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Creating and sustaining disadvantage: the relevance of a social exclusion framework

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Abstract
Over the last decade, public home-care services for elderly people have been subject to increased rationing and changes in resource allocation. We argue that a social exclusion framework can be used to explain the impacts of current policy priorities and organisational practices. In this paper, we use the framework of social exclusion to highlight the disadvantages experienced by elderly people, particularly those who cannot afford to supplement public care with private services. We illustrate our argument by drawing on examples from previous studies with persons giving and receiving care in the province of Québec. Our focus is on seven forms of exclusion: symbolic, identity, socio-political, institutional, economic, exclusion from meaningful relations, and territorial exclusion. These illustrations suggest that policy-makers, practitioners and researchers must address the various ways in which current policy priorities can create and sustain various types of exclusion of elderly people. They also highlight the need to reconsider the current decisions made regarding the allocation of services for elderly people.

Keywords: health and social care, elderly people, practice, Québec, social policy

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Over the last decade, public home-care services for elderly people have been subject to increased rationing and changes in resource allocation. As priorities are increasingly oriented towards economic, biomedical and professional determinants of care, elderly people are increasingly vulnerable to social exclusion. We use a social exclusion framework to demonstrate how policy priorities and organisational practices can impact on elderly people, particularly those who cannot afford to supplement public care with private services. We illustrate our argument by drawing on examples from previous studies with persons giving and receiving care in the province of Québec (Gagnon *et al*. 2001, Grenier 2002, 2007a, NDG-SCC 2002). We argue that a social exclusion framework can be used to better understand how home-care practices implicitly and explicitly affect elderly people's lives and, in particular, can highlight the disadvantages experienced by elderly people.

A social exclusion framework helps to reveal how policies and organisational practices work to deprive people of the capacity to exercise their rights (Ballet 2001) or participate in the activities of citizens in a given society (Burchardt *et al*. 1999). Applying this framework to an understanding of home-care policy and practice pushes us to look at the global and structural ways that policies and practices prevent elderly people from being who they want to be, and living how they want despite physical impairment and/or frailty. It also allows us to move beyond considering issues within home care as merely those of accessibility, quality and adequacy of care. We begin by briefly introducing the conceptual development of social exclusion in the United Kingdom (UK) and European Union, proceed to outline our framework, and then provide illustrations of the various forms of exclusion experienced by elderly persons receiving care in one Canadian province.

The concept of social exclusion

The concept of social exclusion emerged in European sociology as a means to expand critical understandings beyond the popular frames of poverty and marginalisation

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(Berghman 1995, Paugam 1996, Tsakloglou & Papadopoulos 2002). The first studies focused primarily on exclusion from the labour force, questions of social integration, social participation, and social protection (Lenoir 1974, Castel 1995). Although traditionally concerned with issues of economic disadvantage, social exclusion has expanded into investigating the barriers to people's attainment of civil, social and political rights as well as their access to resources that would allow them to achieve personal and social fulfilment (Burchardt *et al*. 1999, Ballet 2001). The concept of social exclusion thus refers to the actual and symbolic exclusion of certain segments of the population from material and social resources (Vranken 2001) as well as the non-realisation of civil rights in key societal institutions (Berghman 1995). The multidimensional nature and the dynamic process of social exclusion (Castel 1995) have made it relevant for use within a social policy domain.

In policy circles in the UK and European Union, the concept of social exclusion has received considerable attention (Littlewood & Herkommer 1999, Hills *et al*. 2002) including research into the ways in which elderly people can be at risk for social exclusion (Room 1995, Guillemard 1996, Byrne 1999, Peace & Holland 2001, Bickel & Cavalli 2002, Ennuyer 2002, Davies 2005). In the UK, the relevance of social exclusion was sparked by the Labour government's public policy agenda (Levitas 2005). While some authors are critical of the ways in which the concept has replaced an analysis of poverty and tends to legitimise only modest policy reforms (Beland 2007), others have suggested that social exclusion can represent a radical critique in particular contexts (Silver & Miller 2003). In the literature on ageing, social exclusion has been used to better articulate the needs of elderly people beyond income measures. Writing from the UK context, Scharf *et al*. (2004) suggest that elderly people are likely to experience exclusion through five interconnected dimensions (exclusion from material resources, exclusion from social relations, exclusion from civic activities, exclusion from basic services and neighbourhood exclusion), and highlight the importance of social policies that lead to the development of supportive infrastructure, community engagement and intimate relationships that reduce feelings of exclusion. While the concept of social exclusion has received detailed attention in the UK and European Union, understandings and the application of social exclusion in North America, where it is not a stated aspect of the policy agenda, are limited.

A social exclusion framework

The social exclusion framework used in this paper (Guberman & Lavoie 2004) was developed in order to provide an interdisciplinary research team in social gerontology with the means to think beyond the dominant framework of social integration used in the province of Québec. Team members felt that social integration was a normative and functionalist concept that did not accommodate the realities of vulnerability and marginalisation experienced by elderly people. In reviewing the literature, the concept of social exclusion held the greatest potential to critically question dominant social relations as they pertain to elderly people. Our framework was built from key themes identified from a comprehensive literature review and is situated within the tradition of critical gerontology that challenges taken-for-granted policies and practices (Estes *et al*. 2003). This framework focuses on the multiple and intersecting processes of social and institutional exclusion that are associated with ageing in Western societies, as well as the ways in which individuals and groups resist and counter these processes. This model does not see social exclusion as the binary opposite of social inclusion, nor does it see inclusion and exclusion located on a continuum. Social exclusion is conceptualised as comprised of the seven intersecting forms shown in Table 1. This framework of social exclusion provides a valuable means to critically analyse contemporary policies and practices by articulating the ways that policies and practices (e.g. institutional, social and political) operate to limit elderly people and their families' participation in society, their access to resources, and their expressions of identity and personhood.

The local home-care context

Although developed with the Québec provincial home-care context in mind, the relevance of our social exclusion analytical framework extends beyond this local application. Reforms taking place in Québec since the 1990s correspond with international trends of rationing home-care services for elderly people, and the movement towards standardised assessment. While the context of service delivery in Québec differs slightly from other provinces and international programmes, local reforms, like those in other Canadian provinces, have emphasised the high healthcare costs of the public system and altered the service structure and delivery of home-care services by engaging in 'fiscal responsibility' and ongoing budgetary cutbacks (see Campbell *et al*. 1998, Armstrong & Armstrong 1999, Bégin *et al*. 1999, Fuller 1999, Duncan & Reutter 2006). What is commonly understood as a mounting neoliberalist approach results in home-care programmes delivered within the 'mixed-economy of care' comprised of a combination of public, para-public and private services, as seen in Québec. This changed context of care also reduces the work of professionals to

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Table 1 Forms of social exclusion

Domain	Definition
Symbolic exclusion	Negative representations afforded particular groups as well as the invisibility of such groups within society.
Identity exclusion	Dismissal or diminishment of the distinctive and multiple identities of the person or group through reduction to one identity such as age.
Socio-political exclusion	Barriers to civic and political participation resulting from a lack of involvement in decision-making, collective power, limited political clout or agency.
Institutional exclusion	Exclusion from social and political institutions resulting from decreased services that negatively affect their health and well-being and/or no consultation with the individual or their caregivers regarding their care.
Economic exclusion	Lack of access to income or material resources required to meet basic needs.
Exclusion from meaningful relations	Exclusion from the development and maintenance of meaningful social relationships through the absence of networks, lack of access to them, or rejection from them.
Territorial exclusion	Geographical isolation, regulation to spaces with limited opportunity for social involvement, lack of geographical mobility or control over one's environment.

administering standardised assessments and establishing a priority for service based on 'risk'. In Québec, however, home-care programmes now focus predominantly on clients discharged from hospital rather than traditional notions of support offered to elderly people in the community. The resulting rationed allocation of services completely overlooks the range of social needs defined and experienced by community-residing elderly people.

Description of illustrative studies

The following illustrations of the various forms of exclusion are drawn from four studies on home care undertaken between 1995 and 2007. The first study, conducted with persons giving and receiving care, sought to explore the impact of the *Virage ambulatoire* (i.e. ambulatory care or hospital discharge planning) policy (Gagnon *et al*. 2001); the second study – a qualitative needs assessment of seniors living in one urban neighbourhood – was conducted with a local seniors organisation (NDG-SCC 2002); the third study was a narrative study on frailty, a concept used to assess eligibility for services (Grenier 2002); and the fourth study was an ethnographic account comprised of document review, observations and interviews with managers displaced by the recent reforms (Grenier 2007a). Together, these studies provide snapshots from within the health and social care context from 1990 onwards – a period of significant reform for home-care services. Although none of these studies originally set out to explore social exclusion, a review of the findings highlighted how a social exclusion framework could help to explain the disadvantages experienced by elderly people as a result of increased rationing and resource-allocation decisions.

Creating and sustaining social exclusion

In this section, we will present how the different forms of social exclusion were experienced as a result of current home-care policies and practices in Québec. The following categories correspond with the domains of social exclusion identified in Table 1.

Symbolic exclusion

The widespread limited public investment in care, the lack of a broad policy vision addressing elderly people's services, and the public statements made about them sustain the dominant public image of elderly people as marginal or without value. These examples of exclusion occur at both the macro and micro levels. For example, at the macro level in Québec, there is both a failure to commit budgets to the care of elderly people, and a lack of an overarching policy statement or perspective, such as the UK's National Service Frameworks (Department of Health 2001), to outline the value of services for elderly people. Québec has only a home-care policy entitled *Soutien à Domicile* (MSSS 2003) and policies focused on the care of frail elderly persons (Regie Regionale 1998, MSSS 2006); the underlying assumption is that only the risks of frail elderly people need to be addressed, but even these should be restricted to reduce healthcare expenses. Examples of symbolic exclusion at the micro level include references to elderly people as a burden on the public purse or questions regarding their right to certain types of care (see Gee & Gutman 2000). For example, we have found that it is not uncommon to hear questions such as: 'why should they receive subsidised housework?' or 'why do they get a paid bath per week?' In some cases, judgements of 'deservedness' exist even amongst home-care workers and elderly people.

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Identity exclusion

Home-care practices can also transfer identities such as 'frailty' or 'dependance' onto the elderly person. In the context of service, the elderly person is identified as a service recipient and practitioners subsequently focus on diagnosis, risk, eligibility and the image of elderly people is increasingly framed in terms of frailty (Grenier 2007b). For example, it is not uncommon to hear workers discuss cases by their diagnosis 'the 82-year-old hip fracture'. Such an approach overlooks or excludes the identities and needs of elderly people. Consider the case of Mrs R.

> Mrs R. has a long history of depression and schizophrenia, and has connections with many community organisations, the CLSC [Local Community Service Centre], and psychiatric hospital. She says it is really hard to get professionals to listen to her because she is labelled schizophrenic. She feels she is 'dismissed' and talked down to. (NDG-SSC 2002)

Furthermore, the implications of such practices is that even elderly people themselves can begin to lose their sense of self.

> I said to the nurse ... 'I don't know who I am anymore ... so many months in [that] ward, people coming and going and I stayed on ... [now, upon returning home] I don't know who I am, I don't know what I can do, or will be able to do ...' (Grenier, 2002)

Policies and organisational practices can create and maintain identity exclusion that fails to acknowledge the various identities and meaningful contributions made by elderly people and results in a practice which can infantilise or reduce elderly people to mere caricatures of themselves.

Socio-political exclusion

Moving to the social context, a major example of the ways in which elderly people are excluded from socio-political participation is the way in which elderly people receiving care become isolated within their home. This type of exclusion is created and sustained by the fact that eligibility for home care is founded on the basis of elderly people's inability to leave their home. This assumption that home-care recipients should be home-bound and the implicit criteria in assessment practices leads to beliefs that 'If they are "well enough" to get out of their homes independently, they don't need public home-care services'. As such, it becomes contradictory or moot to think about or offer services and resources to support elderly people getting out of the house. The consequences for those that do manage to get out of the home is that they may not qualify for services and/or once they are more mobile, may have their services withdrawn. This internal contradiction overlooks elderly people's need for social interaction and political participation. It also deprives them of the rights of participation and/or uses their fulfilment of these rights to disqualify them from service. In this way, elderly people's opportunities for social engagement become limited by, and possibly even limited to, their eligibility and/or receipt of public services.

Institutional exclusion

Organisational practices, such as using income to determine eligibility and the assessment procedures, can create and sustain exclusion. Although it is against policy guidelines to ask about the financial situation of elderly persons requesting public care, review of our four studies demonstrated examples where service providers used existing social policy indicators (such as the Guaranteed Income Supplement) as unofficial eligibility criteria. Discussing the differences that can exist between CLSCs, one worker says: 'There's one CLSC in particular that will not offer any home-care service, aside from bathing or nursing, to a client if they are not on an income supplement' (Grenier 2007a). Such practices limit care options, violate restrictions on using income as a measure of eligibility, and maintain the stigma of those receiving care. Such narrowed eligibility criteria also exclude those with meagre incomes that fall just above the established minimum.

The current classifications and professional assessment procedures used to ration care also create exclusion, in particular when elderly people are uninvolved in the very process that determines their needs and the services they receive. This does not necessarily occur by choice, but as a result of organisational contexts where home care is increasingly delivered or administered via professional determinants of care (Davies *et al*. 2000). The lack of consultation is in part rooted in a system where decision-making is assigned to professional 'experts' who use standardised tools to achieve mandated notions of effectiveness, efficiency and expediency. In these contexts, elderly people are often excluded from the process of identifying their needs and from making collective decisions about what their home care should look like. As a result, elderly people lose social agency and become objects of professional decisions, home-care policy, and larger trends of rationed services. As demonstrated in the case of Ontario (Aronson & Neysmith 2001), allocating care in such a fashion leads to the socio-political exclusion of elderly people in need of care.

Economic exclusion

The rationing of services within the mixed economy of care, that is now prominent in a number of national

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and international contexts (Armstrong & Armstrong 1996, Brodie 1999, Neysmith & MacAdam 1999, Aronson 2002), translates into a shortage of available public services, an increased transfer of responsibility for care to other sectors (including the family), and a growing interest in private services. While this has often led to the development of new services, most are only available to those with the financial resources to purchase them. The result is that elderly people with limited financial leverage cannot access the care they require both in terms of personal care and/or medical supplies not covered by the public plan. Research examples highlight how some may go without medication, while others may go without social outings or more expensive but essential food items in order to purchase their medication or equipment. These choices contradict intentions for care and can actually compromise the health, social participation and quality of life of elderly persons. For example,

> I don't use the oxygen tank anymore. It's too expensive. I can't manage it any more. (Gagnon *et al*. 2001)

> I don't sleep. I sleep sitting up because otherwise I choke. I need a hospital bed but they cost a fortune and we don't have it. (Gagnon *et al*. 2001)

> I told the doctor that some months it costs me $33 for the pills. I said: We don't have it. We have to wait awhile 'til we get together some money to buy the pills. (Gagnon *et al*. 2001)

The current public sector priorities that address only predetermined types, categories, and levels of care (e.g. one bath per week) means that elderly people cannot always afford the level of care they require. They must look for alternatives within the context of the limited choices provided by family and/or the community sector, or simply go without. Furthermore, rationing care has also meant that it is increasingly difficult to meet the eligibility criteria for public services. While assessment criteria are supposed to focus on the functional limitations of the body (e.g. frailty or loss of autonomy), the level of priority for service is increasingly based on income. As a result, only those with the most meagre incomes receive home-care services.

Exclusion from meaningful relations

A review of the four studies produced several examples of elderly people's exclusion from social and emotional networks. In Québec, as elsewhere, defining eligibility according to risk (i.e. mobility, bathing, transfers and dressing/undressing) prioritises the body and personal hygiene to the detriment of social, civic and political participation. In the environments created by these priorities, elderly people experience few opportunities for social interaction. Consider the following illustration where one elderly woman's social interactions were limited by the focus on her medical needs and became the dominant frame for organising her day:

> I had to give myself injections three times a day. I had an hour between when I had nothing to do. But you want to keep your hands sterile, so you can't play cards or anything like that. (Gagnon *et al*. 2001)

The transfer of medical and nursing care to elderly people monopolises their time and limits opportunities for leisure or social interaction. Another way of producing social exclusion is to completely ignore the psycho-emotional aspects of elderly persons' experiences of grief and loss.

> Mrs D. lost her husband 10 years ago after a long fight with cancer. She became very depressed and her blood pressure rose. Her [general practitioner] referred her to the CLSC who sent a nurse to monitor the blood pressure, but no effort was made to deal with the impact of her recent loss. (NDG-SSC 2002)

While such contexts where social care is narrowly defined, deemed less urgent, and/or completely ignored (Estes & Binney 1989, Clarke *et al*. 2003) are predominant in health and social care services, organising care according to such priorities can increase the likelihood that elderly people experience exclusion from meaningful social and emotional networks. It seems that as long as medical care is prioritised, dissolving barriers to meaningful relations does not appear to be part of the care practice mandate.

Territorial exclusion

The following illustrations highlight the implications of home-care policies and organisational practices where there are regional differences in care, limitations on social involvement as a result of care, and/or a loss of control over the private space as a result of receiving professional care. Living in a geographical area that has less available resources can mean that elderly people are excluded from receiving the home-care services they need from both the private (cost) and public sector (types of services). Despite being part of the same health and social service network, access to and quantity of services received varies from one agency to the next. This is best illustrated in the following quote from a hospital nurse:

> We shouldn't have to say: 'Poor patient, he lives in such and such sector, with such and such CLSC. It's not his fault he lives there. But we do say that a lot when we're discharging a patient.' (Gagnon *et al*. 2001)

Home-care practice can also limit everyday activities and social involvement. Consider the following elderly

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woman who remains homebound as a result of her geographical location and the limitations in home-care policy:

> Mrs V. spoke of the way that she is unable to get around because there is an incline on the way to the bus stop and she simply can't get up the hill. Her particular needs prevent her from taking public transportation. She thus remains homebound. (NDG-SSC 2002)

Territorial exclusion can also occur when elderly people's homes become a mini-institution taken over by professionals, their culture, and equipment, leaving elderly people with less and less control over this supposedly private space. Consider the ways that elderly people spoke about the invasion of their home space, and the need to be left alone:

> It finally starts to get on your nerves. You're never alone. I don't know if anyone's ever really thought about that, you can't even go to the bathroom alone. (Gagnon *et al*. 2001)

> They're all very well-intentioned people, very helping. I had to throw a fit to be left alone. (Gagnon *et al*. 2001)

> Well, they suggested, practically forbid me ... instilled upon me – not to go down to the basement because it's very dangerous if I fell. Of course I know that ... So I can go on the outdoor steps stay out there – that I can do that – they don't say anything about that. (Grenier 2002)

Clearly, elderly people remaining at home and in their communities can experience various forms of territorial exclusion. Despite policies having responded to elderly people's wishes to remain at home, the combined forms of implicit and explicit exclusion that may happen as a result of policies and practices that relegate elderly people to this environment can create and sustain very difficult situations for those in need of care.

Implications for policy, practice and research

The social exclusion framework allowed us to better understand and articulate elderly people's experiences of disadvantage in four former studies conducted over the past 10 years. Specifically, we were able to illustrate how the application of Québec's home-care policy in a context of severe underfunding and rationing resulted in seven forms of exclusion that contradict the stated intentions of the policy. Three groups of elderly people experience particular risks: elderly people who are eligible and receive services, but have limited opportunities for participation; elderly people who are ineligible for public care and lack the financial or material resources to meet their needs; and informal caregivers who step in to provide care and are as a result excluded from the work force and social benefits. While the home-care policy intends to maintain and improve elderly people's capacity to be active in their milieu and to accomplish the roles they wish to play under conditions that they judge to be satisfactory (MSSS 2003), the limitations of the policy and practice actually create and sustain intersecting forms of social exclusion that reduce elderly people in need of home care to their physical impairments, diminish their political agency by eliminating them from decision-making processes within society and home-care services, and tend to maintain them as shut-ins while not responding to their social needs. The types of disadvantages experienced by elderly persons are not unique to Québec; they have also been noted in Ontario and the UK (see Aronson & Neysmith 2001, CSCI 2008). The ways in which such findings transcend international boarders calls for renewed attention to the societal and professional responsibilities towards elderly people.

Understanding the intersecting forms of social exclusion produced and maintained by policies and organisational practices draws attention to four specific policy issues that require reconsideration: first, the problems that occur when care systems prioritise medical aspects to the detriment of social issues; second, the challenges involved in organising service provision according to targets rather than universal benefits, including the careful consideration of the implications of these choices; third, the measurement of outcome rather than input or process, including attention to the question of 'what counts as an outcome' within the current context of care; and, finally, the extent to which programmes promote user empowerment and/or professional control. Careful consideration of the ways in which these decisions can create and maintain social exclusion have the potential to alter experiences of care within the current context. Such a debate could be informed by studies such as that of Scharf *et al*. (2004), which point to the importance of developing supportive social policies and infrastructure. Also required, however, is a larger social commitment to care for elderly persons and their families.

As noted in the literature, governments have played a key role in limiting the professional involvement of care professionals and this has a major influence on professional practice and decision-making (Guberman *et al*. 2005). Currently, professionals are under great pressure to abdicate their professional skills and judgement in favour of a mechanical application of assessment tools that increasingly limit understandings of elderly people's situations to their functional incapacities (Armstrong & Armstrong 1999, Aronson & Neysmith 2001). However, the non-critical use of such tools can lead to practices that objectify elderly people and reduce them to a series of instrumental services. Professional practices, however, must move beyond measuring

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quality of services, which often match outcome with what is delivered without reflecting on whether the services offered – even if they are of quality – are indeed what elderly people want or need.

Professional associations and home-care professionals could make it part of their mandate to document and analyse the shift to a mixed economy of care, the persistent underfunding of public services, and the resulting forms of social exclusion. Professional associations should encourage and support professionals in questioning the hidden and unforeseen impacts of policy and programme changes. Suggestions for doing so range from reclaiming the professional capacity and skills required to conduct person-led global assessments (Richards 2000), to exercising caution in accepting the transfer of care activities that were previously universal and free (at least in Québec) such as bathing or meal preparation, to the private profit and not-for-profit sectors for elderly persons above established minimum income levels (Aronson & Neysmith 2001).

Within this context, we have witnessed the complex ways in which professionals both struggle against the care system and buy into practices that seem to contradict their value-base and good intentions of providing assistance. However, while some practitioners actively resist such practices, others have bought in to this transfer, either because their values hold individuals and families as responsible for care, or as a result of constraints placed upon their practices. Yet, workers must also become aware of the ways in which their role and involvement can sustain disadvantage. For example, while training family members is often viewed as empowerment, it can also lead to caregiver's isolation and feelings of powerlessness in their inability to refuse to do things that they would prefer not to do (Gagnon *et al*. 2001). Furthermore, implementing practices that allow income to become an eligibility criterion for access to public services can lead to the re-development of categories such as the 'deserving' and the 'non-deserving' and reinforce forms of social exclusion documented in this article. It should be emphasised that home-care professionals can make changes to their daily interactions with elderly people that will counter forms of social exclusion and achieve partnership with those requiring care.

A true partnership approach with elderly people is diametrically opposed to practices leading to social exclusion. Partnerships are formed on the principle that all are equal decision-makers in the assessment process and the organisation of the care. In the case of elderly people, a partnership with the home-care team implies recognition of their specific expertise about their situation and the putting into place of conditions necessary to ensure their genuine implication in the decision-making process, including sharing knowledge and power. On another level, the shift of the location of care to the home, thereby turning homes into quasi-hospitals and patients and families into nurse aids, potentially reinforces various forms of territorial exclusion in terms of elderly people's control over their environment. Policy-makers, home-care workers and society must understand the complex social phenomenon and relations that restrict elderly people from meaningful participation, opportunities for expression and the meeting of their felt needs. In particular, becoming much more aware of the ways in which decisions made about the locations and forms of care can serve to exclude or allow elderly people to maintain as much say over their lives and space as possible.

Conclusion: social exclusion as a framework

Using a social exclusion framework clearly articulates the consequences that current care priorities can have on the daily lives and experiences of elderly people. The framework explicates the various intersecting ways in which elderly people are excluded from public services, participation in public life and community, and are increasingly relegated to the home. Rather than simply advocating for changed attitudes towards elderly people, the illustrations of social exclusion in this paper lead us to politicise two major problems within home-care policies and practices: first, the lack of attention to the social and socio-political needs of elderly people, including agency; and, second, to draw specific attention to the experiences of a particular group of elderly people whom, by means of their ineligibility and limited financial resources, represent an increasingly marginalised group. Understanding the complex disadvantages created and sustained within the current context of care also highlights the need to reconsider current priorities in the allocation of care services for elderly people.

Using social exclusion as a critical framework provides a promising perspective to understand the ways in which policies and practices create and sustain difficulties for elderly people receiving care. Using the language of social exclusion in a North American context where both notions of exclusion and the recognition of social needs are completely overlooked is a radical challenge that points to increasing disadvantage and an alarming absence of care in its most human sense. Witnessing such perverse forms of exclusion has convinced us to continue critical explorations of the intersections of social policy and organisational practices as well as the ways in which these impact the lives and experiences of people giving and receiving care. We would advocate that governments such as Québec consider these debates and develop overarching

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frameworks related to the care of elderly persons, and in particular, a model of home care that supports elderly people and their carers in ways that are deemed relevant and that allow them to remain valuable and involved members of society.

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