020) COVID-19: hospital discharge service requirements. Available via https://www.gov.uk/government/collections/hospital-discharge-service-guidance. Accessed 23 Mar 2024
13. ONS (2020) Deaths registered weekly in England and Wales, provisional: week ending 16 October 2020, Available through https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredweeklyinenglandandwalesprovisional/weekending16october2020. Accessed 23 Mar 2024
14. DHSC (2020) COVID-19: our action plan for adult social care. Published 15 April 2020
15. Amnesty International (2020) As if expendable. The UK government's failure to protect older people in care homes during the COVID-19 pandemic. Available at https://www.amnesty.org/en/documents/eur45/3152/2020/en/. Accesed 23 Mar 2024

16. Tomkow L (2020) The emergence and utilisation of frailty in the United Kingdom: a contemporary biopolitical practice. Ageing Soc 40:695–712. https://doi.org/10.1017/S0144686X18001319
17. Tomkow L, Pascall-Jones P, Carter D (2023) Frailty goes viral: a critical discourse analysis of COVID-19 national clinical guidelines in the United Kingdom. Crit Public Health 33:116–123. https://doi.org/10.1080/09581596.2022.2090316
18. Tronto JC (1998) An ethic of care. Generations 22:15–20