

## COSMOPOLITANISM AND THE MORAL ECONOMIES OF AGED RESIDENTIAL CARE

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### ABSTRACT

*In this essay I contend that the aged care sector not only constitutes a political economy, but is at the same time a moral economy containing multiple contested moral spaces, purposes and standpoints. Global processes of cosmopolitanisation contain moral agendas that link macro level structures with local communities, families, individuals, workplaces, and organisations. The aged residential care (ARC) facility as a moral economy exemplifies vernacular cosmopolitanisation. The State shapes the moral economy of the New Zealand aged care sector through enforceable policies and regulations, while organisations and facilities compete in a neoliberal consumption-oriented marketplace. Those employed in the sector such as nurses and careworkers seek a living. Residents must find home within ARC, while their families expect they receive quality care from ARC facilities.*

*Keywords:* aged residential care; moral economy; cosmopolitanism

### INTRODUCTION

This article explores cosmopolitanism and concomitant moral economies of aged residential care in New Zealand. In describing the ARC facility as a site of cosmopolitanisation, I am drawing on Beck and Grande (2010, 426–7), as well as Rapport (2012), who argue that global processes of cosmopolitanisation link macro level structures with local communities, families, individuals, workplaces, and organisations. Here, the unit of analysis is the ARC facility itself. I contend that the aged care sector not only constitutes a political economy, but is at the same time a moral economy exemplar. This essay begins with a brief account of the moral economy, then attempts to show how the moral agendas of cosmopolitanism can be viewed critically through the analytic of moral economy. I then apply this analytic to aged residential care in New Zealand, using the

macro and micro standpoints of key stakeholders in the aged care sector to illustrate that the ARC facility is both a site of vernacular cosmopolitanism, and a moral economy in which multiple contested and competing discourses are discernible.

#### MORAL ECONOMY

The social science tradition of political economy describes the ways in which broader national and global contexts and trends that shape processes of production and exchange of commodities also shape human identities and subjectivities (Bourdieu 1998; Foucault 1988; Giddens 1991; Gramsci 1990; Marx 1992; Weber 2002). All human activity is fundamentally moral in the sense that it is imbued with meaning, and political economic activity is no exception (Sayer 2000, 81; Weber 2002). Recent debates about social welfare (Kissane 2012; Morgen and Maskovsky 2003; Sandberg 2015), working mothers (Solinger 2002), healthcare (Wilkinson and Pickett 2010), old age pensions (Macnicol 2015), in the context of neoliberal political economies (Harvey 2007; Larner 1997) illustrate this point. The term moral economy is not particularly evident within the medical anthropology literature although arguably much of the medical anthropological tradition addresses issues of moral economy (see for example, Kleinman 1988, 2006; Scheper-Hughes and Lock 1991; Singer and Baer 1995).

A recent Special Issue of the *Journal of Global Ethics* (2015, Volume 11(2)) very helpfully reviewed the concept and application of moral economy. Gotz (2015, 156), noted that the term has been used in the context of humanitarian projects to describe the accompanying articulation of global and local political processes and impacts upon communities, referencing the notion of moral capital (Kane 2001). Sandberg (2015) identified arguments for the existence of global moral economy movements oriented towards social justice and humanitarianism (citing Calabrese (2005)), and fair trade movements (citing Trentmann (2007)) that illustrate a cosmopolitanism defined as 'the philosophical view that all human beings, regardless of nationality and status, belong to the same moral community' (p.185).

Siméant (2015, 166), another contributor to this Special Issue of the *Journal of Global Ethics*, noted that the term moral economy has also been used to describe everyday or hidden resistance (citing Hobsbawm 1969). She identified three principal themes of moral economy in the extant literature: the first refers to the conflict that arises between the masses and the elite in times of economic turmoil and innovation; she suggests that Thompson's (1971) work exemplifies this category. The second theme explores the relationship between

economic activities and moral practices, based upon an implicit assumption that production and exchange cannot be untethered from the social context that lends meaning to these activities – referencing Polanyi (1944) and Weber ([1919] 2008) as exemplars. The third theme uses the term moral economy in the broadest sense to indicate what Siméant (2015, 169) refers to as a ‘moral architecture’ of socio-cultural norms and values that is not necessarily tethered to economic activities of production and exchange. According to Siméant (2015, 171) the concept of moral economy should constitute a form of thick description. She provides a definition that underpins my own deployment of the term:

Moral economy can be understood as a set of values derived from living conditions that are marked by a preoccupation with subsistence, linked to the reciprocal expectations of elites and the people which are at once pragmatic and normative, and which concern the fair distribution of wealth and the responsibility of leaders. (p.171)

Because political economies reflect power negotiations, genealogies of governance and technologies such as biopower and rarefaction in the Foucauldian sense, they also reflect resistance and alternative, competing, contested alternatives, and this is what infuses them with morality. The troubling normative relativity of morality means that just over one hundred years ago, women had no political voice; 300 years ago, the global slave trade was thriving. The necessity of global organisations such as the World Health Organisation and the United Nations, as well as various global activist organisations such as Amnesty International and Greenpeace attests to the continuation of contested normative moral economies within local contexts.

#### FROM MORAL ECONOMY TO COSMOPOLITAN MORALITY

Attention to the moral dimensions of human activity pervades the extant literature on cosmopolitanism. For example, Delanty (2012, 2) defines cosmopolitanism as pertaining to the extension of the moral and political horizons of people, societies, institutions and organisations. Such extension can refer to the development of common moral goals that exist beyond the nation state, for example in global activist groups such as Greenpeace and Amnesty International, and in unified international concern over planetary and environmental degradation. Werbner (2012, 153), describes an emerging trend in the social sciences to define cosmopolitanism as an ethical horizon, incorporating an attitude of openness, empathy, tolerance and respect for the Other, as well as the ability to connect across cultural difference. Rapport (2012, 32–34) suggests that cosmopolitanism constitutes a kind of relational morality that prioritises

the interests of humanity over those of local or national concerns because local lives and relations, and identities are inextricably bound up with and dependent on those elsewhere.

The cosmopolitan project of anthropology is empirically and objectively to elucidate the nature of human capacity, the workings of individual consciousness, creativity and accomplishment; morally to clarify the conditions whereby individuals may live out their potential for experience and expression to the fullest; and aesthetically to promote an appreciation of the dignity of human identity and individual integrity. (p.42)

Evident within such descriptions and definitions of cosmopolitanism and its moral and ethical horizons is a dichotomy between societal and individual levels of analysis and the articulation between the two (Beck and Grande 2010). Critically, asks the anthropologist, to what degree does cosmopolitanism represent a universalising meta-theory or relativist particularism? How can these dichotomies be spanned? Rapport (2012, 58) ingeniously argues that the human individual embodies the human whole. The notion of vernacular cosmopolitanism described by Werbner (2012) offers a bridge that is palatable to the anthropologist. Vernacular cosmopolitanism begins with membership in morally significant communities such as families, at the same time being characterised by engagement with the world of the Other and transcendence of difference (p.155). According to Noble (2009, 48), participation in a kind of banal cosmopolitanism is increasingly common as a result of the globalising world. This is very much a pragmatic orientation as we assimilate material goods and cultural practices into our own repertoires.

Much of the discourse on cosmopolitanism implies an active and outgoing ethical disposition of engagement with the world of the Other. Processes of migration, transnationalism, and globalisation have reached into the most isolated corners of the world so that individuals and communities have had little choice about whether or not to engage with the expanded horizons of their world. While cosmopolitanism offers a fruitful interpretive framework for examining the major social changes associated with these phenomena (Delanty 2012, 3), I find Beck and Grande's (2010) concept of *cosmopolitanisation* a useful and critical analytical concept because it addresses the ways in which individuals find themselves unwittingly caught up in global concerns and how they respond.

Beck and Grande (2010, 417) argue that we have moved from an age of cosmo-

politanism (characterised by processes of modernity) to an age of cosmopolitanisation characterised by the global Other in our midst. Cosmopolitanisation refers to the ways in which interactions between societies, groups, and individuals result in changed subjectivities and perceptions of the ways in which self and Other are configured. A core driver of cosmopolitanisation is perceived global risks such as terrorism and global warming (Beck 2011). Beck and Grande (2010, 419) suggest that there is a centripetal unifying process around the formation of a global risk society, that at the same time is subject to powerful diversifying and centrifugal processes resulting from competition between different types and visions of modernity, and also from resistance to various kinds of globalisation within societies.

The development of common moral visions and ethical frameworks identifying and mitigating global risk is a core component of cosmopolitanism. The concept of cosmopolitanisation allows for a critical and nuanced examination of the moral economies that are contested within both unifying and diversifying processes across macro and micro levels of analysis. For example, within Western nations and China, the economic risk posed by the aging population is now well documented (Breheny and Stephens 2012; European Commission 2012; Macnicol 2015; Weicht 2013). This is a good illustration of what Beck (2011) describes as an imagined community of risk. Governments are currently planning for the economic management of this dependent and resource-hungry tsunami of older people. In New Zealand, several reports document these projections (Cornwall and Davey 2004; Grant Thornton NZ Ltd 2010; NZ Labour Party, Green Party of Aotearoa NZ, and Grey Power NZ 2010; Statistics New Zealand 2006a). In short, by the late 2030s, the proportion of people over sixty-five years of age is expected to double from its current twelve per cent to approximately twenty-four per cent of the New Zealand population. Similarly, the number of residents in aged residential care is expected to approximately double in 2021 to around 54–65,000, a significant proportion of whom will be over eighty years (Smith, Kerse, and Parsons 2005; Statistics New Zealand 2006a). It should be noted that such projections are not uncontested. Macnicol (2015) for example, critiques the economic assumptions underlying these projections in Britain, suggesting that they reflect the moral responsibilist discourses characteristic of neoliberal political economies, and that alternative economic frameworks do not support the projected risk assessment. Similarly, the New Zealand study by Broad *et al.* (2011) found that while the Auckland population of over sixty-five year olds increased by forty-three per cent, from 91,000 to 130,000, over the same twenty year period the actual numbers in care reduced. Reasons for this trend may include increased availability of home-based services, and growth in retirement villages (Broad *et al.* 2011).

In this section I have attempted to show that the moral agendas and characteristics of cosmopolitanism and cosmopolitanisation articulate with existing political, and therefore, moral economies that present macro and micro facets for anthropological inspection. Political economies contain multiple contested perspectives, and these perspectives represent moral standpoints about what is good, right or desirable. The next section introduces the concept of old age as a cosmopolitanism, and presents the political and therefore moral economy of aged residential care in New Zealand.

#### COSMOPOLITANISM AND MORAL ECONOMY IN THE AGED RESIDENTIAL CARE FACILITY

Rapport (2012, 49) argued that there are commonalities of human experience over and above socio-economic and cultural differences between individuals. Infancy is one and the inevitability of death is another. It is no great leap to suggest that old age with its associated needs and dependencies is another indicator of a shared condition of humanity over and above socio-cultural and other distinctions. Old age also connotes issues of obligation and intergenerational solidarity and equity in most societies (Macnicol 2015). The booming western aged residential care industry is premised on the fact that all human beings age, finding activities of daily life increasingly challenging, and becoming more dependent on others as they progress towards death. It is also premised upon the cultural and perhaps modernist trend for older persons, certainly in Australia and New Zealand, to move into residential care once assessed as being unable to care for themselves in their own homes.

The ARC facility constitutes a legitimate site of vernacular cosmopolitanism for the examination of where and how the intimate details of everyday cosmopolitanism are enacted (Noble 2009, 51). Like the school in Noble's (2009) study, the ARC facility has its own rhythms and flows that are characteristic of global capitalism. Within the ARC, some people are concerned with finding and being at home (Cooney 2011), some are concerned with making a living, while for others the ARC is just one stop among many in their daily schedules (suppliers, visitors, healthcare professionals). The following section relies upon data reported in two small qualitative research projects exploring aspects of work and daily life within three quite distinct ARC facilities (Henley and Jaye 2015; Jaye *et al.* 2015, 2016), and in the report from a Human Rights Commission enquiry into the New Zealand aged care workforce (Human Rights Commission 2012) as well as other relevant New Zealand research. The ARC facilities contributing data to the two small qualitative studies included a relatively new facility owned by a multinational corporation providing hospital level

and dementia care (referred to here as Cecilia Hall) (Henley and Jaye 2015); a small local family-owned business providing rest-home level care (referred to as St Margarets), and a well-established facility that is part of a national church chain providing hospital level and dementia care (referred to as Aroha House) (Jaye *et al.* 2015, 2016).

These activities, rhythms and flows within the ARC facility are constituents of a lived political economy (Jaye and Fitzgerald 2010), infused with meaning and moral purpose. Below, the moral economies of the ARC facility are explored from the perspectives of some of the key players, including the macro perspectives of organisation and State, and the micro perspectives of residents, careworkers, and family members. These perspectives represent a convenient selection based on available research and are not meant to be exhaustive; a valid critique is that general practitioners and other health professionals are not represented here at all, nor have I examined the moral economy from the perspective of the community in which the ARC facility is situated.

### *The organisation*

While the ageing baby boomers are evoking economic panic among western State economists and health planners, they represent what Diamond (1992) has referred to as 'gray gold' to the burgeoning industry of aged residential care. In New Zealand, aged residential care institutions for veterans date from the early twentieth century (Swarbrick 2012). Following the second world war, the aged residential care landscape was dominated by church run and charitable organisations, such as Presbyterian Support Services (Saville-Smith 1993; Swarbrick 2012). Lazonby (2007, 14) identified a trend in the previous twenty years for not-for profit organisations to exit the ARC market while for-profit corporations have expanded their share. The ARC facility has become a point of articulation for corporate aims of producing profit for investors, at the same addressing local concerns by meeting the demand for aged care and providing a care workforce. The corporate for-profit organisations in New Zealand include Bupa (<http://www.bupa.co.nz/>), Metlife Care (<http://www.metlifecare.co.nz/>), Oceania (<http://www.oceaniahealthcare.co.nz/>), Ryman (<http://www.rymanhealthcare.co.nz/>), and Summerset (<https://www.summerset.co.nz/>). These organisations offer a range of care options, from retirement villages with independent living, to rest home and specialised hospital level care. Anecdotal evidence suggests that small locally-owned ARC are in decline, unable to meet the costs of regulatory compliance and demand for higher rates of pay (Harris 2017; Mitchell 2016; Roy 2015; Stowell 2018).

At an organisation level, the ARC institution must be financially solvent in order to satisfy its investors and stakeholders. This means they must be not only competitive, but successful in the marketplace. For a small family owned business like that of St Margarets (Jaye *et al.* 2015, 2016), this is about making enough money to maintain the required State regulatory standards, to provide personalised high quality care, and to make a living for the family owners. Their local social capital and family-orientation was a point of distinction that they used to distinguish their own boutique business from the major national and multinational corporations (*ibid.*). Many small ARC facilities do not have their own website, instead having a webpage hosted by Eldernet, an information service for older New Zealanders. Small ARC facilities often emphasise their local social capital and community embeddedness. Not for profit and charitable organisations such as the church-run aged residential care chains are not obliged to return income to investors other than their parent organisation but must remain solvent and competitive nevertheless. Although New Zealand is an increasingly secular society (Statistics New Zealand 2006b), the moral capital accrued through not for profit denominational affiliation is still considerable. The Presbyterian Support Services website (<https://ps.org.nz/>), as an example, emphasises the charitable nature of its organisation by highlighting the community good work it does, calls for donations, and its slogan, 'making a difference together'.

The competitive market element informs aged residential care corporations to a greater degree than the family-oriented and church-run organisations. For example, Ryman's website (<http://www.rymanhealthcare.co.nz/>) offers information on its facilities and includes a webpage for its investors. The website boasts the 'Ryman difference' also emphasising its commitment to high quality care and 'peace of mind guarantee' and has a strong rhetoric of customer satisfaction. The organisation uses its resort-like facilities as a point of distinction from other corporations, something noted by Fitzgerald and Robertson (2006) in their exploration of the meaning of home for residents in a multinational, corporate-owned ARC facility. This trope perhaps renders palatable the fact that capital is being transferred from customers to investors. Certainly, Cecilia Hall resembled a large modern hotel. In Australia, Braithwaite (2001, 444) claims that the multinational ARC provide more institutional forms of care, but have better risk management systems and quality assurance programs than the smaller and charitable ARC facilities. However, Braithwaite (2001) also argues that the drive to return profits to investors can result in economising that delivers lower quality of care to its residents.



While the macro-level moral discourses distinguished each ARC facility in these two studies, at the micro level of the actual facility itself, managers and careworkers in each ARC facility emphasised their commitment to providing quality care for their residents (Jaye *et al.* 2015, 2016). Ultimately, however, the cost of providing care to residents must balance favourably against the income received for these services; the predominant proportion of which is provided by the State subject to needs and asset assessments for each resident (Ministry of Health 2018a). This means that ARC managers must constantly strive to contain escalating costs in ways that do not impact on the health and safety of residents, and become entrepreneurial in providing extra services for which they can charge additional fees. In many ways this is consistent with the utilitarian and distributive justice ethical frameworks that underpin the rationales by which healthcare services are delivered to citizens (Coster 2000).

### *The careworkers and nurses*

*Careworkers:* There are several moral discourses around carework that articulate somewhat uneasily in the ARC facility. In New Zealand (Human Rights Commission 2012; Kiata, Kerse, and Dixon 2005), as elsewhere in the western world (Walsh and Shutes 2013), the aged care workforce is predominantly female and increasingly migrant; twenty-five per cent according to the 2006 Census (Human Rights Commission 2012, 104). The sector is highly dependent upon migrant labour sourced predominantly from the United Kingdom, Ireland, the Pacific Islands and the Philippines (*ibid.*, 105). The flow of female migrant care labour around the world, particularly from developing to developed countries has been well documented (England 2005; Hochschild 2000). In some part it is a response to what Hochschild (1995) has referred to as a care deficit in western societies arising largely from women's increasing participation within the paid workforce and decreased availability to provide care for their own children and aging parents. This phenomenon has been attributed to globalisation and neoliberalisation of western political economies (Hochschild 2000).

The Human Rights Commission (2012, 17) argues that the lack of value and social respect for aged care work reflects the lack of social value and respect for older New Zealanders. Careworkers in the aged care sector are among the lowest paid workers in New Zealand, reflecting 'the historic systemic under-valuation of the roles played by women in society' (*ibid.*, 45), and also the 'prisoner of love' analysis emphasising the altruistic motivations and intrinsic rewards for carework (England 2005). England (2005, 389) argues that the nonpecuniary satisfaction that careworkers derive from their work enables employers to

fill these jobs offering lower pay than in comparable jobs without the caring component. In New Zealand the high staff turnover in the industry as a whole is estimated to be around twenty-two per cent annually; much higher in the USA with estimates from thirty-eight per cent to 143 per cent (Kiata, Kerse, and Dixon 2005), a rate that bears witness to careworkers' dissatisfaction with the poor pay, demanding working conditions, limited opportunities for career advancement, and the perceived low social value of their work (Henley and Jaye 2015; Human Rights Commission 2012; Kiata, Kerse, and Dixon 2005). The high workforce turnover in the industry is one indication of the highly contested nature of the aged care moral economy. The managers of ARC facilities participating in Jaye *et al.*'s (2015, 2016) study took great pride in their very high workforce retention rates compared to the industry as a whole, an intrinsic moral standpoint about the conditions of employment in their ARC facilities and the workers they attract.

Despite the low pay and poor working conditions, it is clear that many careworkers derive enormous satisfaction in their work (Henley and Jaye 2015; Human Rights Commission 2012, 18; Jaye *et al.* 2015). This represents yet another dimension to the moral economies of the aged care facility. A careworker in the multinational ARC facility of Henley and Jaye's (2015) study commented, 'I think it's just my nature to give and care for people. It's something I've always enjoyed – helping people and feeling like you're actually valued for what you are doing' (p.8). This illustrates the point that the attributes of a good careworker are deeply moral judgements (Kittay 1999), and good careworkers reinforce these stereotypes. A readily identifiable care ethics was apparent in all ARC facilities that included respect for residents' dignity and personhood, and dedication to facilitating as much independence and autonomy as possible given residents' abilities. It also included being attentive to the needs of participants, facilitating the settling-in process so that residents could find home within the ARC facility, encouraging friendships, and providing meaningful activities that promoted fun and happiness (Henley and Jaye 2015; Jaye *et al.* 2015, 2016; Robertson and Fitzgerald 2010).

In the ARC facility, careworkers and residents can become enmeshed in each other's lives through conversations, sharing stories and confidences within the intimate context of carework. Bonds of genuine affection occur and careworkers can come to fill daughter and other kin roles as their relationship with the recipient of care develops over time (Karner 1998). It was clear in the studies by Jaye *et al.* (2015, 2016) and Henley and Jaye (2015) that residents highly valued and supported their careworkers.

*Nurses:* The registered nurses (RNs) employed in ARC facilities are distinct from careworkers in several ways. One is that they organise rosters and shifts and supervise careworkers, thus having higher status in the facility. Secondly, they have professional qualifications and must maintain registration with the Nursing Council of New Zealand, thus are representative of a recognised trained and skilled workforce. They are also highly politicised with a strong workers' union that has won considerable concessions for nurses' pay and conditions of work over the previous twenty years. In the aged care sector, it is estimated that approximately one-third of registered nurses are migrants (Human Rights Commission 2012, 106). Within the ARC facility, it is RNs who have authority to sign off on medications, draw up care plans, liaise with other health professionals such as community general practitioners and hospital specialists. Nurses carry intrinsic moral capital as health professionals and are one of the most trusted professions in New Zealand (Staff Reporter 2015).

### *The residents*

Old people are time travelers. They have witnessed tremendous change over the course of their lifetimes. For example, the current cohort of over eighty year olds in New Zealand were born before the second world war, and have witnessed the Korean and Vietnam wars, the Great Depression, and they have experienced the effects of globalisation, transnationalism and mass migration, social revolutions of women's, indigenous, gay and other human rights, not to mention the technological and communications advances of the twentieth and twenty-first centuries. They have experienced economic reforms; notably from welfarist to neoliberalist policies that have impacted upon labour and employment and the provision of welfare. The chances are high that their grand- and great-grandchildren are growing up in very different socio-cultural conditions with very different normative expectations from those of their own childhoods. The identities of this cohort cannot be disarticulated from the political economies and concomitant normalising technologies of the previous eighty years (Foucault 1988; Giddens 1991). Rapport (citing Hannerz (1990) 2012, 57) argues that since the 1950s individuals have become far more oriented towards global and less towards local identities. The television brings the world into the ARC facility, as do migrant careworkers and nurses, and visiting family and community members. Residents are likely to wear clothes and shoes made in China, to take medications produced in India, and to use specialised equipment manufactured in Germany. This invokes the image of the ARC resident as an armchair cosmopolitan, but also illustrates that there is no escaping cosmopolitanisation.

It has been previously argued that reminiscence and storytelling is the work of the old, the process by which older people come to terms with, and prepare for the end of their lives (Butler 1963; Kenyon and Randall 2001). Storytelling draws together events, places, oneself and other people into coherent narratives that at the same time construct the storyteller and the characters within it, as particular kinds of people (Garro and Mattingly 2000; *Jaye et al.* 2015). In addition to the construction of characters as protagonists and antagonists, good and bad, innocent and guilty, stories frequently offer a significant message, or contain a moral lesson. Arguably, the extent to which the stories of older people connect events, places, and people across the world and the span of their lives, renders the storyteller a cosmopolitan. Indeed, older people sit at the centre of various concentric and overlapping cosmopolitanisms within the ARC facility.

Many residents gain admission to ARC facilities as the result of a fall or inability to care for themselves in their own homes. The transition to care can be a traumatic one, requiring adjustments to institutional life and grieving over the loss of one's cherished home and possessions, as well as daily routines and missing one's spouse and pets (*Jaye et al.* 2015, 2016; *Lagace et al.* 2012; Pirhonen and Pietila 2015). In 2005, it was estimated that approximately ninety-five per cent of ARC residents in NZ were ethnically European or New Zealand European (Kiata, Kerse, and Dixon 2005). It is unlikely that the previous decade has seen significant change in this demographic. While the shorter lifespans of Māori and Pacific people relative to European and NZ European is one explanation for their absence in ARC, there are likely to be cultural factors that underlie the high acceptability of New Zealand and other Europeans to enter residential care and the preferences for Pacific Island, Māori and Asian elders to be cared for in the homes of their families. Saville-Smith (1993) suggested that State social policies of the 1950s and 60s supported the household unit of the nuclear family and this reinforced a separation between older people and their families. Inability of ARC facilities to accommodate cultural requirements has been suggested in the case of Māori (Radio New Zealand News 2014; Raukawa-Tait 2013); and the availability of younger family members to care for older Māori and Pacific people in their own homes (Kiata and Kerse 2004). Because these decisions are driven by notions about what is good, right and desirable, they are highly moral in nature. Residents may be resigned to the inevitability of a move into residential care because they feel they have become an unacceptable burden to their family members (Breheny and Stephens 2012); family members may make the decision to place a parent or spouse in residential care because they do not feel competent to provide the level of care required to keep them in their own homes, or to keep their parent or spouse safe in the family home. The ARC facility becomes the most pragmatic option. However, it is apparent that many

residents find home within their ARC facility (Fitzgerald and Robertson 2006; O'Connor 2015), participating in its community and developing friendships with staff and other residents. As recipients of institutional care, residents can find themselves subject to normalising technologies that subtly encourage them to take up the identity of the 'good' resident; compliant, pleasant, agreeable, grateful (Jaye *et al.* 2015).

### *The families*

Family members can experience mixed feelings when their parent, spouse or relative enters residential care (Davies and Nolan 2003; Moore and Dow 2015). They may feel relief because their family member will receive the specialised care they require, such as incontinence management, but also guilt for their own inability to provide this care, and concern that their relative is reluctantly entering residential care, i.e., would prefer to remain at home (Ryan and Scullion 2000). The move into care may precipitate a loss of sense of purpose for the caregiver left at home and prompt identity issues (Moore and Dow 2015, 878) such as those described by Jowsey in this volume. The decision may be more easily justifiable in the case of a parent or spouse who has dementia or who has had a serious fall and can no longer be left unattended. This process involves consideration of the relative merits in terms of what is best for whom; in ethical terms, balancing rights, autonomy, virtue, obligations, and consequentialism (Davies and Nolan 2003). However, according to Davies and Nolan (2003, 444), family members' desire to do the best thing is often constrained by circumstances beyond their control, and decision making is frequently described as making the best choice among a set of bad options (p.437).

In many ways, the ARC facility becomes a proxy for family-provided care; with an expectation that residents will be kept safe, treated with kindness and dignity, and receive quality care. Generally speaking, it is important to family members that their parent or spouse does not receive poorer care in the ARC than they would from family members in their homes. This makes choosing an ARC a morally-charged exercise. Anyone who has needed to place a parent or spouse in ARC can attest to the research they do to find the best facility for their family member. In addition, bed availability within ARC facilities is somewhat unpredictable and haphazard and this means that family members' preferences for placement may not be realised.

The government will contribute a maximum of \$800 per week to pay for residential care. Around forty-three per cent of ARC facilities in New Zealand offer additional services for an extra fee (Grant Thornton NZ Ltd 2010). This means

that families can choose to pay for extras such as a premium room, ensuite bathroom, private telephone and internet (Clement 2012). In 2012, in order to qualify for the residential care subsidy, an individual had to be over sixty-five years and have assets worth \$210,000 or less (Clement 2012, Ministry of Health 2016). The cost of care is another consideration for family members. Unless their assets are protected by robust family trusts, the longevity of a parent or spouse in ARC can significantly deplete inheritances, a highly moral economic and ethical issue.

The trust that family members place in ARC to care for their parent or spouse is no more apparent than when they have not received the level of care that family members' expect. Media headlines reporting failures in ARC facilities attest to the moral outrage of family members, many of which are based on publicly-accessible reports of investigations by the Office of the Health and Disability Commissioner. A sample will suffice:

*Wellington rest homes being investigated after claims of abuse of elderly patients.* (Macandrew 2018)

*Rest Home Failed to Provide Adequate Care to Elderly Woman Who Died of Sepsis.* (Staff Reporter 2018)

*New Plymouth rest home's standard of care below par watchdog says.* (Keith 2015)

*Woman found covered in faeces at retirement home.* (Blundell 2013)

Another component of moral concern is evident in recent newspaper reports of ARC closures in rural communities (Mitchell 2016; Rangi 2015; Stowell 2018). In larger communities, there are usually many ARC options to choose from. When the only ARC facility in a small rural town cannot meet local demand, or closes, residents must move from their own communities to ARC facilities in distant towns. Not only does this represent a dislocation that can exacerbate the transition to care, but it means that their family members can no longer 'pop in' for daily visits.

### *The State*

Since the enactment of the Social Security Act in 1964 (2016), the New Zealand State has been required to meet the costs of aged residential care for its citizens. Compared to many other western nations, New Zealand invests much less

capital into aged residential care, despite having a much higher proportion of its population in such care (Grant Thornton NZ Ltd 2010, Appendix F).

Individuals who are prepared to pay the full costs of their own residential care have always been able to access private ARC. As the demand for ARC increases with an ageing population, restrictions on access to ARC ensure that only those with the greatest need are admitted to publicly-funded ARC. There have always been functional and means criteria for admission to aged residential hospital level care. The government's Residential Care Subsidy was introduced in 1993 when long-term rehabilitation was moved from hospitals to ARC as part of the hospital reforms of the 1990s (Lazonby 2007, 6). Eligibility depends upon income testing and the issue remains contentious for the public (Clement 2012). The standardised national needs assessment was introduced in 2000 (Coster 2000, 1) to determine the necessary level of care required (Lazonby 2007, 9). It also served to limit access to publicly funded ARC to only those individuals who can no longer satisfactorily and safely perform functions of daily life, as a proxy for capacity for independent living (Broad *et al.* 2011, 492). As a result, those entering ARC facilities in the previous twenty years have become progressively older and more frail (Lazonby 2007, 6).

Neoliberalism promotes individualism and self-responsibility in lifestyle choices and health seeking. This means that later life circumstances are constructed as the culmination of good individual decision making, something that Breheny and Stephens (2012, 439) suggest can mask the structural foundation of inequalities in older people's situations. In Australia, according to Braithwaite (2001), the market-driven neoliberal policies pertaining to ARC are problematic because residents as consumers of ARC facilities are less able to complain or to leave if their care is inadequate because of comprised functional and cognitive capacity.

New Zealand uses a regulatory design that includes a combination of what O'Dwyer (2015) describes as 'command-and-control' where national prescribed standards are imposed and backed by criminal sanctions, and 'disclosure regulation' where information about ARC facilities is provided directly to the public in order to weed out underperformers (p.119). The Ministry of Health is responsible for the overall regulation of the aged care sector. ARC must meet the industry standards prescribed in the Health and Disability Services (Safety) Act 2001 (Ministry of Health 2018b). The standards were revamped in 2008 and are intended to 'provide the foundation for describing good practice and fostering continuous improvement in the quality of health and disability services. They set out the rights for consumers and ensure services are clear about their

responsibilities for safe outcomes' (Ministry of Health 2008). The Donabedian (1992) framework for quality health care services is apparent in these, with an emphasis on processes, structures and outcomes. The government requires all ARC facilities to sign a national contract with their local District Health Board agreeing to meet the industry standards (Ministry of Health 2016).

Compliance with these standards is assessed through audits conducted under the auspices of the governmental agency HealthCert. ARC are assessed on the degree to which they meet standards on consumer rights, organisational management and continuum of service delivery, safe and appropriate environment, restraint minimisation and safe practice, and infection prevention and control (Ministry of Health 2018b). Auditors spent time observing in the ARC, reviewing ARC and medical records for residents, and they also interviewed residents and ARC staff. The final auditor's reports, along with their assessment of risk and updates are available to the public on the Ministry of Health website. The ability of audit to provide an accurate view of the quality of care provided in an ARC facility is contested. Audit represents a means of managing risk that can be described as a verification ritual (Power 2003, cited in Braithwaite (2001, 445)). Braithwaite (2001, 445) suggests that audit represents the triumph of accounting methodologies over other methodologies that could more accurately record quality care.

The distributive justice principles that underlie the State's provision of an aged residential care subsidy to its citizens are evident in efforts to prioritise access to aged residential care (Coster 2000). In New Zealand, the neoliberalism evident in the healthcare sector with its emphasis on responsibility and individualism appears to be tempered by an ethic of paternalism towards older people in general and to the most vulnerable of these in aged residential care. This reflects, according to Weicht (2013), the ways in which social discourses and social policy strip older people of their identities as active contributors to society and the economy, at the same time constructing older people as unproductive, dependent, and passive.

## CONCLUSION

The political economy of aged care is also a moral economy containing multiple contested moral spaces, purposes and standpoints. The standpoint of the State carries significant weight in this landscape because it shapes the moral economy of the New Zealand aged care sector through enforceable policies and regulations. Yet, even within these policies, there are tensions in moral and ethical discourses. The industry standards (Ministry of Health 2008) are both



paternalistic (reminiscent of welfarism) and rights-oriented (a characteristic of liberalism), while policies for means and asset testing are strongly utilitarian (greatest benefit to the greatest number of population) and distributive (prioritisation and rationing of healthcare services). ARC organisations and facilities compete in a neoliberal consumption- oriented marketplace, driven by diverse moral standpoints, the basis of which is financial viability, but distinguished by motives of charity and public good, local service, and the return of dividends to shareholders. Those employed in the sector such as nurses and careworkers seek a living; finding a sense of vocation and reward in the work itself is a bonus that also shapes identities and provides a sense of moral purpose. The decision to enter ARC can be a morally charged exercise that requires balancing what is best for spouses, families and the older person with what can be afforded and the availability of ARC beds. Residents must find home within the institutionalism of ARC facilities; compromising independence against needs associated with decreasing physical and cognitive function. Depending on cognitive capability, they also engage in the moral work associated with receiving care. These standpoints articulate within the everyday rhythms and routines of the ARC facility as a vernacular cosmopolitanism that also bears witness to cosmopolitanisation.

One central orientation in cosmopolitan inquiry concerns existential and moral reflections on what it means to be human, and what obligations we have towards our kin and towards strangers (Josephides 2010). Caring work is deeply cosmopolitan because it epitomises laudable moral qualities of humanity, such as compassion, openness and responsiveness to the needs of the Other. As Jackson in this volume suggests, it is the act of caring that creates caregivers as cosmopolitans. This is also true of paid careworkers. I suggest that although careworkers in the aged residential sector are underpaid relative to similar jobs in the healthcare sector, 'good' careworkers nevertheless accrue significant moral capital, which is recognised at the micro level of the ARC by co-workers, residents, family members, spouses, and managers (Henley and Jaye 2015; Jaye *et al.* 2015, 2016).

Central to the moral economy in aged residential care is the framing of care, what constitutes quality in care and how this is measured. Health and safety discourses are characteristic of neoliberal bureaucracies that seek to mitigate risk and therefore State liability in the workplace (MacEachen 2000); as such they also reflect global processes of cosmopolitanisation. The ethical paternalism and principlism of policy makers is reflected, somewhat paradoxically, in neoliberal regulatory systems such as audit that prioritise the safety of residents. While it is not unreasonable that residents should be safe within ARC facilities,

one critique of the prioritisation of health and safety regulatory discourses is that residents are frequently bored and depressed within sanitised, safe and risk-free environments (Mozley *et al.* 2004; Theurer *et al.* 2015). The degree to which residents can engage in meaningful activities such as helping with household chores, gardening, making mosaics or pottering in a workshop with real tools might prove to be a better measure of the quality of a facility from residents and family perspectives (Gawande 2014; Jaye *et al.* 2016, Mozley *et al.* 2004, 195). Theurer *et al.* (2015, 202) argue that it is time for a social revolution in aged residential care. The much vaunted Eden Alternative in the United States (<http://www.edenalt.org/>) and work of Grace O'Sullivan (2011) in New Zealand illustrate competing moral discourses informed by a care ethics that also upholds principles of autonomy, beneficence and non-maleficence.

In an aged care sector dominated by multinational corporations, how can organisations meet the costs of regulatory compliance, improve the pay and working conditions of careworkers, provide residents with a meaningful and engaged life within ARC facilities and high quality care, and return attractive dividends to investors? Siméant (2015, 171) argues that moral economies are always temporal in that they are tied to particular economic regimes and contexts. On one hand it might be argued that cosmopolitanism as a moral purpose transcends the temporality and geography of political economies. On the other hand, cosmopolitanisation as a critical analysis of global responses to imagined risk is very much rooted within particular political economies, although these are not necessarily constrained by nationality. Mattingly (2012, 173) suggests that Foucault's moral practices of self-cultivation can only ever reflect normalising technologies of truth regimes, perhaps an illustration of Rapport's (2012, 58) claim that the human individual embodies the whole of humanity. The aged residential care sector, as a moral economy encompassing macro and micro levels of perspective, experience and analysis, is host to a plethora of competing and contested moral standpoints. The micro level of the ARC facility affords an inspection of the situated individual described by Gay y Blasco (2010) and the ways in which cosmopolitanisation is experienced and lived, while the macro level allows an examination of the ethical frameworks and moral standpoints evident in policy discourses and the articulation of these with practice.

#### NOTE

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