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Discourse

The Politics of Home Care: Where Is "Home"?

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> "Why the hell should I vote? What have politicians done for me." ...[Bryan]...has been living on the streets of Centretown for the past two years. During the day, the 54-year-old sits with his dog on the pavement at the corner of Bank and Slater streets looking for change from passers-by.
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> At night, he goes back to his home — a dark corner of pavement behind the old Ottawa Technical high school on Albert Street. His bed is a pile of tattered blankets tucked in between a cement wall covered with graffiti and a partly rusted metal railing. (Nicolle, 2000)

What might be the meaning of home care for Bryan? Bryan's situation is by no means unique. As the health-care reform movement has gained momentum, and as the drive towards home-care management has accelerated, homelessness and poverty have become realities in the lives of many. An October 1997 headline in the *Globe and Mail* read, "Shelters running out of space: Warning sounded as winter looms." That same year, it was estimated that about 5,350 people in Toronto slept in shelters each night, compared to about 3,970 the year before. And the newspaper article reported that it was not only single men who faced homelessness; shelters for women and children were also full (Matas & Philp, 1997).

The crisis of homelessness reflects, among other social issues, a rise in urban poverty. Lee (2000), "using data from the 1996 Census and Statistics Canada's Low Income Cut-offs to measure poverty," found that between 1990 and 1995, poor populations in metropolitan areas grew by 33.8%, far outstripping population growth (6.9%) for the same time period (p. xv). Moreover, "certain population groups were more likely than others to be poor. The average poverty rate among all city

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residents was 24.5 per cent" (p. xv). The poverty rate among urban Aboriginal populations was 55.6%, "followed by recent immigrants (52.1 per cent), visible minorities (37.6 per cent), and persons with disabilities (36.1 per cent)" (p. xv). In 1993, according to Health Canada's Women's Health Strategy (Government of Canada, 1999), 56% of "senior women living alone or with unrelated persons, had low incomes. This compared with 38% of unattached senior men.... The lives of women seniors are more likely to be marked by poverty as a result of interruptions or non-participation in the paid labour force, or of low wages and few benefits" (p. 14). Homelessness among elderly women is an increasingly common phenomenon, as affordable housing becomes less accessible.

How should we understand and interpret home care against this social landscape?

In promoting the concept of home care, several government commissions have constructed "home" as the preferred locus of care. The British Columbia Royal Commission on Health Care and Costs noted, for example:

> A clear message received by the commission is that, whenever possible, care provided in the home or on an outpatient basis is preferable to institutionalization.
>
> According to a recent Ontario study, informal caregiving by family, friends, neighbours and volunteers provides up to 90 percent of the assistance required by dependent people. The caregiver is usually female, usually the spouse or an adult daughter of the dependent person. Professional caregiving only supplements and supports this informal system.
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> There are many costs involved with keeping people in institutions, and from a quality of life as well as an economic perspective, we must encourage home and community care. (Government of British Columbia, 1991, p. C-154)

Although the need for practical and appropriate support to "informal caregivers" is recognized in the above report, the effect of the caregiving process on a woman's life (e.g., what it means in terms of her employment outside of the home, pension benefits, etc.) is left unquestioned. "Most people feel better and get better more quickly in familiar environments with the support of family members and friends close at hand," echoed a later report (Government of British Columbia, 1993, p. 14).

One might argue that these documents were produced in the early 1990s, prior to the sharp rise in poverty and homelessness. Yet the

assumptions and ideologies that underpin them continue to drive health-care restructuring and the home-care movement. While crafted to reflect the notion that home care is for the good of the individual, the documents have as their fundamental precepts a concern with government spending on health; home-care management as a gendered activity, and the expectation that women will take on the role of caregiver; and the ideology of one's individual responsibility for oneself. Furthermore, the home-care discourse is based on deep-seated assumptions about home and family, for example, that we all have homes with family and friends close at hand to provide a nurturing environment, and that resources are in place (bedding, laundry facilities, etc.) to make home-care a reality. In other words, the notion of home care is entrenched in a particular meaning of "home" and constructed from a particular social location: the privileged middle class. Most importantly, it represents an off-loading of responsibility from the state to the individual and "family," even in those instances where "home-care services" are supposedly provided. As I point out elsewhere, the home-care movement must be understood in the context of societal and health-care ideologies that stress individual and family responsibility (Anderson, 1990) and that are enmeshed in the notion that personal misfortunes (as well as personal successes) are *individually* produced. In addition, as Williams, Deber, Baranek, and Gildiner (2001) argue, in the process of shifting the locus of care from hospital to community, we are shifting care "outside of the 'rules' and universal entitlements to medicare" (p. 10).

Towards a Critical Discourse: From Neoliberalism to Postcolonialism

If the voices of those who live on the margins and in poverty are to be heard in the discourse on home care, alternative ideologies will have to be brought to bear on the reframing of issues: theorizing must include the "polyvocality of multiple social locations" (Brewer, 1993, p. 13). This will mean challenging neoliberal ideologies, crafting health policies that reflect the multiple social and economic contexts of people's lives, and developing integrated health and social policy initiatives. I draw upon Green's (1996) definition of neoliberalism as "an ideology that advocates an economic arena free of government regulation or restriction...and certainly, free of government action via public ownership. It advocates a retreat from the welfare state's publicly funded commitments to equality and social justice. It views citizenship as consumption and economic production" (p. 112). Neoliberalism drives the push towards privatization and profitization of health care. As Williams et al. (2001) note, "because it is publicly funded and regulated, medicare is

portrayed by adherents of neo-liberal free market ideologies as a source of inefficiency, waste, and abuse in an era of increasingly competitive global markets" (pp. 7–8).

Alternative discourses would hold the ideology of neoliberalism up to question and help us to move forward with an agenda that upholds the principles of equity and social justice. Postcolonial perspectives (see, for example, Bhabha, 1994; Quayson, 2000) that are now being drawn on in nursing (see, for example, Anderson, 2000a, 2000b) might provide a valuable theoretical stance from which to critique neoliberal ideologies and provide direction on issues pertinent to health and social policy and health-care delivery. Quayson tells us that "a possible working definition for postcolonialism is that it involves a studied engagement with the experience of colonialism and its past and present effects, both at the local level of ex-colonial societies as well as at the level of more general global developments thought to be the after effects of empire" (p. 2). While some might interpret such a definition as irrelevant to the Canadian context, I argue otherwise. I take the position that Quayson's perspective provides the conceptual apparatus for a critical analysis of the root causes of structural inequalities, and allows us to see how these inequalities are being produced and maintained by historical and social relations in a global and transnational context, underpinned by the dominant ideology of neoliberalism. Through the lens of postcolonial scholarship, and, I might add, a postcolonial *feminist* scholarship, we can critically examine the class relations produced by neoliberal ideologies and the forces that sustain the feminization of poverty. Such an analysis provides insight into the factors that lead to poverty and homelessness, and is a prerequisite for the development of transformative knowledge to guide health and social policy and practice that will address social inequities. "By transformative I mean knowledge that is, first of all, undergirded by critical consciousness... and that unmasks unequal relations of power and issues of domination and subordination" (Anderson, 1998, p. 205).

As we — nurse practitioners, administrators, educators, and nurse scientists — examine directions in health care for the 21st century, we must reflect on the scope of our mandate, given the issues that confront us today. There is overwhelming evidence that health cannot be separated from the social context of people's lives. It is also recognized that health-care delivery at the local level is bound up with global issues and the economic ideology of neoliberalism. In other words, health and health care are not isolated issues but are embedded in a nexus of social, historical, political, and economic relations. Nurses have a social and ethical responsibility to recognize these factors. However, we must

not only recognize them, but actively address them in our research and practice. For example, homelessness and poverty among marginalized groups, and the factors that contribute to women's poverty, must be central to our research agenda. But doing the research is not enough. We must position ourselves collectively to use this research as a means of influencing policy decisions; we must also put the research into practice as we reconceptualize the management of health care and home care for the years ahead.

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