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Accessibility to long-term care: A comparison of Fredericton, New Brunswick, Canada and Clark County, Nevada

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ACCESSIBILITY TO LONG TERM CARE:
A COMPARISON OF FREDERICTON,
NEW BRUNSWICK, CANADA AND
CLARK COUNTY, NEVADA

by

Schuyler Van Rensselaer Quick

A thesis submitted in partial fulfillment
of the requirements for the degree of

Master of Arts
in
Sociology

Department of Sociology
University of Nevada, Las Vegas
May 1996
The Thesis of Schuyler V.R. Quick for the degree of Master of Arts in Sociology is approved.

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May 1996
ABSTRACT

There has been extensive debate in this country on the ability of the health care system to adequately distribute Long Term Care (LTC) to the elderly. Three perspectives have emerged to explain current problems in access to LTC by the elderly indigent: The Market Model Perspective, Weber's Bureaucratic Perspective, and the Neo-Marxist Perspective. This study will assess these three theories, by examining constraints to accessibility within two systems, Canada and the United States. The LTC delivery service systems of the Fredericton region of New Brunswick and Clark County, Nevada, were examined in the summer and fall of 1992, to ascertain impediments to access as identified by service providers.

The research also analyzes the Fredericton region, before and after their enactment of the Single-Entry Point System for LTC. The research is composed of three components: 1) Historical Perspective, 2) Interviews with LTC providers and, 3) Content analysis. Of the three perspectives, the Neo-Marxist Perspective was found to best explain identifiable constraints among the two countries.
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THREE ECONOMIC SYSTEMS, ACCORDING TO ABIGAIL VAN BUREN

SOCIALISM: You have two cows. The government takes one and gives it to your neighbor.

"BUREAUCRATISM": You have two cows. The government takes both of them, shoots one, milks the other, and sells you the milk.

CAPITALISM: You have two cows. You sell one of them (for a profit) and buy a bull.

BANGOR DAILY NEWS, 1995
CHAPTER 1
INTRODUCTION

There has been extensive debate in this country on the ability of the health care system to adequately distribute Long Term Care (LTC) to the elderly. At the national level issues pertaining to health care treatment and coverage for the lower, and many middle class individuals are predominant. Opposition towards America's current health care delivery system has heightened, with mounting political debates concerning the 37 million citizens declared to be uninsured. While the consensus is high regarding the need for reform among most states, including Nevada, proposals for revision remain smothered with controversy. Health care reform was a major issue for the 1992 elections, yet all reform efforts proposed by Clinton have thus far failed. Criticisms targeting the lack of sufficient coverage for treatment of remedial medical conditions continue to gain momentum, yet relatively little attention is focused on compensation for the high costs associated with extended care for chronic illnesses - the subject this research report purposes to address. Consumer Reports (June 1991) attributes the omission of Long Term Care compensation among reform advocates, in part, to the frequent misconception of Americans that the federally mandated and funded Medicare plan for the aged, blind, and disabled includes provision for such care, when actually, like most insurance plans, Medicare covers virtually few LTC costs. This same fallacy on Medicare LTC provision, is nurtured in political debates concerning long term health care coverage, preventing any major discussion on reform measures. Consequently, as this report will unveil, those without sufficient resources to provide for required LTC, tend to encounter restrictive
access to such care. According to the National Institute on Aging, the increasing extension of today's life-spans presents two significant challenges: how to maintain good quality of life with advanced age, and concurrently generate cost-effective health care. (Las Vegas Review Journal/Sun Sunday June 26 1994 pp. 1-4) From a policy standpoint, however, according to Suzanne Ernst-Administrator of Nevada's Division for Aging Services that, with the (America) taxpayers' general focus on the reduction of services to the financially deprived, resistance by state legislators and others involved with strategic planning, to direct attention towards the needs of seniors is. (same: 1D) The result of this "state policy viewpoint" is that the US Medicare system, like all other federally funded programs, continues to be shadowed by confronting budget cuts, which invariably effects our less advantaged seniors. Those seniors suffering from chronic diseases often have no place to turn. The problem with acquiring LTC is compounded by the lack of available and affordable community services, and the denial of access to LTC facilities due to inadequate resources with which to pay. Given the attention of (national) policy makers to the current inequities of the US long term care system, it is important to examine why these problems exist, in an effort to develop plausible solutions.

With regard to both political and sociological analyses of (LTC) social policies and their implementation, three general theoretical perspectives emerge: The Market Model Perspective, the Weberian Bureaucratic Perspective, and the Neo-Marxist Perspective. All three perspectives are discussed in greater detail at the end of the chapter. This case study examines the adequacy of these three perspectives, by comparing the US and Canadian LTC delivery systems, within the two specific areas of Clark County, Nevada, and the Fredericton region, New Brunswick, Canada. With respect to the Fredericton region, this study further examines the delivery of LTC services, before and after the implementation of their Single-Entry Point System (SEPS). These systems will be
compared along several theoretical dimensions; degree of governmental regulation or restricted competition, degree of bureaucratized rationalization, instrumental reasoning, or objectification, and degree of profit orientation or commodified medicine; and utilizing this framework will answer the following:

1. Does one regional system allow more equitable access than the other?, or;
2. What contributing factors most strongly influence accessibility to LTC in Clark County, Nevada? In the Fredericton region, New Brunswick?
3. Which of the three theoretical perspectives best explains the systematic differences in accessibility?, or;
4. How can we best compare the multi-entry point, multi-payment source for LTC currently embraced by Clark County, and the single-entry point, single-payment source system for LTC in the Fredericton region?

With the use of multiple methods of field research, this project employed the unstructured interviews of 15 care providers within both regions' LTC delivery systems, to determine the most frequently experienced impediments to accessibility. Each of the identified constraint factors were coded, as to whether the respondents identified them to have a strong, moderate, minimal, or no impact on accessibility. Accordingly, the ten major constraint factors were each coded, for equated relevance to the applied theoretical constructs previously listed. Though this approach is an admittedly subjective indicator of accessibility, I believe it to be relevant, as it allowed for the categorized distinction of response patterns. The content analysis of governmental documents from within each region's systems, (Medicare Handbooks, Nevada State Welfare Manual, Clark County Social Service Medical Assistance Manual, Single-Entry Point Systems Manual and Evaluation, Directives Manual for Nursing Homes), reflected regulatory distinctions, along many systematic dimensions: governmental structures, operational structures, pre-
admission screening processes, population need, reimbursement rates, provisional care, financial eligibility guidelines, nursing home point-of-entry, and overall philosophies. These distinctions were examined, to the extent that they revealed differences in degrees of government regulation, bureaucratic rationalization, and profit orientation, among these two diversified LTC delivery systems.

OVERVIEW OF THE US AND CANADA

With reference to the United State's current approach to health care, the provision of LTC represents a multimillion dollar industry, encompassing both the private, for-profit sectors and governmental, non-profit sectors of the economic system. As evinced by Estes and Wallace (1989), in 1987 the combined total of US private and governmental expenditures for the total population's medical care exceeded 11% of the Gross National Product (GNP), or just under $500 billion. Over one-half of these funds were consumed by hospitals and nursing homes, with 31% of these expenditures applied to costs incurred by the nation's 12% elderly population of that time. Because the elderly are significantly more susceptible to incurable illnesses and debilitating diseases, they are subsequently more likely to require long term, or "chronic care", nursing home sustenance that curative, or "acute care", hospital convalescence. Nationwide statistics revealed by Wallace and Estes in 1989 indicated that over 5% of those over 65 resided in nursing homes, climbing to an estimated 22% of those over 80 years old. In June 1991, Consumer Reports (p. 425) proclaimed that out of all Americans reaching age 65 that year, 45% would ultimately come to require some form of long term nursing home care. Of this group, 25% were anticipated to remain institutionalized for at least one year, for a projected individual cost of between $30-40,000, generating a substantial economic investment in LTC facilities. Research findings by Ph.D. candidate, Marc Aaron Cohen (1987)
illustrated that comprehensively considering the aggregated elderly population in the US, the average expected lifetime costs for LTC, in facilities alone, will reach between $11,500 and $13,000. In the United States we currently utilize a multi-entry, multi-payment source system or LTC. The US Medicare program is linked specifically to the Social Security system, and provides medical coverage to elderly persons over age 65 and disabled persons after a two year qualifying period, contingent on the substantiation of a perpetual impairment which restricts competitive employment. Under the Medicare program's traditional "fee-for-service" payment system, the program offers coverage for in-patient hospitalizations to all recipients; however, high deductibles and co-insurance costs are required, which will be explained more thoroughly in Chapter four. It covers no doctors fees, out-patient hospital care, diagnostic tests, ambulance charges, or durable medical equipment unless the recipient opts to enroll in an additional coverage plan offered by Medicare for a monthly premium rate of $31.80. Neither the regular plan or the enrolled plan provides for long term chronic care costs. With the amount of Medicare coverage being based on the predetermined designation of a "Diagnostically Related Group" (DRG) for hospital admissions, according to Estes and Goldberg (1990), once the established medical problem has been resolved, or the number of days allotted for treatment under the DRG reimbursement policy have been depleted, Medicare's coverage is promptly terminated and the patient is technically discharged. If a patient continues to require extended care for convalescence, or for ongoing chronic conditions, arrangements for such care must be made, either in the patient's own home or in a nursing home, without the assistance of Medicare. In Clark County there are no 24 hour care programs or services available for persons without sufficient resources to pay privately. With the cost of 24 hour licensed health care provision in the home averaging over $200 a day, and the cost of 24 hour nursing home care averaging over $90 per day, few can afford either
type of care for any length of time without completely exhausting any available assets or resources.

Adjusting to a long term, chronic ailment faced by an elderly person is not an easy process and, as the research will show, is often overlooked by those in the medical and social service professions. If a person lacks sufficient resources to pay for LTC they must consider approaching a governmental agency for assistance. In Clark County there are two such agencies—Nevada State Welfare (NSW), and Clark County Social Services (CCSS). Where one applies is solely dependent upon the person's total monthly income. The application process for LTC assistance with both agencies requires the prospective client to verify their indigent status beyond a shadow of a doubt. Eligibility determination frequently averages approximately three months by Nevada State Welfare, the agency which receives the most requests for assistance in accordance with the state established income guidelines. Many LTC facilities require a second application to be made to Clark County Social Services as a back up the a Nevada State Welfare Medicaid application to assure payment in the event of a Medicaid denial, which the research will reflect occurs frequently. Acceptance to a nursing home of a person without an established means to provide payment is an extreme rarity in Clark County. Typically referred to by economists as "supply and demand", literary sources and other research findings reveal that only when a facility acquires a certain quantity of empty beds will they consider accepting the person lacking a payment source for their care, and then only if an application for public assistance has already been submitted to the appropriate assistance agency(s). In other words, only if the supply of available nursing home beds is high in Clark County does a facility have incentive to accept an indigent client, taking the risk that the person's care costs will eventually be reimbursed; but only then if the facility can be relatively assured of payment, which the research will further demonstrate. With the pressure by hospital administrators to discharge patients no longer covered by Medicare, according to
Consumer Reports (July 1992) the system's DRG reimbursement practice has backfired, and instead created motivations for the hospitals to discharge patients prematurely without adequate follow up care.

Many of Clark County's elderly residents fall between the cracks, being too "well off" to qualify for county or state assistance for LTC costs not covered by Medicare, but not financially secure enough to avoid a poverty trap should such care be required. To qualify for either county or state assistance one must meet stringently enforced guidelines which require the depletion and maintenance of available assets to no more than $2,000, creating a dependency on the welfare system. According to Ms. Ernst and the Division for Aging, 85% of those over 65 are unemployed, making the possibility of replenishing resources next to impossible. The General Accounting Office (GAO 1993) relates that neither Medicare nor a majority of the states' Medicaid reimbursement rates are designed to pay for the cost of an individual's actual needed care, causing hospitals and nursing homes to literally lose money on such admissions. Additional obstacles arise for the indigent person seeking 24 hour nursing home care from the community, because to qualify for either the Nevada State Medicaid program or Clark County's Medical Assistance program, one must actually remain in a hospital or LTC facility for 30 consecutive days. If discharged prior to this, no payment can be retrieved by the provider.

It is the GAO's assertion that high medical charges, along with cost controls and gradual cutbacks on these governmental programs have ultimately created a serious dilemma for providers and recipients alike. Neither physicians nor 24 hour LTC facilities or home health care providers are mandated to accept patients under the auspices of Medicare, Medicaid, or Clark County Medical Assistance. Although the extent to which indigent seniors encounter access problems to nursing homes and other forms of LTC is difficult to assess, the GAO attests that a patient's medical treatment needs, in combination with the nursing home bed supply clearly limits accessibility by some Medicaid and
potentially eligible Medicaid recipients, with preference given to persons needing less care and those with available private resources to pay for their care. It is maintained that the research findings will substantiate this writer's position that the availability of LTC services to Clark County seniors is directly related, not only to the amount of care required and the respective individual's ability to pay; but that the assurance of a stable payment source tends to take precedence over actual care needs; and that the programs designed to assist the less advantaged have instead created constraints, or restrictions to accessibility. It is claimed that while it appears this county's established assistance programs have served to assure a stable source of revenue for providers - however insufficient, they have done relatively little to change the actual delivery of health care to disadvantaged seniors. As the literature reviewed will confirm, America's attempts to manage the health care system a piece at a time have been extremely ineffective, with our "band-aid" philosophies and solutions creating additional problems. Further, as asserted by both Neo-Marxist and Weberian analysts, the literary sources and research findings will affirm that, with the US health care industry's conflict between medical and financial priorities, cost-containment measures have seriously de-emphasized chronic care needs and quality of life issues. The following case examples should offer credence to this stance by revealing factors which restrict equitable access to LTC by disadvantaged seniors and contribute to the fragmentation of services.

Case Example #1:

An 88 year old man suffering from end stage prostate cancer and his 86 year old wife with advanced Alzheimer's disease are moved to Clark County by their son so that he might offer enhanced physical and emotional support and monitor their conditions more closely, while promoting their requested independence by arranging for home health services in their own environment. Both are adamantly opposed to nursing home
placement because their medical conditions require different types of care and would necessitate their separation into either different wings of a care facility or different care centers all together. After 52 years of marriage this prospect seems intolerable to them. The son therefore secures a temporary apartment until their California home is sold and another purchased in Las Vegas. Because his mother's condition requires 24 hour awake supervision, shift care is contracted through the home health agency. Costing over $9,000 per month, the minimal savings they have acquired will soon be depleted; however, the son feels confident that the sale of their California home will more than adequately provide for the cost of medical care in their new home. Both are in need of physician's services and expensive medications which, while covered by their Health Maintenance Organization (HMO) insurance in California, are not in Nevada. Even though their HMO has a sister agency in Clark County, their insurance will not transfer until a brand new policy is established in Nevada. This procedure entails another application and will not go into effect for a minimum of 30 days, they are told. During this transition period, neither have any health insurance to cover the cost of short or long term medical needs, for when they opted to contract with the HMO to supplement the federal Medicare plan, their actual Medicare coverage automatically ceased. It cannot be reinstated until the first day of the subsequent month following the self-initiated termination of the HMO.

Just eleven days prior to this couple settling into their new home, the father's cancer begins to progress forcing them to return to California where he can obtain necessary medical treatment. With the higher cost of 24 care on the same shift basis in California, and the couple's home being their only remaining substantial asset, they are unable to afford such care, and home health services are terminated. They both deteriorate rapidly due to the lack of necessary care. With the father's death, the mother faces nursing home placement, but has no means to pay until their house is sold. She is denied governmental assistance due to the possession of a small undeveloped lot in Texas.
The son is eventually able to secure placement, however she expires shortly thereafter. Not only is the couple's demise quick, but emotionally painful for the son as he witnesses the dignity and happiness of his parents being compromised during their last days together as an apparent result of our LTC delivery system.

**Case Example #2:**

A 69 year old man desperately seeks voluntary medical attention from a local psychiatric hospital for what he believes to be a problem with his mental state. He is found to be "gravely disabled and in need of immediate hospitalization"; however, because he is unable to produce his Medicare card to verify medical coverage he is transferred to the "county hospital" for treatment due to his assumed indigent status. There he is evaluated by a non-medical mental health crisis team and, without even seeing a doctor, is diagnosed with "psychosis as related to Organic Brain Syndrome (OBS)". Because OBS is not considered to be a "mental health problem" by the state funded and operated mental health system, he is not treated, but rather sent back to his home in a cab and referred to Clark County Social Services for nursing home placement and county medical assistance. He is eventually placed in a nursing home by CCSS which he consequently pays for privately, without any help from Medicare, Medicaid, or Clark County Medical Assistance. As his disease progresses it is determined that he actually suffers from Huntington's Chorea, not psychosis or OBS. His illness may have taken his life, but once again our health care delivery system managed to destroy his dignity long before.

**Case Example #3:**

A 62 year old resident of a local group care facility, diagnosed with throat cancer and undergoing radiation treatment, is in dire need of costly dental care due to the increasing pain caused by decaying teeth. Because the state Medicaid program only provides assistance to indigent persons over 65 who reside in group homes, he requests
the assistance of the means-tested Clark County Social Services Medical Assistance program. Under this program, however, only tooth extractions are covered, with no denture replacement unless deemed "medically necessary". Also under this program he can only be treated by an oral surgeon as referred to by the University Medical Center's out-patient clinic, who will receive no reimbursement because the county does not pay for physician's services. As this gentleman's cancer advances he is placed in a skilled nursing facility where his medical coverage transfers to the Medicaid program which does provide for tooth extractions as well as dentures. Unfortunately, his condition is such that he can no longer tolerate the procedures required as a result of increased radiation treatment. Due to his restricted access to health care services, not only did he have to endure the pain of the cancer during his remaining days, but also unnecessary agony from ignored orthodontic care.

**Case Example #4:**

Initially placed in a nursing home out of state from a Las Vegas hospital due to the unavailability of a local nursing home vacancy, an 83 year old woman faces a similar dilemma. She has no resources to pay privately for the cost of her care, yet has been denied by the Nevada State Welfare's Medicaid program as her $744.00 her month income exceeds their eligibility criteria. In her case, Clark County Social Services does agree to pay for her medical care under their Medical Assistance program; however, when an increase in income guidelines occurs with the Medicaid program, a second application is submitted to Nevada State Welfare to assume financial responsibility for this person's medical care. She is again denied, this time under the premise that their state agency had not been the one to evaluate the type of nursing home care she required prior to her transfer out of state. (It should be noted that the state and county refer to this process as screening for "Level of Care" (LOC), and, in essence, follow the same guidelines to
determine the LOC for billing purposes.) Following needless and costly appeals to Nevada State Welfare by Clark County Social Services, assistance is finally approved by the state. Unfortunately the victim of this controversy is the nursing home resident pending approval of a payment source for her care.

Case Example #5:

An 88 year old resides in a nursing home under Nevada Medicaid assistance to supplement his income for the cost of his care. Every three months, however, he receives an additional pension check which places his income over the limit allowed by the program, and his assistance is terminated. Without any means to offset the extra cost the nursing home is faces with either absorbing the expense or discharging the resident. The corporate owned nursing home chooses the latter. A subsequent application is made to Clark County Social Services for medical assistance who does agree to pay for one month's care. At the end of the month a whole new application is required by the state, with a reevaluation for possible assistance, during which time the nursing home receives no payment but agrees to keep him, pending Medicaid approval. This procedure is repeated every four months due to the income change. Unable to handle his own affairs or complete these applications by himself, and having no local family to help obtain necessary documentation for the application process, the Clark County Public Guardian's involvement is requested to assure continuous medical coverage and equitable care for the resident. Again, the victim of this situation is the nursing home resident in need of 24 hour care.

Case Example #6:

A 59 year old man is hospitalized on the Intensive Care Unit with a long list of medical problems which have temporarily altered his mental state and left him totally incapacitated. Although this man has managed to secure a few assets in the form of bonds and an Individual Retirement Account, they only equal $17,000, while his medical bills
have excelled to over $300,000. In need of financial assistance to cover the balance of these incurred expenses and the cost of impending nursing home care, an application is submitted for him by the hospital to Nevada State Welfare for Medicaid assistance. He is denied, however, due to having "excess resources" above the allotted amount of $2,000. It is argued by the hospital that he is unable to access his resources because of his medical and physical incapacitation; and if he were able, said resources would only cover a very small portion of his growing debt. Regardless, Nevada State Welfare does not recognize his severe medical condition as being an obstacle which prevents him from attaining his insufficient assets, and stands firm that he is ineligible for assistance in accordance with Nevada law. According to Kathleen Buto, Acting Director of the Bureau of Eligibility, Reimbursement, and Coverage-Department of Health and Human Services, "if there was a legal impediment to the (respective) owner's conversion of resources, such as a law or statute preventing a mentally incompetent (or incapacitated) person from converting resources into cash to be used to meet his or her needs, the (resource) would then not be counted for eligibility purposes. "In the absence of such a legal impediment", says Ms. Buto, "(the state) has no authority to disregard resources just because the owner lacks the mental or physical capacity to utilize them." It is the Clark County Medical Assistance program that inevitably pays for the cost of this man's care, but only after the Clark County Public Guardian's office has him deemed incompetent by the court to assume control of his estate, agreeing to offer partial reimbursement to the county upon recovery of his assets. This man was accepted by a nursing home once a payment source was established and eventually approved for Medicaid assistance; however, it is believed that the above scenario does indeed represent constraints to accessible LTC caused by the present health care delivery system in Clark County.

What is wrong with this picture? The above authentic case summaries represent only a small sample of the barriers challenged by the poor and near-poor elders in Clark
County in accessing equitable long term medical care. As previously attested, those in need of LTC for chronic diseases often have no recourse, with the lack of affordable community resources, and denied access to LTC facilities by those with financial liabilities. On the other hand, because of the required need to deplete their assets to qualify for state or county assistance, many in dire need of 24 hour care adamantly refuse placement if found, creating a nightmare for hospital discharge planners and community service workers attempting to secure appropriate LTC services or placement for persons living in their own homes.

According to the Las Vegas Review Journal (June 26 1994: pp. 1D, 4D), in 1970 approximately 13,990 people over age 65 resided in Clark County. By 1990 this population grew to 77,678. This age group accounted for 11% of the overall Clark County residents in 1993. The United States Census Bureau projects that Nevada will experience the most rapid population growth of those 65 and up from now until the year 2000. By 2020 the percentage of senior residents in Nevada is anticipated to reach 15.6%. This prediction presents a significant dilemma to Southern Nevada and Clark County as senior retirees migrate in search of a mild climate, low cost of living, and exciting atmosphere to live out the rest of their lives, leaving their extended families behind. Many retired couples relocating to this area arrive healthy and in good financial standing. As this group advances into old age, potentially losing half of their income with the death of a spouse, and develop chronic illnesses along with an inability to care for themselves or cover the cost of extended care, the burden of such will inevitably create significant implications for Clark County. Ms. Ernst warns that "if all of these people move here, age here, and grow sick and poor here, Southern Nevada is not prepared."

(Las Vegas Review Journal, June 26, 1994: pp. 1D, 4D)
OBJECTIVE OF THE STUDY

Few will dispute that the United States' overall methods of health care provision for long and short term medical conditions are marred by deficiencies and in dire need of reform. Several conflicting theories prevail which we can use to address why this country's faltering system has developed in this way, and why it continues to face obstacles in assuring uniform accessibility to comprehensive medical care. In order to examine different approaches to LTC and assess the explanatory power of these three models, a comparison study was conducted in our neighboring country, Canada, involving the province of New Brunswick, with emphasis on the confined region of Fredericton. The selection of this particular region was based on its comparable policies on LTC financial coverage, and contradistinctive delivery system. Like Nevada, government compensation for LTC services and placement in Fredericton is dependent upon the respective individual's inability to pay. Unlike some of the other provinces, extended or non-curative care is not covered in New Brunswick under the Canadian universal medical plan. Those who lack sufficient resources to pay must apply for assistance just as they do in this state and county. Most significant to my selection of the Fredericton region, however, relates to it's current operation of a program devised for provisional LTC services, referred to as the "Single Entry Point System". Involving one agency to initiate LTC placement or services; determine the type, or level, of care needed; and establish a payment source for the particular medical care, this region appeared to provide the necessary elements for the comparative analysis of governmental regulation, (bureaucratic) rationalization, and profit orientation. Being a one step process by which elderly persons can implement LTC services, and or placement as deemed necessary, considerable deliberation will be offered on the SEPS operation's stated objective to insure more uniform access to equitable care by the lower economic groups, for distinctions in accessibility.
In addition, the vast majority of LTC service providers in Fredericton are non-profit, with the few remaining organizations being slowly fazed out or voluntarily converting to non-profit status. A second distinction is that the consensus among most Fredericton residents and LTC providers, whether for-profit or non-profit, is that comprehensive medical care from birth to death is a guaranteed, unconditional right among all its citizens. Presently in the United States consumers and providers alike, along with politicians, are torn between two prevailing thoughts; medical care as a right, or medical care as a privilege.

The purpose of the following research project is to examine why inequitable distribution of medical treatment to underprivileged seniors exists in Clark County, Nevada, for those who come to require care for prolonged, chronic illnesses. My stated objective is to disclose explanatory evidence for this county's failed operation for long term health care delivery to the poor and near-poor seniors that reside here. In the following chapters it is my determined goal to parallel the Clark County LTC delivery system with that of Fredericton, by analyzing proposed justifications for common and differing traits found among to two, and exploring reasons set forth to explain why disadvantaged seniors in this country continue to receive inferior care. It is my further intent to ascertain whether the constraints to LTC accessibility reflected within our capitalistic, for-profit, bureaucratic, multiple payment source, multi-entry point system are similarly encountered within a non-profit, single-entry point system such as the Fredericton region’s. Additionally, it is my aim to project why the comparison of a profit verses non-profit system is considered appropriate to analyze the impact of capitalism on accessibility; and why the comparison of a multiple payment source, multi-entry point system verses a single payment source, single-entry point system is appropriate to analyze the impact of governmental regulation, bureaucratic organization, and profit orientation. Importantly, as a further test of these three factors, particularly the impact of
bureaucratization, I will examine the Fredericton region’s system, both before and after
the implementation of the Single-Entry Point System for LTC delivery.

A brief synopsis of each theoretical perspective employed for this proposed
analysis is as follows:

I. The Market Model Perspective advocates for greater reliance on competitive
forces in the marketplace, and the deregulation of governmental control over the
US free-market enterprise. This market model perspective, according to Lee and
Benjamin (1988), attributes the inadequacies of the US system to the improper
functioning of market competition and the stifling role imposed by the government
in health care. Therefore, social policy must look to minimize government
regulation and restrictions on the marketplace to better the system. The Market
Model hypothesizes that the least constraints to accessibility will result from:

A. Federal Deregulation - with the decentralized shift in health care
regulation to state government, minimizing the need for federal
involvement with state operated programs. According to the Market
Model, the system with the least amount of federal governmental
involvement will be the most accessible, and;

B. Private, For-Profit Competition - with concentrated reliance on the
competitive forces of private enterprise for equitable health care delivery.
The system with the highest number of competing, for-profit LTC health
providers and care facilities will be the most accessible.

II. The Bureaucratization Model places the blame of the system's failures on the
increasing bureaucratic consumption, by corporations and hierarchically organized
welfare organizations which, according to Weber are characteristic of a capitalist
society. The Weberian Model argues that the differences in bureaucratic
organization between the two economic systems best explain differences in LTC
provision. Consequently, social policy solutions must look to down-sizing bureaucracy to better the system. This perspective hypothesizes that the least constraints to accessibility will result from:

A. **De-Rationalization** - that the system with the least emphasis on rationalized, efficiency based services will be the most accessible, and;

B. **De-Bureaucratization** - that the system with the least amount of governmental regulations and uncompromising impersonal rules (the less bureaucratized system for LTC delivery) will be the most accessible.

III. The Neo-Marxist Perspective asserts that the deterioration of the US medical system is directly related to the health care industry's profit orientation and accompanying commodification of care. They claim that by minimizing the medical market emphasis on profit, with substituted emphasis on service provision, LTC delivery will improve. This model hypothesizes that the least constraints to accessibility will result from:

A. **De-emphasized Profit Orientation (Commodification) of health care** - that the system with the least amount of for-profit LTC service providers and nursing facilities will be the most accessible. The system with the least emphasis on cost-benefit analysis for provided services will be most accessible, and;

B. **Decreased Governmental Consumption** - with a consolidated centralization of responsibility for LTC delivery. The system with the least amount of governmental consumption for LTC delivery and compensation will be the most accessible.

Chapter two will examine each of these major perspectives on social policy and implementation in detail, from their origins in classical theories, to their implications for understanding health care and the elderly. This chapter, in essence will expound on the
theoretical perspectives singly, and analyze reasons behind their varying views. In Chapter three, I discuss my specific research methods, including the choice of regions, the sample of providers, the interview process, and the analysis of documents. To classify what determinant factors must be detected to support or disprove the respective theories, this chapter will operationalize the relative concepts maintained by each perspective, and highlight elements which will lead to their recognition. In Chapter four, I lay out the historical background of the health care systems in both the US and Canada. In Chapter five, I discuss the constraints to accessibility identified by those interviewed, and analyze each as they indicate degrees of influence by government regulation, bureaucratic rationalization, and commodified profit orientation. Implications for the three theories are also discussed. In Chapter six, I discuss the analysis of documents and literary sources, along the dimensions of government and operational structure, admission screening processes, provisional care distinctions, reimbursement rates for provisional services, population need, financial eligibility guidelines for LTC assistance, nursing home entry system, and overall philosophy. In Chapter seven, all sources are analyzed to the event they revealed differences in degrees of "government regulation", "bureaucratic rationalization", and "profit orientation"; with further implications for the three theories. In Chapter eight, I further discuss the findings, conclusions, and policy implications of the research. The findings indicate that the respondents from Clark County consider LTC to be less accessible than the respondents from the Fredericton region before SEPS, and that the Fredericton region after SEPS is considered by respondents to be most accessible. The findings further indicate that, while the Bureaucratization Model explains much of the differences between the two systems with its "inflexible, efficiency based, policy rationalization", the Neo-Marxist Model is found to explain most of the differences between the systems, with its projections on "for-profit orientation", "cost-containment policies" (government consumption), and "commodified medicine"; with the Market
Models' conceptions of "government regulation" and "restricted competition" offering limited explanatory reasoning.
CHAPTER 2
THEORETICAL PERSPECTIVES

As previously attested, several differing theoretical perspectives have been proposed to examine and understand social policies and their implementation, particularly regarding the United States' health care system. For the purpose of my research, however, qualified emphasis will be applied to three established theoretical perspectives, with the intention of qualitatively evaluating inferentially verifiable propositions. To assure adequate comprehension of the specified perspectives adopted, a detailed description will follow which will incorporate each one's individual ideological developments; outline the formulating principles relative to each; and detail their respective philosophical contexts as they pertain to the long term health care issues addressed in this manuscript.

I. Market Model Perspective:

Some analysts assert that the US health care system has failed to insure equitable access to Long Term Care (LTC) by all elderly because its structure has not adequately embraced the market model. This perspective argues that only by fully embracing the market model, can this society establish a equitable and impartial health care system. Advancing the practice of free trade, this model professes that, if businesses and industries were allowed to operate without government interference, regulation in the form of competition among the private sector would collectively compel business owners to improve products and services, maintain reasonable costs, and, in essence, moderate the
economy for the benefit of everyone.

In his article “Command vs. Market: Across the Centuries”, University of Chicago history professor William H. McNeill discusses the symbiotic relationship between the concept of a free market enterprise the formation of capitalism in Western Europe (Aronoff and Ward 1984). Considered by historians to be a relatively recent economic system, capitalism paralleled the advent of Europe’s Industrial Revolution. Prior to the revolutionary movement the traditional productive components of land, labor, resources, and currency were largely controlled by government and/or by the wealthy elite who were tightly associated with the government (Coser 1971). Production was implemented mainly for the support of the state and the church, with the small amount of excess to be shared among the masses. With the inception of capitalism, control over the means of production (e.g.: factories, power companies, railways, etc.) shifted to private ownership by individuals or corporations. Used interchangeably with the principle of “private, or free, enterprise”, the capitalistic economy based its foundations in markets and prices to interpret consumers’ wants according to supply, demand, and financial value. Those who possessed the wealth to organize and support the factories and other industries, and hire laborers to run them were referred to as capitalists. In contrast to preceding economic systems, the capitalistic market approach interjected the division of labor in production, the utilization of an organized price mechanism, and the precedence of bargaining power for the exchange of goods and services (The Economic Literacy Series No.1 1958).

Also synonymous with the practice of free enterprise is the concept of laissez-faire which, as disclosed by Fine (1967), embraced the conviction that functions of the US government, though accepted as an unfortunately necessary component of the economic system, should be ostensibly limited. Emerging out of Great Britain in the early 19th century, Fine accredits the laissez-faire traditions for the invocation of capitalism’s basic principles regarding private property, profit motivation, unrestricted competition, and the
economic freedoms of individual choice, contract, and progressive engagement in enterprising pursuits.

Involving the practice of unrestrained merchandising with regard to production and distribution, free from governmental regulation, it was the laissez-faire ideology that was first advocated by a leading theorist on capitalism, Adam Smith, in the 1700’s. In his *Wealth of Nations* manuscript, Smith paralleled the principles of “natural liberty” with those distinctive to capitalistic production and trade (Jenkins 1948). Emphasizing the Jeffersonian commitment towards limited government, Smith strongly enforced the bond between political liberty and economic freedom. Smith equated the encroachment by a system on economic freedoms to the direct violation of an individual’s basic rights (Roche 1984). Roche accentuates Smith’s steadfast conviction that free interaction among societal members would inevitably produce a methodical union; and that the advancement of public interest within the framework of a competitive market enterprise would, as a natural consequence, result in maximizing the greatest welfare for all societal members.

The object of a free enterprise economy in Smith’s estimation was to benefit the consumer as well as profit the capitalist by allowing the capitalist to produce according choice, and the consumer to likewise purchase according to choice. Smith argued that unrestricted competition in the marketplace would lead to increased production, improved goods, and reduced prices. Smith surmised that the inherent components of capitalism - among them currency, property, labor, channels of distribution, and the mechanics of exchange - all work collectively to produce such a market. Smith further proclaimed that an individual’s natural tendency is to pursue their own self-advantage, and if left to themselves unaided, would seek to improve the quality of their lives (Justman 1991).

Following Smith’s aspirations, economist John Stuart Mills furthered the endorsement of private pursuits, asserting that, individually, we are all the best judge of our own personal interests and better qualified to ascertain that which enhances our well-
being. As a utilitarian, however, Mill maintained a firm conviction to the governing Democratic principle of “the greatest good for the greatest number” (Rees 1983). Rees clarifies this apparent contradiction between Mill’s regard for self-fulfillment and commitment to the common good by qualifying his distinction between offering charity to another and offering assistance to another through the enhancement of their individual distinctive strengths and abilities. Mill did not condone acts of charity, comparing them to the corruption of one’s independence and subjection of dependency on the system. Mill emphasized that a citizen’s primary responsibility in life is to achieve their fullest potential for the advancement of a progressive society and solid economic foundation. Rees reviews Mill’s stance on what he referred to as “civic humanism”, with the contention that an individual’s development towards self-fulfillment is only attainable if the individual acts like a citizen, embodying a sense of obligation to the public in their search for personal gratification. Like Smith, Mill radically condemned any interference by governmental or societal forces in the private sphere. In concurrence with ascribed principles relative to a free-market enterprise, Mill emphatically opposed any restraints imposed on trade which restricted the consumer’s purchasing power or caused infringements on their liberties.

During the mid to late 1800’s, Darwin’s doctrine of biological evolution was awarded much credence, with its principle philosophy being stressing the survival of the “fittest”. It was Darwin’s of “biological evolutionism” that was studied and interpreted by sociologists, Herbert Spencer and William Graham Sumner, to indicate specific evidence to support the laissez-faire principles maintained by Adam Smith. In Coser’s word’s, Spencer’s idea of good society was dependent on contractual arrangements among individuals to preserve social order. Darwin’s theories were further studied and interpreted by philosophers and economists alike to validate the same principles. The goal of society under this influence was to survive and flourish. To attain this goal, all persons were responsible, as members of society, to accomplish their prescribed functions.
Arguing Darwin's theory of natural selection with the defense that all life is a continuous struggle for existence in which some organisms are better adapted than others to survive their environment, this ideology fit extremely well with the concept of free market enterprise. Bellah (1985) notes that the same principles were also considered to be highly compatible with the Protestant ethic as it was manifested in the development of American capitalism. The founders of the American republic, says Bellah, placed great significance on the mechanics of individual perseverance, with the conviction by the majority that no one should get more out of the system than they contribute, and their accompanying rejection of any type of systematized welfare organization by the government. Like many of the other ideologies prevalent in Europe prior to and throughout the Industrial Revolution, Bellah stressed that the strict adherence to freedom from governmental intervention was instrumental in establishing laissez-faire capitalism as the major economic system for American democracy. Bellah criticized the Protestant's dominating emphasis on individual pursuits and attainment of material success which paved the way for the maturation of capitalism in America. Bellah directly attributed the application of these Protestant ethics to the evolvement of a predominating characteristic in today's American ethos - "individualism". In defense of capitalism, however, economist George Glider (1981) expounded on Smith's argument that, although the greed associated with capitalism may drive individuals to unacceptable behavior, it also acts to lift the material standard of living for society as a whole. He maintained that we could not create a capitalistic system without indecently rich capitalists. As indicated by Bellah however, it was the concurrently developing evils of capitalism (such as greed and unconditional materialistic desires); the abuses of capitalism (including child labor, low wages, and the production/marketing of hazardous or inferior products); the creation of monopolies; the occurrence of economic depressions; and the resulting societal discontent that eventually prompted corrective measures through governmental regulation.
While capitalism and the doctrines associated with a free enterprise economy are a distinct product of western civilization, economic advisors, Jerry Jordan and Paul Rubin (1984) advise that, in actual practice, there has never been an economy based on absolute free enterprise. In concordance with today’s interdependence of social policies and the activities of advanced capitalism, Ian Gough (1979) stresses that the public cannot escape the constraints imposed by the capitalist mode of production, warranting the parameters of governmental intercession. According to Jordan and Rubin, in principle the economic policies of modern capitalism are constrained by the US constitution and involve a mixture of private enterprise and governmental regulation. The Market Model refers to today’s American economy as a “modified free economy”. Journalist Irving Kristol (1984) proclaims that with the current system of “democratic capitalism”, one or more of the basic foundations of free enterprise have been compromised. Insofar as we have deliberately modified free enterprise by promoting joint decision making by private and governmental organizations with regard to economic issues, it is proclaimed that we have done so for the purpose of better serving our democratic ideals. This series portrays the relative role of government in our mixed economy as basically threefold: to insure a political framework conducive to the principle component of free enterprise competition; to govern the economic enforcement of antitrust laws restricting monopolies; and to regulate the efficient operation of public service programs and their delivery by both private and governmental firms.

In application of the free Market Model to health care and the elderly, Laura Katz Olson (1982) discusses the free market enterprise’s conservative views towards government today, with their continued emphasis on individualism, economic inequality, competition in the marketplace, and the application of private solutions for public, or social, problems. Olson recounts the continuing strong conviction by today’s free market perspective that through the proper functioning of free competition for goods, services,
and labor, economic growth will be enhanced; the needs of society will be served; and social problems, alleviated. Olson further refers to contemporary free-market conservatives' declaration that the private sector is far better able to produce and distribute goods and services with more effectiveness and efficiency than the public sector. Consequently, this perspective encourages greater reliance on the marketplace, recommending that the government's role be limited to the promotion of economic incentives, such as government subsidies for housing, medical care, food, jobs, and retirement income. Advocates of this perspective proclaim that inequality with regard to material conditions is inevitable, but that all socio-economic groups in society will improve their relative positions as production increases and the economy expands. They further maintain that improved economic conditions for the elderly are tied to the growth enhancement of private and public retirement systems including pension trust programs and all-inclusive medical insurance plans.

According to Olson, the free market conservatives attribute the social problems of the modern (elderly) society to, what they regard as "pathological abnormalities" within the political process. Referred to as "residualism", the free market approach argues that private and voluntary support to the needy should come first, resorting to assistance by public agencies only when private resources are exhausted. With regard to the elderly, residualism stresses that public policies for the culturally deprived should focus on providing opportunities for better adaptation to the prevailing system, including the removal of employment barriers, encouraging personal savings, offering additional incentives for the private pension system, and generating more competition among health care providers. Public aid, according to this view, should only be extended to seniors who are without family and lack proper access to private resources due to extenuating circumstances.

Congruent with the above persuasion, Market Model affiliates strongly endorse the
implementation of "New Federalism". Initially introduced as a legal concept over 200 years ago, the practice of "Federalism", according to Wallace and Estes, originally applied to the division of governmental authority between federal and state dominions, and the allocation of different societal functions to each government level. With regard to the currently structured intrinsic relationships among this country's layered governmental branches, the New Federalism ideology promotes the delegation of certain major fiscal and political responsibilities for social's poor-including education, law enforcement, and health care-to the states. Stressing the importance of each government levels established independence from one another, New Federalism empowers the states with increased discretion over the formulation of socials programs in accordance to their specific needs. New Federalism postulates that through both decentralization and deregulation greater efficiency in the service market should be achieved.

To cover the costs associated with LTC provision to America's elderly, today's marketplace ideology fosters a government-private mixed approach. Acknowledging that America already has a taxpayer-financed nursing home insurance policy under the state operated Medicaid program for the indigent, the free market perspective urges the expansion of private LTC insurance policies at affordable prices for seniors. As attested by columnist, Jane Bryant Quinn (1989), while the Medicaid program does provide a safety net for seniors in need of nursing home care, it does not allow for preservation of assets, which must be depleted to a bare minimum prior to eligible coverage. Another market-oriented suggestion for financing LTC has been the incorporation of a viable employee-sponsored comprehensive group insurance. Additional suggestions include structuring a pre-paid insurance plan which allows for the purchase of a comprehensive benefit package covering LTC in consolidation with a social health maintenance organization. Incentives to purchase LTC policies, according to Dorothy Rice (1989), would include a reduced premium tax for insurers; offering tax subsidies to purchasers;
setting precedent standards for private insurance policies, and mandating guaranteed reinstatement regardless of health status. The establishment of an Individual Retirement Account (IRA) specifically earmarked for LTC coverage has also been suggested by Market Model advocates.

The goal of Market Model conservatives with regard to health care is to minimize the current federal role in its administration and regulation. It is their hope that as federal responsibilities for health care are shifted to the states with increased block grants and additional program budget cuts, federal restrictions on state-run programs will dissipate, and further strengthen the competitive market's dominance in the health care industry. In essence, the market model perspective proclaims that with enhanced competition and suppressed government involvement, the system will work itself out naturally. It is the steadfast conviction by this perspective that their proposals for LTC provision and coverage will inevitably benefit consumers and providers alike within a cost-conducive, economically sound enterprise system.
II. (Weberian) Bureaucratization Perspective:

There are other contemporary analysts of the US long term health care system that fault the entangled maze of bureaucracy enveloped within today’s health care operations, as the cause of its failure to assure equitable access by the poor in need. This perspective incorporates many of the arguments impelled by classical theorist, Max Weber. Born the son of a Protestant politician in Berlin during a time when Germany was searching for its identity, Weber immersed his life’s efforts towards the reformation of his society. As Germany’s industrial revolution advanced and massive changes infiltrated nearly all societal institutions, Weber focused his attention on the emergent social changes that paralleled the development of capitalism. One of Weber’s most pervasive themes related to the increasing rationalization of modern society. Though Weber’s depiction of rationalization was multi-faceted, according to Raymond Aron (1964), he applied it most intensively with regard to the capitalist economy, in illustration of how the fulfillment of political and economic needs over human needs had become increasingly rationalized.

According to Grusky and Miller, Weber attributed the ideological developments of the capitalist economy directly to the influence of Protestant Asceticism, or self-sacrifice. Weber discerned the existence of an elective affinity between the teachings of Protestantism and the formative values of modern, "rational" capitalism. In Weber’s correlation between early Capitalists and Protestants, he pointed to the fact that there were far more capitalists among the Protestant sector than any of the other religious orders. Weber openly criticized the Protestants’ sanctimonious lectures professing that the road to heaven was paved by one’s virtuous acts on earth; and argued that religion enshrined one’s laborious role in life as being preordained by God, and therefore indisputable. In Weber’s estimation, therefore, the implicit relationship between religion and the mode of production only acted to rationalize capitalism by instilling hard work ethics in return for salvation.
Weber applied this notion of rationalization to other exponents of social action and emergent social structures as well. His preoccupation with rationalization led him to the analysis of large scale operations, including bureaucracies. Weber believed bureaucratic organizations to be distinctive to the modern era; and, with respect to bureaucratization in private enterprise, distinctive to the most advanced capitalist industries. Weber’s analyzed Germany’s internal structural changes, noting them to be inclined towards monopolized capitalism, increased bureaucratization, political authoritarianism, and militarism; which stimulated his quest to reformulate liberalism among the culture’s social order.

Weber considered society to be a delicate balance of multiple opposing forces. Maintaining that changes in society were essentially based on changes in the economy, he argued for collective action among the oppressed to initiate reform. According to Grusky and Miller (1970), Weber asserted that the methodological design of a unified societal action was decisively superior to the shared efforts of any community action in its capacity to withstand and overcome any resistance by disgruntled masses. In theory, Weber acknowledged bureaucracies as being highly instrumental in channeling the limited power of community action into a rationally ordered, and hence more forceful, societal action.

Germany at this time was already considered a bureaucratic state, with all social servants under the state’s employment. Being a liberalist, however, according to Siedman (1983), Weber was suspicious of Germany’s purported “Democratic Bureaucracy”; and warned that, by definition, the true meaning of democracy referred to equal ruling power by the governed, which totally contradicted the objectives of a bureaucracy. It was Weber’s observation that, in actuality, the entire concept of democracy was undeniably suppressed by bureaucratic organizations, alluding to their enormous size and unprecedented power. It was feared by Weber that the authority of a Democratic Bureaucracy would reinforce intrusion on privacy, considering the socialistic tendencies abounding within Germany’s democratic society.
As noted by Siedman (1983 p.212), Weber submitted that, in contrast with the capitalist economy advanced by means of independent operations within a competitive market system, Germany's capitalist market was tied to the controlling power of the state, with "rationally" enforced policies on tariff laws and trade restrictions. Similarly, Siedman projects Weber's impression that the development of Germany's monocratic bureaucracy represented nothing more than an instrument for the attainment of formalized order through systematic policy implementation. Therefore, as Weber perceived it, the German bureaucracy, while assuming the dimensions of an "ethical" class in pursuit of national interests, in essence acted primarily to obstruct any advancement by the country's self-conscious middle class.

According to Held (1980), Weber introduced his theory of "Instrumental Rationalization", or "Instrumental Reasoning" in association with bureaucratic capitalism, and equated this theorem to an enterprise system's employment of the most rational (or reasonable) methods available to achieve aspired goals. Weber projected how instrumental rationality anchors itself within social structures, and by confronting individuals as external objects, "rationally" determines the best means to a given end. He identified social change as a derivative of increasing rationalization, involving conscious and deliberate choices based on the calculation of this means-end dichotomy. He further affiliated the advancement of the means-end tradition directly with the propitious development of industrialized capitalism, with its economically inspired cost-benefit analyses.

Because the logic behind Instrumental Rationalization accentuated efficiency, Weber found the dictates of its practice to be most prevalent within bureaucratic frameworks, under the umbrella of clear and concretely established rules, laws, and regulations. With regard to industrialized capitalism, Weber conceptualized Instrumental Rationalization as being indoctrinated by the bureaucratic structure; and then externalizing
the individual workers' participation from the process of rational determination process. Weber noted all bureaucratic organizations to utilize the cost-benefit analysis as their primary solution method for efficient goal achievement. Modern industrial capitalism, in Weber's view, had become totally dependent on this concept of cost-benefit projections; and on the notion that society would be best governed within a dominating bureaucratic framework; both for the sake of efficiency.

According to Coser (1971), Weber applied the concept of "ideal type" as an analytical tool in classifying principle features of a particular social phenomenon. In this respect, Grusky and Miller (1970, p.1) refer to Weber's categorization of the bureaucracy as a most ideal type of what he referred to as rational-legal authority. The bureaucracy, in Weber's view, was characterized by its innate disposition to create a typically ideal organization. Under the rational-legal authority of a bureaucracy, Weber specified how the rules of conduct were explicitly spelled out in a judicial format to facilitate uniformity and achieve bureaucratic utopia. As conveyed by Weber, strict subservience to the organization was expected by all associates within a bureaucracy, including subordinates and authoritative officials alike. The staff members within a bureaucratic organization in essence belonged to that organization, heart and soul, during working hours.

Organized according to rational principles, Weber described the bureaucratic structure as encompassing specialized offices, ranked in a hierarchical order, with its operational production characterized by firmly enacted, impartial rules. Emphasizing the element of specialization, Weber denoted how the ideal typical bureaucracy rationalized the need for three layers of personnel in making decisions, operating under the premise that each layer enhances the accountability, stability, and predictability of the organization.

Within the ideal type of bureaucracy there exists precisely programmed instructions, formats, and procedures that clearly outline how each job function is to be carried out. In fact, Weber considered them to be so specifically outlined that they tend to
become automatic and unpassioned when applied, supposedly to insure equal treatment of associates. Held (1980) depicted Weber’s reference of bureaucracy as a "state of mind", with respect to its strict allegiance to a written manual. That which is documented in the manual is to be acknowledged by the worker as truth, and that which is not documented in the manual cannot be regarded at all. The bureaucratic manual is treated as law and considered to be conclusive, leaving no margin for supervisory discretion.

Labeled by Weber as “Bureaucratic Authority” when referring to governmental operations, and as “Bureaucratic Management” in association with private enterprises, Grusky and Miller (1970) summarize Weber’s distinguished characteristics of the bureaucratic organization into three major components:

1. The official functions of a bureaucratically governed organization are administered uniformly in accordance with stringent guidelines, allowing for no deviations;
2. The authority to direct the functions prescribed by the bureaucracy is also executed uniformly with respect to strictly enforced guidelines;
3. The bureaucracy incorporates a methodical approach to assure the continuous fulfillment of a respective official’s duties and execution of associated rights.

Consequently, only those persons who meet categorically implicit qualifications are considered for employment by the bureaucratic enterprise.

According to Weber, the inductance of state control over bureaucratic administrations highly influenced society, with social status and religion governing which societal members were allowed to participate. Weber noted a developing growth in demands on society to fulfill its needs, and associated this with an increased ascendancy by society’s most influential. Subsequently, Weber related the advancement of bureaucratization to its acquired dependence on increased possession of goods for the populace, and on the manifestation of more sophisticated approaches to the needs of society. Weber claimed both of these elements to be inherently dependent on
opportunities provided by the wealth of society’s most influential. Weber paralleled attributes of the capitalistic bureaucracy with their perceived impact on both the standard of living and the enhancement of subjective reasoning by society, in recognizing the need for an organized, collective, interconnected; and therefore, bureaucratic system to provide for society’s destitute, which in the past had been dispensed totally by local parochial and other private sources.

Considered by Weber to be a purely political factor, he attached a symbiotic relationship between the increased demands of society and the course of bureaucratization. For illustration, Grusky and Miller discuss Weber’s reference to the enactment of the “so-called policy of social welfare”, and the subsequent delegation of its essential responsibilities to the state’s jurisdiction to fulfill. Weber further attributed the advanced direction of bureaucratic enterprises to their appraised superiority over other types of organizations, with respect to their assessed aptitude for precision, efficiency, decisiveness, judicialness, cohesiveness, and compliance to strict subordination. Though the capacity of the state’s social welfare operation depended largely on economic factors; according to Weber, the state’s management of such was solidified by the determination that the costs associated with the complex and diversified functions necessary to promote social welfare were far less extensive when administered by a specialized bureaucratic system.

Weber charged that the progressive evolvement of bureaucratization was also largely connected to demands by entrepreneurs within the capitalistic market economy for continuity in the precise and efficient administration of private business enterprises. Concurrently, Weber asserted that it was actually the larger capitalistic enterprises that best exemplified a pure bureaucratic organization. Adhering to the principles of “specialized administrative duties” in accordance with “strictly objective considerations”,

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bureaucracies to have a naturally incorporated, dehumanizing approach to their and freed from subjective interference by “precalculated rules”, Weber observed the more developed operations. With reference to the proclaimed success by enterprises under bureaucratic management, to isolate emotional elements from official business, Weber discerned this impersonal approach as being quite popular with the private enterprise system; for only through bureaucracies did he believe that economic resources could be centrally organized and systematically distributed.

Among Weber’s noted dysfunctions of bureaucracies, he ascribed that the same major advantage they have with regard to the accurate calculation of cumulative results, also leads to the externalizing depersonalization, or “objectification”, of individual cases. According to Siedman (1983), Weber’s concept of “rationalization” was further interpreted by him to lead to the objectification of world institutions and cultures, as exemplified by the imminent loss of meaning and suppression of individuality found within those cultures. Weber attributed society’s movement from idealism, charisma, and volunteerism to the materialism and routinization he attached to the “iron cage” authority and management of bureaucratized capitalism, specifically with its rationalized emphasis on efficiency.

According to Held (1980), Weber warned that if the efficiency based logic of instrumental rationality becomes the sole standard by which society judges life, individuals would tend to be more objectified, which he felt would eventually lead to inefficiency. He anticipated that continued expansion of the rationalization philosophy could become dangerous and risky with regard to social relations, for by lowering the status of individuals to objects, estrangement and alienation would surely result. In this sense, relates Held, instrumental rationality was not rational in Weber’s estimation.

Weber adjudged the influences of both Bureaucratization and Rationalization to be not only irrational, but inherently inescapable once firmly incorporated into a system. He
forewarned that the bureaucracy was one of the most difficult structures to dismantle in its fully developed form. This element of permanence within the bureaucratic organization was attributed by Weber to the following identified characteristics:

1. Its substantiated ability to transform community action into societal action, as previously discussed.

2. The immutable structure of its hierarchical chain of command, affording the individual bureaucratic official no power to alter the structured order.

3. The inability by governed subordinates to replace the authoritative structure they are chained to, in Weber’s estimation, due to their lack of expertise, occupational specialization, and mastery of the methodologically developed functions integrated within.

4. Its capacity for continuity in its functioning power, afforded by its hierarchically systematized order of official offices, which remain operational even in the event of a massive takeover or conversion.

In accordance with the bureaucracy’s fixed authoritative structure, Grusky and Miller discuss Weber’s assessed confinement of an individual bureaucrat by the strictly enforced chain of command respective to the delivery of their prescribed functions. The subordinates of a bureaucratic establishment do not possess the power to dispense or remove the bureaucratic mechanisms of authority, due to the very way the bureaucracy is structured. Accordingly, Weber surmised that the professional bureaucrat is not only chained to their assigned position, but to the dictates of a hierarchical order for the facilitation of the specialized functions entrusted to them.

With reference to its specialization, Weber advised that the highly developed bureaucracy ultimately relies on the expert training to enhance specialization by designated officials in the administration of respective functions and duties. Weber concluded that if a bureaucratic official fails to carry out their particular tasks, or if the system is forcibly
obstructed, the inevitable result would be surmounting chaos. The ability to replace those in authority from among those governed, who have the expertise required to handle such chaos, was in Weber's assessment, highly restricted.

Weber attributed the bureaucracy's capacity for operational continuity to the observed strong alliance established among individual bureaucrats to the system, bonded by their common interest in assuring that their respective functions remain operational. Nonetheless, Weber insisted that any rationalized and centrally coordinated production system, especially that under Socialism, would surely lead to alienation by the workers. However, he maintained that this aspect was also rationally justified by bureaucracies, for the promotion of stability and loyalty to one's career. Weber postulated that the more dependent society's masses become on the steady and accurate functioning level acquired by increasingly bureaucratized organizations, the less probably the idea of eliminating them would become.

Both Weber and his contemporary, Karl Marx, agreed that the, then, modern methods of bureaucratized labor did increase efficiency and effectiveness in production: but that the practice of rationalized efficiency, in Weber's terms, was highly conducive to the dehumanization, or objectification, of the worker. As previously alluded to, Weber's perceptions on rationalization and bureaucratization were notably similar to Marx's concept of alienation, with respect to their mutual ascription to humankind's domination over the world. Weber's views departed from Marx, with regard to Marx's portrayal of alienation as being only a transitional stage towards the total emancipation of society; for Weber did not foresee a future world of freedom. Weber predicted, rather, a more dismal future under the unprecedented domination of the state's bureaucratized control. Like Marx, Weber specified how the satisfaction of political and economic needs had taken a decisive precedence over human needs. While both Marx and Weber contended that changes in society were dependent on changes in the economy, Marx placed a much
higher precedence on the need for collective action among society’s oppressed to change the system. In contrast, Weber’s irrefutable image of the bureaucracy’s “iron cage” endurance was that it was relatively inescapable. He felt that society’s only hope for emancipation from its dominant power would be through the emergence of a charismatic leader with, not only the fortitude, but the persuasive esteem, to authenticate society’s barrage on the system. According to Weber, successorship by a “charismatic authority” would first require society’s legitimization of the perspective incumbent’s qualifications to fulfill the respective authoritative position. For the transformation of a new charismatic influence into a permanently established structure, the adaptation of an economic system which allows for the continuous provision of societal necessities, and is conducive to expansion by the system’s budget through taxation and contributions, would be required. Weber considered such charismatic authority to be extremely unstable however, with its survival power being only as strong as its predominate appeal to society.

Categorized by Coser (1971) as a more radical philosopher, Georg Lukacs was highly inspired by Weber’s work, and integrated many of his themes within his own theoretical context. Studying under Weber, Lukacs ascribed to his colleagues perception of instrumental rationalization as it becomes infiltrated within society’s bureaucratic frameworks and transcends to increased domination over the modern world. Coser illustrates how Lukacs, like Weber, based the formative constructs of capitalism on the principles of instrumental rationality and the axiom that modern society would be best governed within the auspices of a bureaucratic infrastructure. With respect to Weber’s assessment of the capitalist economy’s profit orientation and subsequent concentration on efficient operations, Lukacs attested that if one’s goal is monetary gain, they will readily compromise their values (referred to as “value rationality” by Weber) in order to achieve such. Consonant with Weber’s concepts of objectification and instrumental rationality, Raymond Aaron (1964) points to Lukacs’ key postulate with regard to societal
dysfunction, "reification". Reification is by definition, "the treatment of abstract phenomena as if it were a concrete, material object; or, to the attribution of qualities to something it does not possess". According to Aron, Lukacs conceptualized reification as pertaining to the process whereby people come to view humanly created social organizations as customary, universal, and absolute; and hence, considered to be unchangeable and outside the realm of their control. Through Lukacs' defined reification process, individuals come to perceive themselves, and to be perceived, as external to the course of their productive role in society. In congruence with Weber's depiction of instrumental rationalization, Lukacs related his reification concept to capitalism's customary qualification of societal components in terms of profit. From an economic perspective, Marx used the term "commodification" to distinguish the process through which human beings are not only externalized from the modus operandi, but dehumanized by the production system; being regarded as commodified objects, or products of the system, with respect to purchase and exchange of human labor. With respect to the bureaucratization of society, Grusky and Miller relate Marx's affirmation that in Germany, individual laborers were subjected to the bureaucratic control of the state from birth on; and his proclamation that all major institutional structures within the capitalist economy were marked by conditions of alienation. Marx projected society as becoming increasingly bureaucratic in structure, as more institutions were generated to address the needs of society.

Considered to be the major link between Weber and Marx, Lukacs was described by Aron as transferring Weber's ideas into Marx's framework with respect to capitalism's basis on instrumental rationality. According to Lukacs, humanity's tendency towards reification and commodification extends beyond the mode of production into other societal spheres, including health care provision, which he also surmised to be indicative of the increased rationalization of modern civilized society. According to Aron, Lukacs
proclaimed the issue of commodification to be the central, structural problem of our capitalistic society today.

Lukacs paralleled elements of his reification concept with those of instrumentalism, as evidenced within the bureaucratic capitalist economy, relating to both processes' reference to effectiveness as a measure of validity. As Aron relates, Lukacs considered capitalism by nature to categorize everything from individuals, to family units, to educational programs, to laws, to health care in terms of their estimated, measurable utility; and in so doing, reduces all things to one dimensional level. When the primary motivation for societal action becomes material gain, in Lukacs' estimation, instrumental rationality then becomes capitalist rationality. In brief, Lukacs cautioned that when all life is reduce to the logic's of rationalized efficiency, regard for humanity is narrowed substantially, and life becomes meaningless. Aron reflects Weber and Lukacs' mutual assertion that, within the efficiency based bureaucratic framework of advanced capitalism, what may have once been deemed as technically rational, becomes morally irrational. Referred to by Lukacs as "scientifism", with capitalism's emphasis on efficiency, current decisions for society's well-being are scientifically based on estimated worth and associating cost factors.

Bureaucratization and Health Care for the Elderly

Many contemporary analysts, like Weber and Lukacs, have determined that, with regard to health care, what is considered to be instrumentally reasonable in the US today is not care, but cost. Consequently, today's analysis of health care reveals that its provision is not based on need; but rather, whether one can pay for it, or has an insurance plan that can pay for it. As a result of our modern age of competitive capitalism, according to Paul Starr (1982), human services and resources that were once considered as an entitlement have since been minimized by the higher bureaucratic priority of cost-containment.

According to Starr, the US state government systems paved the way to stifled,
costly regulation of the health care industry. He relates New York to have been the first state to regulate capital expenditures on hospitals and nursing homes in 1964, with other states following as a result of the rising consumption by state Medicaid programs. Claims Starr, in our current movement towards integrated control, the traditional boundaries of health care are being challenged, with hospitals being synthesized towards acute care only, and the consequential integration by medical practitioners' towards less costly institutionalized services for their patients. Additionally, as America continues to shift emphasis on health care from voluntarism to competition, Starr illustrates the parallel shift from nonprofit, governmental health care organizations to for-profit enterprises. He warns that if the current rejection of "big government" by both the public and the medical profession continues to persist, we will be witnessing a massive transformation, with far more reliance on the private sector.

In full concurrence with the Bureaucratization perspective, contemporary analysts emphasize the fact that we humans have created the bureaucratic machine and that it is now destined to choke us out. Economists refer to the bureaucratic systems organized in the 60's in the name of social welfare, for illustration of this sentiment, and relate how they did originally appear to be effective—at least instrumentally. The prices we have paid for our established social programs, however, are considered by many to be excessive, with our bureaucratized assistance programs costing more than the medical care they provide for. Proponents of this perspective challenge the need for the multiple layers of government and their associated bureaucratic systems, currently involved in the regulation, service provision, and financial payment of LTC in this country. Emphasizing the amount of bureaucratic waste absorbed in money and time with the present three-tiered governmental system, in determining who qualifies for what LTC services and financial coverage, they propose the consolidation, or down-sizing, of some governmental programs. It is believed that by lessening the amount of bureaucratic waste involved with
LTC, government spending could then be allocated for the betterment of those in need of such care. Rather than a complete reorganization of the system, proponents to this field recommend moderating change within the present structure.
III. (Neo-Marxist) Profit Orientation Perspective:

As the world becomes increasingly fragmented, and resources become more sparse, concern for their resiliency becomes more pronounced. This is especially apparent within the welfare state of modern America. Yet many today, like Marx in the past, question whether the problem is indeed scarcity of resources or, in fact, a result of improper distribution. In contrast to Weber’s symmetrical tie between Protestant Asceticism and the capitalist economy’s formation, Marx considered the major determinant of society’s organization to be its coexisting material conditions. In his argument for “economic determinism”, Marx instructed that the key to understanding how society works is to look at the organization of the production system as it has evolved over time. David Held (1980) portrays Marx’s belief that capitalism was not a humane system; and, though considered to be more progressive than feudalism, was still contingent on the exploitation of the human species. According to Marx, the class system had evolved because of the scarcity in resources. He maintained that capitalism had taken care of the scarcity problem by introducing inequality in distribution, which he determined to relate to buying power.

From Marx’s perspective, the prevailing interpretation of history was, that it was shaped by the dominating force of a perceived divine providence. Coinciding with Weber’s theory of Protestant Asceticism, Marx observed the prevailing theme of his era to advance that people were born into a fixed social position, as predetermined by God. Commencing from this postulate, it was theorized that all people had a preordained role in life to fulfill, in accordance with universal laws, which were similarly based on uniformity found in nature. The goal of society was to survive and flourish; and to obtain this goal all persons, as members of society, must satisfactorily fulfill their prescribed functions. Those who followed the rationale of a world based on a fixed hierarchy dared not make any changes, for to do so would be to go against God’s will, and the church. To Marx, this
whole mode of thinking only acted to justify the class system and social inequality through God and religion.

Though the basis of all Marx’s work on social structures most clearly pertained to his analysis of commodities, according to Aron, to understand Marx’s philosophies in full we must recognize that people’s realms of production involve social structures as well as economic objects. As Aron points out, Marx maintained that labor-power can only become a commodity under the capitalistic system if the one possessing it exchanges it as a commodity. Although capitalism was thought to be a radical idea when first introduced, it gained popularity with the presentation of “consumerism”, with emphasis on consumer interests and the conception of values in commodities, which many today consider to be our way of life.

Building from this philosophy, theorists of the Neo-Marxist perspective contend that a number of services in our present society, including health care, are treated as commodities, to be bought and sold according to one’s ability to pay, and on the strict basis of profit. In contemporary times, Neo-Marxists have incorporated concepts from Weber’s theory of Instrumental Rationality, emphasizing efficiency and value; and Lukacs’ theory of Reification, emphasizing estimated cost and worth; with Marx’s theory of Commodification, emphasizing profit motives to describe how our health care system has been transformed from a relatively non-profit, fundamental service to a commodified industry, and how our culture has become more bureaucratized, with more spheres of society breeding institutionalized thinking. As a consequence of this commodification process, it is concluded that relations between medical practitioners and patients have become increasingly impersonal, with individuals being characterized more as “objects” for lucrative gain, or “commodities”, so to speak, among the medical field. The Neo-Marxist perspective attributes the failures of the US health care system to its dominating profit orientation, and the accompanying commodification of medicine.
Marx proclaimed that, what orchestrates the world is not great people or great
designs; but rather, the way people produce and reproduce societal conditions over time.
The Neo-Marxist tradition expounds on Marx’s socio-economic philosophies and
interjects the dynamics of “historical materialism”. This concept reflects the importance
of historical specificity with economic analyses, maintaining that certain factors may only
apply to a particular historical era. This perspective considers Marx’s concept of
economic materialism to be significant here, in that it represents the emancipation of
society’s thinking patterns from the dominating influence of Idealistic philosophy.

According to this perspective, Marx’s analysis of capitalism no longer applies to
the US, at least in content. For one, while Marx’s socio-political theories applied to the
antithetical relationship between the bourgeoisie, or upper class, and the proletariat, or
working middle class; contemporary Neo-Marxist’s find these terms to be obsolete. With
the rise of our modern day service industry, these theorists relate today’s classes to be far
more complex. Additionally, Neo-Marxism addresses a more recent historical period, the
depression of the 30’s. With reference to Roosevelt’s New Deal, Neo-Marxist’s consider
this era to represent our economy’s transformation to what they refer to as “Corporate
Capitalism”. This perspective’s operational definition of capitalism outlines three major
distinctions from Marx’s era.

1. The increasing concentration of capital. In early America, our economy was
basically comprised by small, independently owned business enterprises. This
perspective reflects today’s economy as having fewer businesses, with increasing
ownership by large corporations, and the respective conglomeration of shared
monopolies by three to four companies. This point is considered to be significant
because, according to proponents of Neo-Marxism, this form of capitalism is in
direct violation of Smith’s principles of competition.

2. The internationalization of capital. Neo-Marxist’s display the US economy’s
transformation from ownership by national corporations, with a reciprocation of capital back into our economy; and multi-national corporate ownership, with the disbursement of capital to foreign countries in return for cheaper labor. The significance here applies to the ability of international corporations to increase profits through health care, while making this country poor.

3. **The rise of governmental intervention.** In contrast to America's earlier phase of laissez-faire capitalism, with an anti-government emphasis, those of the Neo-Marxist persuasion, consider the state's intervention of our present capitalistic system as engendering a politically based economy. This element is considered significant due to the Neo-Marxist's conception that, while governmental intervention may have temporarily rectified the problems that capitalism produced; it has now become too costly, as exemplified by the fiscal crisis of our states. With its operational perseverance being dictated according to political dominance, today's government controlled health care system is considered by this perspective to be totally ineffectual, placing the responsibility for the system's inequities, including health care, on the working class.

Theorists of the Neo-Marxist perspective equate the actual breakdown of our health care system to governmental intervention in the 60's, which incorporated the state operated programs of Medicare and Medicaid, in a proclaimed attempt to distribute our resources more evenly. Accordingly, they assert that the solutions of this era have now become the problems.

A common theme for Neo-Marxists who have examined the delivery of US health care, is to discuss how the commodification of medical care has resulted in a two-tiered service delivery system, with the best of medical care being offered to those who can afford to pay, and a second class "fast food, assembly line" type of medical service to the less advantaged. Specific concern is directed towards the many citizens who fall between
the cracks and get no medical care at all from the present health care industry. As emphasis on profit increases, these theorists claim that monetary returns for medical services to all income groups appear to take precedence over quality of care; yet, none seem to feel the effects quite as strongly as the lower-income classes receiving more rationed care. It is the assertion of Neo-Marxists' that when a society makes science and profitability the basis of how we deal with social relations, we then come to treat people as objects, or products (commodities), placing the poor and destitute in a class which is less than human. In accordance with Marx and Lukacs, if we look at health care as a commodity, to be bought and sold accordingly, then we do not actually speaking of care, but rather, of our economy.

Critical theorists within the Neo-Marxist perspective assert that, as the US health care delivery system becomes more commodified and resources become less plentiful, health care logic becomes market logic. With America's free enterprise system based on market principles, health care is then analyzed on the aforementioned basis of the cost-benefit scheme, as opposed to actual need. In Neo-Marxist terms, the question therefore becomes, "What is the overall cost to make all American citizens healthy?"; or "What is the cost to provide quality care to all those in need?"; or - better yet - "Whose interests are best served by our society’s organized assistance programs and, how do those inadequately served come to accept the unequal distribution of resources bestowed upon them?" In line with this, as social theorists Carroll L. Estes and Laura Katz Olson both attest, the bureaucratization of today's US health care system appears to accentuate more importance on its continued profitable existence, than addressing the medical needs of the elderly population and other disadvantaged groups.

Following Marx's economic profile, those of the Neo-Marxist persuasion interprets America's aging policies, like others, to be guided by an intertwining relationship between politics and our economy. Stated otherwise, it is the country's
current political factors as well as economic factors that effect our society’s view of the aged. As Estes, and other political economists profess, the status and resources allotted to the elderly and to the aging process itself, are all conditioned by one’s location in the social structure of the time, and the respective economic and social factors that effect such. (Minkler, 1984) In our society, all persons over age 65 have been categorized as a single, distinct group from the rest of the population. Because the elderly are the most frequent users of medical care, and because a good percentage of them can expect to spend some time in a nursing home during their lives, be it short term convalescence for a broken hip or long term care to live out their lives; Neo-Marxists confirm that medical care for the elderly, and especially LTC, has taken on some unmistakable political undertones.

As history projects, it used to be that those persons who reached old age were poor, being forced to retire from the work force without any ability to recover lost income. The aged without sufficient support systems were left to fend for themselves, or be placed in poor houses. Ian Gough (1979) interjects a phrase which entered the English vocabulary during and immediately following World War II. The term is “the welfare state”, which refers to the rash of legislative proposals enacted in post-war Britain, and surrounds issues of the various welfare and social service operations of our states in the 40’s. The issue of medical care as a privilege or an entitlement gained momentum during the anti-poverty movement of the 60’s. Politically determined by the voters to be an entitlement, Congress approved the enactment of the federal Medicare program and the state Medicaid program to cover medical costs for the aged and disadvantaged, respectively. In current times, the same questions and debates that were raised then continue, regarding the purpose, cost, and effectiveness of many of the state services being administered.

In our modern age of competitive capitalism, as previously asserted, services that
used to be conferred as a human right have since been relegated in consideration for cost-
containment. As this perspective points out, every administration since Johnson has
attempted to cut Medicare, Medicaid, Social Security benefits, and other assistance
programs for its indigent citizens. The Reagan administration is represented as being
most successful in manipulating American citizens towards the acceptance of his strong
public directive to involve less governmental intervention with regard to social problems.
Following Hoover’s progressions in the 30’s, Reagan was considered triumphant in
convincing much of the public that one’s wealth, or lack of; and consequently, one’s
health, or lack of, was again, solely the responsibility of the individual. In line with the
concept of “Federalism”, the Reagan administration did succeed in its attempt to transfer
much of the financial burden of health care and other social programs back to the state
governments.

The Neo-Marxists advocate for a single-payer health care system. Though the
response to Reagan’s 1982 mandate suggested that the American people supported less
government intervention, Margaret A. Adams (1987) related that several polls
administered during his administration actually supported increased governmental
spending for the aging population, especially in regard to health care. Similar support for
universal coverage of comprehensive medical care holds true today. As the Bush
administration came to an end and a new political leadership ascended, analysts reflected
that a vast majority of US citizens were once again strongly urging governmental
intervention, with a major focus on some type of LTC insurance plan. According to a poll
conducted by the Villers Foundation (“Long Term Care and Personal Impoverishment:
Seven in Ten Elderly Live Alone at Risk” 1987: p. 121), respondents favored universal
coverage for LTC by a margin of five to two. The greater majority of the sample polled
acknowledged that LTC would entail more governmental spending, but were willing to
pay increased taxes to support it. An astounding 86% opted to involve the federal
government as the funding mechanism.

Neo-Marxists maintain that Reagan's revised New Federalism philosophy has once more given way to the precedence of medical practice for the benefit of profit as opposed to social good; and the ties between the industry, capital, and the medical providers continue to promote the commodification of health care delivery to the aged and the poor. Literary sources reveal that high medical charges, along with cost controls imposed by the Medicare and Medicaid have resulted in fewer health care services and facilities available to the indigent. With the dominance of profits over human need, this perspective asserts that health care has become increasingly reified and commodified for the sake of the service industry, by developing products and medical treatments or strategies which can be marketed for a comfortable return. In Starr's words (1982), doctors and other health care providers have successfully escaped becoming victims of capitalism, and have instead evolved into what Gough (1979) refers to as "democratic welfare capitalists". As Olson states (1982), our privately controlled health care market has continued to promote the exploitation of illness for profit by those of the medical profession, at the expense of the oppressed.

According to this perspective, the welfare system in the United States has become too expensive and totally inefficient. Our piecemeal attempts to curb poverty and provide equitable, uniform medical services to all income groups are criticized by the Neo-Marxist doctrine as offering little more that "band-aid" solutions, which inevitably lead to greater problems. Olson maintains that the programs aimed at improving America's quality of life have failed miserably; and, have instead created enhanced profits for the private sector and perpetuated inequalities. She further asserts that the same programs have not only acted to escalate health care costs, but have failed to alter the allocation of equitable health care, and have neglected overall social and environmental causes of disease and ill health in our society.
The Neo-Marxist perspective supports the establishment of a single-payer system, with equal care for all those in need of acute or long term medical care, regardless of income status. President Clinton advances a variation of a proposal referred to as the ‘pay or play’ method for hospital and physician’s coverage, with a complete revision of Medicare and Medicaid programs, to cover LTC for all American citizens. Clinton advocates for a complete revision of the Medicare and Medicaid programs, to cover LTC for all American citizens. According to Ronald Schwartz (1992), Clinton adamantly believes that no one in this country should have to become totally impoverished to qualify for LTC coverage. Though this proposal might possibly eliminate some of the governmental bureaucratic waste, it is far from a single-payer source; and, even if Clinton’s stated proposals did show promise; again, if our programs for change must begin and end according to political elections, the Neo-Marxist perspective questions whether we will ever resolve the issue of inequality among our citizens, due to the immense disparities among our dominant political parties.

Presently the public and politicians alike remain torn between the two prevailing thought patterns, with medical care being a right or a privilege. Within this dichotomy, to the disadvantaged seeking both short and long term medical care, in the US it appears as though such care has become the rich person’s right and the poor person’s privilege. Marx strongly defended his belief that oppression can be overcome, by projecting self-awareness onto those victims of inequality, and by raising their levels of consciousness in regard to why they are where they are. He stressed, however, that the total elimination of oppression would require more that just rudimentary changes in our society. He maintained the need for paramount transformations that politics and laws alone will not resolve. In Marx’s view, to successfully institute change we must begin with the basic root of the problem, and facilitate a complete overhaul of the public’s major attitudes. Most political economic analysts and theorists concur with this philosophical approach,
emphasizing that the “problem” of aging is a structural one and must be attacked from this frame of reference. Their main argument is that aging has been stereotyped by those who devise our social policies. The result, they claim, is that the policies and programs established to service the elderly have, in essence contributed to an "aging enterprise", which in turn creates dependency and perpetuates class differences. According to the political economy approach, these socially created policies and programs have been developed for the purpose of social control, and tend to fit the needs of our capitalistic society as opposed to benefiting the elderly. One thing for certain according to Neo-Marxist theorists, as long as inequality prevails among our classes and medical care is treated as a commodity, the ideologies depicted by Weber, Lukacs, and Marx will continue to dominate our society.

Chapter three will identify how these three perspectives can be tested, using a case study of two different models of health care, the US and Canadian systems. I will further lay out the specific elements each model would identify as constraints to accessibility, and discuss how these might be examined.
CHAPTER 3
RESEARCH METHODOLOGY

For the purpose of this study I am assessing three theoretical perspectives, by examining constraints to Long Term Care (LTC) accessibility. In this chapter I outline the research procedures employed for this comparative analysis. The chapter first defines how the particular geographical areas were selected for study, as well as the sample groups within those parameters. Secondly, detail is given to how the adopted interview guide was utilized to distinguish identified barriers to equitable LTC provision, differentiate accessibility rates to LTC among the two diversified economic systems, and ascertain conclusive explanatory evidence for the following research questions:

1. What contributing factors are most often encountered as strong impacts to LTC accessibility by elderly residents of Clark County, Nevada? By elderly residents of the Fredericton region, New Brunswick? Is one delivery system more accessible than the other? If so, why?

2. How can we best compare the multi-entry, multi-payment source system for LTC currently embraced by Clark County, and the single-entry, single-payment source system for LTC in the Fredericton region; with their mutually prescribed objectives to promote continued independence by seniors, through the provision of requisite care within the least restrictive environment, and to enhance accessibility to appropriate LTC facilities by the less advantaged senior population?

In this chapter I further illustrate ten factors demonstrated by the research to act as constraints to accessible care by Clark County seniors, five of which were also identified.
to pertain to the Fredericton region, prior to the enactment of the Single-Entry Point System (SEPS) for LTC. These factors are then compared to the predicted constructs within each of the perspective models, to explain how the interview data will come to answer the theoretical questions proposed.

**IDENTIFICATION OF KEY STAKEHOLDERS AND ESTABLISHMENT OF THE SAMPLE UNITS**

This research proposal evaluates which factors most affect rates of accessibility to LTC services among the elderly population. For this objective, the populations of Clark County, Nevada, and the Fredericton Region of New Brunswick were selected for a comparative study; based on their diversified economical systems, and evidenced distinctions between their LTC delivery systems. The Fredericton region was chosen, following literary examination and independent empirical research of three separate Canadian LTC delivery systems: 1) the Halifax region of Nova Scotia, 2) the St. Stevens region of New Brunswick, and 3) the Fredericton region of New Brunswick. From these three regions, the Fredericton region was given preference, as its system for LTC delivery appeared to be the most dichotomous to Clark County’s system, and therefore most suitable for a variegated comparison. Within the Fredericton region, LTC delivery is administered through the use of a Single-Entry Point, Single-Payment Source system, whereas, Clark County utilizes a Multi-Entry Point, Multi-Payment Source system for LTC delivery. Through qualitative research methods this writer compared the equity of LTC accessibility, by senior citizens from within these two dichotomous systems. The approach employed for this study was that of analytic induction, proceeding from the hypothetical statement that “accessibility to LTC services by financially disadvantaged seniors in Clark County is extremely limited, and that the systems established in Clark County for assistance to disadvantaged elders have instead created impediments, or
constraints, to accessibility”. This study was implemented to determine whether the Single-Entry Point System currently being utilized by the Fredericton region, as a one step "referral" process for all senior residents in need of LTC services or placement, allowed for more uniform accessibility by all income groups; and, if so, why?

The comparative analysis of these two systems was incorporated, for the purpose of analytically determining any discernible factors among them that might indicate similarities and differences. It was determined that all key agencies involved with each system’s LTC service delivery process, must first be identified, and then interviewed to clarify each operation’s relative role in the respective LTC industry. The intent of this writer was to interview a representative sample of service providers, in affiliation with each area’s primary service operations for the provision of LTC to indigent, or financially deprived, seniors. With respect to both systems, three autonomous groups of providers were determined to be most significant to this research design, as illustrated below:

1. **Government assistance operations, working with people in both the community and acute care institutions, for the facilitation of nursing home placement or other LTC services, and provide financial assistance to eligible seniors, when necessary.**

   In Clark County there are two government assistance agencies for LTC costs not covered by the (federal) Medicare program: Clark County Social Services (CCSS), and Nevada State Welfare (NSW). In the Fredericton region, only one government agency is involved for this purpose, the Department of Health and Community Services.

2. **The acute care hospitals delegated the responsibility of determining proper discharge plans for those requiring LTC services or placement.**

   In Clark County this group included one "for-profit" institution and one "non-profit" institution for selection comparison. Because all hospital facilities in the
Fredericton region are non-profit, only one institution was elected from this sample group.

3. **The LTC facilities administering to those in need of extended care.**

In Clark County, all nursing home facilities are "for-profit". To eliminate bias, representative sampling for this comparison group was compiled from among four categorically defined nursing home operations: one large corporate owned facility (categorized as having more than 50 residents); one small corporate owned facility (with less than 50 residents); one privately owned large facility (with more than 50 residents); and one privately owned small facility (with less than 50 residents). In contrast to Clark County, all but two of the nursing facilities in the Fredericton region are "non-profit". Consequently, sampling from among this comparison group involved only one of the "for-profit" homes, and one of the "non-profit" homes.

The selection of individual subjects for this study was established strictly on the basis of professional experience and knowledge, with the representative sample of respondents being purposive, in relation to each area’s specified provider groups, to be later discussed.

The purpose of this approach was to evaluate the two selected areas’ systems of LTC provision, by examining each organizations’ stated procedures, as indicated by associated documents and manuals; interviewing agency workers from each area’s reciprocal agencies on how they perceive their respective system to operate; and then correlating responses from among each of the sample groups; for the measured rate of comparative accessibility to LTC within each area’s systematic protocol.

Although this writer attempted to match regions according to demographics, as specified under the data analysis section, this was concluded to be unfeasible. It was found that demographic similarities did indeed exist between the confines of Clark County, Nevada, and the whole province of New Brunswick, as revealed in Chapter six. A form of
frequency matching was, therefore, incorporated to pair samples accordingly, to assure equal representation by both evaluated systems. The representative sampling from within each of the nursing homes, hospital facilities, and government assistance agencies in both areas, consisted of one administrator, and one social worker involved with the admittance, social services, and discharge of all patients. As previously attested, major disparities did arise with the selection of sampling frames respective to each sample unit, consequent to the fact that: 1) Clark County utilizes two financial assistance agencies, whereas the Fredericton region utilizes only one, 2) all of the acute care hospitals in the Fredericton region are non-profit, whereas Clark County has both non-profit and for-profit hospitals, and 3) the majority of the LTC facilities in the Fredericton region are non-profit, with all of the LTC facilities in Clark County being for-profit.

The geographical regions selected for study represent convenience samples based on location. Clark County was targeted because it is the residence of this writer, and one with which personal experience and knowledge has been acquired, giving rise to an awareness of pertinent agencies and facilities to drawn upon. The Fredericton region was selected due to the close proximity to relatives; which was highly considered in lieu of the costs involved for this study. The samples chosen were also purposive, in that only those respondents which were believed to best meet the purpose of the proposed research study were targeted. In both Clark County and the Fredericton region, the intent was to examine the LTC assistance agencies from their own perspectives, and then compare the perspectives of associated organizations, to determine any inconsistencies between how the respective assistance agencies profess to operate, and how those associated with them perceive their operation. Secondly, the intent was to compare and contrast the Clark County system for LTC provision to the indigent, with that in the Fredericton region. In this sense, the Fredericton region was selected because of their implementation of the SEPS program three years prior, which this writer also wished to study.
The process used to identify the essential organizations for researched in New Brunswick was strictly through non-probabilistic snowball sampling due to this writer’s lack of awareness of their system and its relative components. On May 1, 1992, a call was placed to the Chamber of Commerce in Fredericton, New Brunswick to determine which agencies might be contacted to ascertain information specific to this thesis project. The Chamber of Commerce in turn forwarded a brochure entitled “Marketplace Fraud and the Elderly Consumer” which was distributed by an organization out of Halifax, Nova Scotia, Canada, known as the Consumer and Corporate Affairs of Canada. Among other things, the brochure offered elders advice regarding the "proper" disposition of property and assets before entering a nursing home or other type of senior living arrangement. Additionally, the brochure touched on the number of victims of financial exploitation by their children or significant others, often due to a misunderstanding of the way the needs of the elderly person are assessed prior to entering a care facility. It further addressed the tendency of some elders to sign over their savings and other assets to another person, on the premise of protecting them from "government confiscation." (It should be noted that the above signifies duplicate issues faced in Clark County, Nevada, quite frequently.)

The brochure made reference to the organization’s Regional Director, Judy MacDonald. It was through Ms. MacDonald’s referral to Joan Snow, Regional Supervisor for the Department of Community Services in Halifax, that the proper counterparts to her agency in the Fredericton region were obtained. On June 24, 1992, a lengthy conversation was held between Frank O’Donnell, Regional Director of the Department of Health and Community Services in Fredericton, and this author, about the Single-Entry Point System, which he stated had been initiated and administered as a pilot project three years prior. According to Mr. O’Donnell, several more regions would soon be following suit with the implementation of the SEPS program and that it is contemplated that the SEPS model could eventually be instituted across Canada. Director O’Donnell
referred to the Extramural Hospital, as an ancillary unit of SEPS, and suggested I consult with Lisa Daigle, Director of Unit Operations. He further recommended contact with Robert Kirby, the Adult Protective Supervisor and current coordinator of SEPS; and with Eric Gionet as the initial coordinator of the program, and current Regional Director of the Department of Income Assistance. For information from an acute care hospital’s perspective, I was directed to Doctor Everett Chalmers Regional Hospital due to their employment of Dr. Ian MacDonald, the SEPS panel physician. York Manor was recommended in representation of a non-profit nursing home; as the Assistant Director, Joan Zappia, had worked within the Provincial Nursing Home Unit, which was identified by Mr. O’Donnell to be an essential component to this study as well. Mr. O’Donnell suggested contact with Ron Crawford, Director of the Nursing Home Unit, for additional input. The importance of including the Provincial Department of Health and Community Services’ perspective, was also suggested, with reference to either the Executive Director, Bernard Poulin, or the Assistant Director, Peter Alderman. Mr. O’Donnell was unable to refer to any for-profit nursing homes and stated it would be hard at best to find one, due to the non-profit status of most facilities in New Brunswick. Further inquiry did, however, lead to the Woolastock Manor in the nearby community of Gagetown.

Because the St. Stephens region was initially included in this research design, communication was additionally initiated with Paul Donnelly, Regional Director of the Department of Health and Community Services in St. Stephens. During the initial conversations with Mr. O’Donnell, Mr. Donnelly, and the St. Stephen’s Regional Nursing Supervisor, Shirley Clarke, it was ascertained that New Brunswick had established separate health care regions in 1986 to allow for better management of services. At that time, according to Mr. Donnelly, the government was opposed to the increase of civil services. Because the Department of Health and Community Services still held the mandated responsibility to provide services, they were required to purchase this
commodity from private, for-profit agencies, primarily for the senior sector. Eventually, the agency was allowed to hire more staff and essentially eliminate the purchase of services from the for-profit sector. At present services are only purchased from non-profit agencies.

All three agencies shared information with regard to the SEPS program, which was to begin operation in St. Stephen’s region on July 1. Adopted from a similar program in Alberta, it was explained that the main objective of SEPS is to determine what services might benefit a referred senior most, and that nursing home placement is only authorized by a SEPS panel if deemed appropriate and necessary. The SEPS panel consists of a hospital nurse, a geriatric physician, and a licensed social worker who completes the assessment process. It was learned that if an individual lacks sufficient resources to pay for a nursing home placement, they or their families are referred to the Department of Income Assistance, following placement; with payments for eligible clients being generated from the Regional Department of Health and Community Services, through funding from the provincial level of government. According to Mr. Donnelly, only two for-profit nursing homes exist in his region.

As previously attested, the selective process applied in Clark County to establish a comparative sample of agencies and facilities was quite different. A pertinent component to the selection process is this researcher’s familiarity with the respective hospitals, nursing facilities, and assistance agencies in the county. In acknowledgment of the larger sampling frame of acute-care hospitals and nursing facilities in Clark County, the acute care hospitals were separated into sampling units according to their profit oriented status, providing three non-profit facilities to choose from, and four for-profit facilities. The nursing home facilities, all classified as "for-profit", were categorized according to private or corporate owned status. The privately owned facilities were further separated into small-private (less than 50 residents) versus large private (more than 50 residents).
Because there are only three privately owned nursing homes in Clark County; one with 20 residents and the other two with 98 and 104 residents, respectively (both owned by the same proprietor), this left marginal allowance for random sampling. The small corporate sample unit, marked as those corporations owning less than five facilities (in contrast with corporations owning facilities nationwide), also comprised of three, with two of them being owned by the same corporation. In comparison, the larger corporate owned sample unit consisted of ten "for-profit" units. With respect to the "non-profit" acute care hospitals, the sample selection was based on location, as two of the three were located in bordering towns. This process further applied to the small corporate owned nursing facilities, as only one of the three was local. With respect to the "for-profit" hospitals and large corporate hospitals and large corporate owned nursing facilities, selection was based on the incorporated process of simple random sampling. By assigning numbers to the four sampling units, each units' numbers were placed in two jars and one selection picked from each. Though it is acknowledged by this writer that this method is not considered the most suitable approach to random sampling, it was considered to offer the closest approximation to such due to the sample size.

Initial contact with the varying agencies and facilities was made by phone to introduce myself, to acquaint each one with my research proposal and its purpose, and to advise how their particular input would be of benefit. Follow-up letters were sent to provide a more detailed explanation of the project. It should be noted that some letters were routed prior to the actual phone contact with the respective department heads, which will account for the differences in the body of some letters. Prior to my departure for New Brunswick, telephone contact was again initiated to confirm my plan to visit, and to schedule my appointments. The above approach resulted in a 100% response rate.

Intensive face-to-face interviews were conducted with selected subjects from the targeted groups. Using a prearranged interview schedule, all interviews were conducted
using an unstructured format, as most responses were elicited by open-ended questions. All questions posed were direct and intentional, yet phrased so as not to influence or structure the respondents' replies in any way. This technique appeared to allow for a more free-flowing exchange, considering the complexity of the issues at hand and the unknown determinants, especially with regard to the New Brunswick system. While some questions were presented in a standardized form, many were phrased to be specific to the particular respondents in accordance to their association with LTC provision. For example, elected questions were advanced to the different associates to obtain background information specific to their respective organization. This seemed especially pertinent in respect with the assistance agencies in order to analyze their historical development, for comparative elements.

A tape recorder was utilized during all of the interviews conducted in Clark County; and with all but one respondent in the Fredericton region who requested it not to be used. In all cases it was explained that the use of the machine would economize time otherwise required to assure accurate handwritten documentation, and prevent misrepresentation of their individual testimony. Although both anonymity and confidentiality were assured to all participants, this did not appear to be a concern; and as the interviews came to a close, the tape recorder seemed to allow for a more natural flow of dialogue. In fact, many commented on how they had dismissed its presence after awhile. A few respondents did relate that the tape recorder would only bother them if the interview addressed a sensitive question, in which case they were given the option to have it shut off. This situation never arose, however. Where handwritten documentation became necessary, careful recording measures were taken, with an edited transcription of the interview write-up being initiated following the corresponding sessions.

In addition to the interview studies, an examination of documents relevant to the
individual agencies was implemented to augment the research study. Within Clark County, the main documents reviewed were the Nevada State Welfare Manual and Clark County Social Services Manual, to obtain their written eligibility criteria for assistance; their definitions for different classifications of care provided by facilities; their categorized distinction of which items and equipment are the responsibility of the facility to provide the resident (e.g.: wheelchairs, diapers, etc.), as opposed to the responsibility of the government assistance program to provide; and their respective regulations for spousal impoverishment. Application packets for the eligibility process, as offered by the two above agencies, were also examined. The United States Federal Medicare handbooks from 1991 and 1992 were reviewed to determine specific guidelines and definitions of medical services covered.

From the Department of Health and Community Services and the Department of Income Assistance Manuals in the Fredericton region, written regulations pertaining to the above issues were also examined. A complete copy of the Single-Entry Point Systems reference manual from the Department of Health and Community Services was also reviewed for comparison. This document provided insight for an in-depth understanding of the operation's history, underlying philosophy, and objectives. The manual further described the assessment process from intake, to the comprehensive medical, social, and mental health evaluations, and finally, to the relative service recommendations. The 47 page "New Brunswick Assessment and Continuing Care Instrument" packet was also provided and examined to comprehend the inclusiveness of their assessment tool. The "Evaluation Report of the Single Entry Point System" was offered by the Department of Health and Community Services in both Fredericton and St. Stephens, New Brunswick. A thorough explanation of the SEPS program, plus a description of the results from extensive pilot projects initially conducted within the Fredericton region and Peninsula Acadienne regions, was derived from analyzing the manuals formatting the protocol of
SEPS. The Directives Manual for Nursing Homes, relative to the Nursing Home Service Unit, was examined to determine their system's applied criteria to establish permissible nursing home use and hospital extended care units. The manual further provided a description of the Canadian Nursing Home Act and its respective regulations. Further reference was made to nursing home directives with respect to each resident's personal needs allowance, liquid asset allowances, burial trust fund allowances, and standards for a facility's admissions and discharges. Their "Nursing Home Services Annual Statistical Report" from March 31, 1992 was also reviewed to obtain calculated figures for associated nursing home admissions. In addition, pamphlets offered by the Extramural Hospitals in Fredericton and St. Stephens were referred to for background information and an in depth explanation of services rendered. Although the Medicare Handbook for New Brunswick was in revision at the time of this research, it was later obtained for review.

The aforementioned documents are believed to be pertinent and valid sources, as they represent an official record of agency proceedings, consisting of information directly relating to the respective organization's frameworks. Being non-reactive and unobtrusive, these documents reviewed additionally offer an objective means for formulating the actual mechanisms of each agency under investigation. Furthermore, the fact that the documents referred to represent the foundation of LTC protocol, to be followed by all involved parties as standardized operating procedures, gives credence to their validity and reliability.

The data collected through the above research methods was then analyzed to identify any reoccurring patterns that may possibly have emerged between the two systems, which will be addressed more specifically under Chapter five.
Devised by this author, on the basis of professional knowledge and experience with Clark County's long term care delivery system and components, an interview schedule was prepared for each of the three main groups of providers involved with LTC provision to the indigent in both areas. Through the use of the unstructured interview schedules, illustrated under Appendix I, responses were collected from all targeted respondents believed to be significant to this research's cause. Although quite similar, each interview schedule differs somewhat, as they were designed to generate questions relevant to the particular participants from the three established groups; "nursing home (LTC) facilities", "acute care hospitals", and "placement assistance agencies". Using the interview guide, respondents were asked to reflect their most frequently encountered impediments to LTC accessibility. (See Appendix II) The data collected from each interview was then analyzed to identify evidence of response patterns that characterized potentially strong constraints to accessible LTC services or placement. This interview process evoked ten major factors determined to most strongly impact accessibility in Clark County. Contrarily, using the same interview process, only five factors were identified to strongly impact accessibility in the Fredericton region before SEPS, with no impacting factors indicated after SEPS. Responses pertaining to these constraint factors are recorded on Chart 1 of Appendix III, for the purpose of comparing and contrasting the two areas studied. The ten identified constraints are as follows:

1. **Application Process for placement and assistance:**

   As indicated by the data, this factor cross collated in both regions as an impact on accessibility, with separate measurement of impact within the Fredericton region, prior to SEPS. In Clark County the "application process" refers exclusively to the process required to apply for LTC financial assistance. The main factor addressed
here is the number of government agencies involved with LTC provision and coverage, strictly on the basis of indigent status and level of care need (LOC). In Clark County the application process for LTC involves three government layers: the Federal government for Medicare coverage; the State government for Medicaid coverage, and the County government for separate indigent categories. From the hospital setting the application process involves many entities in Clark County. A respective patient is given a discharge order by an attending physician according to type and level of care need upon release. This order is assessed by a discharge planner (either a nurse for "Medicare" discharge, or social worker), for level of care need, community support system, financial resource status, and appropriate placement options. If the patient requires LTC placement that is not covered by federal Medicare coverage, the discharge planner must contact Nevada State Welfare to initiate the "PASSAR" screening assessment tool to discriminate mental health care needs from medical care needs, to determine "type of placement" required. If the mental health needs outweigh the medical needs, the "state" operated mental health care system is approached. If a nursing home facility is deemed appropriate, but the patient cannot afford, the discharge planner must approach either Clark County Social Services, or Nevada State Welfare again, or both to apply for financial assistance. Because of the high rate of denial by the state, most nursing homes require a second application to be made to the county, for a backup payment "guarantee". The impact of this factor in Clark County was associated, in part, to the time and paperwork involved. While the PASSAR screening packet is only 3 pages long, the Medicaid application is 15 pages, and county's, 11 pages. A similar process is required for those needing LTC in the community, but involves different coordinators.
In the region of Fredericton, this category refers to the application process for both financial assistance, and the a SEPS assessment, however, the financial assistance does not impede accessibility to LTC, being attended to following a person’s admission. In Fredericton, the application process for nursing home placement involves one call, to their region's Single-Point Entry System, which dispatches a nurse to assess the patient’s medical needs, and a social worker to assess support system and arrange for the least restrictive treatment option, whether that be in the community or a LTC facility. The assessment (application) packet, which is completed by the "placement team" of physician, nurse, and social worker. Its purpose is only to establish the medical care need. (Payment provision is determined after placement, and involves a three page application.) This assessment tool is in turn presented to a multi-disciplinary panel of five members; the chairperson, the SEPS regional director, and the three appointed team members. It is my belief that the Market Model offers little explanation for this constraint. Even though the Single-Entry Point System for LTC delivery is operated at the regional level, with minimal federal regulatory control, it is noted that, the (centralized) Medicare hospital insurance programs for the elderly in both areas, involve the least amount governmental levels to operate, which contradicts the Market Model's argument for federal de-regulation. This constraint has nothing to do with competition. Considering the multitude of both private and governmental bureaucracies involved with Clark County’s application process for LTC delivery, and the single-entry application process in the Fredericton region, the Bureaucratization Model would apply the influences of budgetary concerns and operational structures to this constraint. Similarly, the Neo-Marxists would apply their concepts of profit orientation and commodified medicine, due to the strong connection of "application process" to monetary concerns in Clark County, by
both the private and government sectors. Market Model adherents would have financially orientated reluctance to participate in, what they would refer to as bureaucratic regulation which stifles their for profit competition. Neo-Marxists would see the application process in Clark County, as a continuation of the Market Model through use of the bureaucratic rationale, thus denying accessibility and objectifying the elderly because they no longer have a value rationale within the US "modified-free" enterprise system, perpetuating the commodification of medicine.

2. Time Limits for Required Information:

In Clark County, this category refers to the time allotted to an applicant by the respective assistance agencies, to produce information required for the eligibility determination process. The average time in this county is two weeks. If the requested information is not provided within the time frame, assistance is denied; with no recourse by either the provider or the client to redeem financial reimbursement for services rendered, unless appealed to the state, and honored. This factor was indicated by the majority of Clark County providers, to be a major constraining factor to accessibility, for the simple fact that in Clark County, if there is no payment source, available medical services for elders with chronic care needs are severely limited. In Fredericton, "time limit constraints" was applied more to the nursing home "placement" process, due to the limited number of facility vacancies before SEPS, and was not indicated to impact accessibility, either before or after SEPS.

In review, the Market Model emphasis on "federal government regulation" and "restricted competition" would not apply, or offer any explanation evidence for this factor. The Bureaucratization Model would imply the influence of "rationalized, inflexible rules" to explain this constraint, due to the black and white finality of a
Medicaid denial. The Neo-Marxist Model would relate to the influence of profit motives on this factor, considering the private sectors' prioritization of payment concerns over provisional care. As in the first constraint, this period of waiting is associated with profit orientation by the Market Model while protected by the bureaucratic rationale, which indicts both perspectives with objectification through externalization of the client in need to keep health care as a commodity. This again was found to be pertinent only to Clark County.

3. **Multiple-Government Agencies for LTC provision and financial coverage:**
This constraint refers to the impact of having more than one government assistance agency involved with the provision and financial coverage of LTC services or placement. According to the data, this factor was only identified as a constraint by the respondents in Clark County. Contrary to common belief, LTC health care is not considered to be an entitlement, or an insured health care benefit under the Canadian nationalized health insurance in New Brunswick. The federal Medicare program covers no nursing home coverage in this province. Consequently, similar to Nevada's system, governmental assistance for the costs of LTC involves a means-tested assessment of income and assets, for eligibility. However, in the Fredericton region financial assistance for LTC involves only one governmental agency, at the regional level. In Clark County, as stated, there are three levels of government involved in the financial coverage for LTC services and placement.

The United States "federal" Medicare program provides for a very few LTC costs. In Clark County, Nevada, the state and county "cost-share" the responsibility of LTC coverage for indigent seniors. Because the Canadian national (federal) Medicare insurance was not involved with LTC coverage, either before or after the Single-Entry Point system, the process of federal "deregulation" does not apply to this constraint factor. Furthermore, the effects of "restricted competition" are
equally inapplicable. Thus, the Market Model offers little explanation for the impact of multiple agency involvement.

The Bureaucratization Model would claim that this constraint is best explained by Clark County’s over-sized government, agency protected fiscal budgets, and discriminated payment provisions. The Neo-Marxist Model would refer to both profit orientation and commodification, due to the prioritized concern by Clark County providers for payment rather than provisional care, and the Clark County systems’ costly governmental consumption. While the Market Model perspective could argue that multi-agency involvement is still regulated, and stifling of quality service growth, the Neo-Marxist would agree that this multi-tiered approach is denying access, but not for the same reasons. While both the Market Model and Neo-Marxist perspectives would like to see this multi-agency system dismantled, the outgrowth of this process would yield differing results. De-regulation for the Market Model gives for-profit competition room to allow Darwinistic selection for societal benefit. The Neo-Marxists would say that multi-tiered provision of funding, if dismantled would be a step in the right direction for de-commodification of medicine, and bringing the humanistic approach back into a basic right. The object at fault, in the views of both Market Model and Neo-Marxist advocates, is the government bureaucratic organization. Weber initially felt that a bureaucratic approach to regulation would benefit the Market Model free enterprise through decentralization, thus increasing societal benefit through efficient administration. However, Weber was quick to recognize, that once a regulated, centralized bureaucratic structure is firmly entrenched, it is difficult to dismantle, or de-regulate. The Bureaucratic Model prefers it’s own rationale of societal benefit for self-service. However, society is not buying the Bureaucratic

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rationale being offered, particularly in the area of health care funding, when the distribution of that funding could exclude portions of our society that, historically and traditionally were in support. Without that societal rationale of support, the Bureaucratic Model is now defending itself against Neo-Marxist and Market Model charges of being responsible for inaccessibility, especially because of governmental consumption.

4. Population Need (number of indigent elders requiring LTC):
This category relates to the associates impact that "number of clients in need of LTC", and the corresponding size of applicant caseloads within government assistance agencies, has on accessibility to LTC services or placement. This constraint was implicated by respondents in both Clark County and the Fredericton region before SEPS, to impact LTC options. Within governmental agencies, this factor was related to effect individuals' caseloads, which in turn postpones both LTC provision and cost reimbursements to providers. With the hospital respondents, population need was indicated to delay the "proper" discharge of an uninsured patient from the "acute" care setting to "custodial" care setting. If population need is high, and LTC facilities are full, accessibility is severely restricted to indigent seniors. Often times, indigent patients without means to pay, are required to go out of state (usually Utah), to a facility that will accept a person without a payment source. In Fredericton, though population need was identified as a constraint factor before SEPS, its impact had nothing to do with insurance coverage, only nursing home vacancies and community service provision. The Market Model proclaims that if the United States federal government would minimize its costly regulation of the LTC industry, and remove government sanctions on facility expansion, to afford higher bed ratios for indigent admissions, population need would not be a problem. It is noted, however, that neither of the
Market Model postulates had any relation to the diminished impact of this factor in Fredericton, after SEPS. The Bureaucratization Model would equate the constraining impact of "population need", to governmental cost-containment procedures, including budget cut backs, high volume caseloads, and other rationalized components of bureaucracy. The Neo-Marxists would equate this constraint measure to the practice of capped admission rates of indigent elders, by the for-profit LTC facilities and providers in Clark County. While "population need" is a factor that none of the perspectives can control, each perspective cites its own approach of societal benefit within the population. The Bureaucratic rationale would postulate that, through an "in-house" moderation of structural operation, a more equitable approach to provisional services would result, better serving the population in need. While both the Weberian theorists and Neo-Marxists agree that the government sector is an essential component in the provision of care, the Neo-Marxists would argue that moderated change is not enough, and that only through centralized de-bureaucratization will the population in need gain equitable access to care.

5. Waiting Period for Placement from an Acute Care setting:

This factor refers to the length of time imposed on the hospital discharge process of indigent patients in need of LTC placement. In Clark County this factor relates most to the inaccessibility to LTC facilities by "uninsured" low-income patients. Also in Clark County this hospital waiting period often means no reimbursement of care costs. After the acute care need is resolved Medicare, along with other insurance plans, terminates coverage. In the hospital, this means that, not only are they unable to discharge an "unpaying" customer, they cannot admit a "paying" customer for replacement. In Fredericton, before SEPS the discharge waiting factor affected all patients, regardless of income status. The Market Model
would again relate to the effects of governmental regulations and restrictions on the marketplace, stating that the waiting period for LTC placement would be minimized, by lifting governmental sanctions on facility expansion. The Bureaucratization Model would cite the effects of "efficiency-based" bureaucratic operations and rationalized eligibility processes, to rationalize the extensive waiting period, and maintain that through bureaucratic renditions, this constraint would be removed. The Neo-Marxists would fault the cost-efficiency tactics of multi-layered government, and the prioritized concern by the private sector on cost provision, for delayed hospital discharges.

6. Bed Availability:
In Clark County this constraint refers explicitly to the availability of a facility (bed) vacancy to the person pending approval for financial assistance by a respective governmental assistance agency. In Fredericton, this factor related to the availability of nursing home beds, period. Bed availability was again indicated by both Clark County and the Fredericton region before SEPS, to impact accessibility. The Market Model would again associate this factor to the governments restrictions on nursing home expansion, and claim that by lifting government sanctions, ample bed space would be allotted for the indigent. With the implicated relation between governmental agencies and indigent LTC patients, those of both the Neo-Marxist and Bureaucratization persuasions would point to government bureaucracy's commodious use of "cost-benefit analyses" and extensive eligibility processes ("pending" periods), both cost-containment procedures, to explain this constraint in Clark County. The Neo-Marxist Model would equate limited bed availability for indigent elders, to the capital gain priorities of private enterprise; with the analogous distinction of medical care being viewed as a commodity in Clark County. Both the Neo-Marxists and the
Weberian theorists would explain the diminished aspect of this constraint, following SEPS, on the moderated centralization of government involvement, simplified bureaucratic structure, and a revived emphasis on the human element.

7. **Method of Payment for LTC:**

In Clark County this constraint measures the impact on accessibility by the established source of payment available to the prospective LTC recipient. (e.g.: private resource provision, Federal Medicare or other insurance coverage, established recipient of state Medicaid or Clark County Medical Assistance, or pending state or county government assistance.) Again, if the client is seeking a payment source for LTC assistance, accessibility is limited. However, if the client is already insured by a pre-established payment source, or qualifies for federal Medicare coverage, accessibility is increased. In contrast, for the person contracting for care with private resources, accessibility is highly elevated. In Fredericton, "method of payment" was not considered by the respondents to impact accessibility, either before or after SEPS, as method of payment is of no consequence in arranging for LTC services in Fredericton. The Market Model would assert that LTC provision would be more equitably distributed with increased reliance placed on the private sector, where for profit competition would enhance societal benefit. Advocates of the Bureaucratization Model would theorize that LTC inaccessibility is a result of the bureaucratic structure's rigid adherence to agency guidelines, instrumental procedures, and lengthy application processes for funding, as explanation for this impacting factor. Proponents of the Neo-Marxists would identify this payment issue, with the accented capitalistic emphasis on profit and assured payment provision, as evidenced by the lack of accessible community services and resources availed to seniors without an established means of payment; and the bureaucratized rationale of government
eligibility.

8. **Waiting Period for Community Services:**

This category relates to the availability of community services to the client without the means to pay. This constraint factor means essentially the same thing in both study areas. It refers to those seniors, either already in the community, or those waiting to be discharged from a hospital or nursing home facility, who require community services. Though this category was identified as a constraint factor by respondents in both Clark County and Fredericton, before and after SEPS. In Clark County, community LTC services are offered through Nevada State Welfare and Clark County Social Services, when Medicare does not apply. Contracted services with the private sector are becoming more prevalent with the state and county agencies. The constraint ratings given by the Fredericton respondents, in question to the degree of influence for this constraint prior to SEPS, referred to the inadequate community service programs. Constraint ratings given by respondents with respect to accessibility, after SEPS, referred more to the time it took the SEPS multi-disciplinary panel to process referral and elicit services. The Market Model would contend that alleviation of impact for this constraint would result from increased reliance on the free-market enterprise, and voluntarism. According to the Market Model, volunteerism would be stimulated automatically through this transferred reliance. The Bureaucratization Model would profess that this constraint has been minimized, through the centralization of community service funding, to the bureaucratic mode already in place, creating greater accessibility to indigent seniors. The Neo-Marxist Model, in reference to the governments contracted service with the free-enterprise, would argue that this constraint, though not strong, does exist, and would view the government-private mixed approach to community LTC services to still be inaccessible by those
without a payment source, thus reflecting both, commodification of health care by
the private sector, and reification of health care by the government sector.

9. Establishment of a Physician to follow

This area of constraint references accessibility to physician’s care by the client who
is entering a nursing home without an established payment source, creating
reluctance by the private enterprise circuit to offer service. Though this category
of LTC service was interpreted by respondents to mean the same in both areas,
respondents in Clark County only indicated this parameter as a constraint. In
Clark County, finding a physician willing to follow care of an indigent patient
placed in a nursing home is difficult. Doctors are reluctant to serve both Clark
County Medical and Nevada State Medicaid recipients, being aware of the low
reimbursement rates provided. The majority of doctors in this county deny
services to the person who is "pending" assistance. Because the county does not
fund physician’s care of their established clients, establishing a physician for the
county client can be even more difficult to secure. Theoretically, the Market
Model would relate this problem to governmental regulations, and restricted
competition, claiming that societal benefit would be best served within a
deregulated, profit-oriented system. It is this model’s contention that medical care
is a commodity to be bought and sold for profit, and that inaccessible care is
directly related to the governments’ insufficient reimbursement rates.

Acknowledging the Weberian Bureaucratic model, free market analysts would
associate inaccessible care, as the fault of rationalized cost-containment policies.
More appropriately, this constraint factor appears to be best explained by the Neo-
Marxist Perspective, with its emphasized assertion that denial of doctoral care is
directly related to the private sector’s emphasis on profit, and subsequent
commodification of medicine.
10. **Type or Category of Required Care:**

This last constraint refers to the category and degree of severity of a person's medical care need, as it affects accessibility to required placement. The "type of care", in nursing home admission policy, relates to a patient's "level of care". The LOC factor is a specified factor within both the Fredericton region and Clark County for LTC guidelines. The classified evaluation of care is specific to both systems, and is the standard for treatment needed and placement options.

In Nevada, the acute care hospital centers, and some facilities provide high levels of care, referred to as "skilled", or "acute" care. There is no "skilled care" provision in the Fredericton nursing homes, automatically sending all residents requiring intensive care to the regional hospitals, under federal Medicare coverage. In Canada, lower levels of care, termed "intermediate, or custodial" care, are provided for in community nursing homes, funded by either private resources, or government assistance. The national health care system (insurance) in Canada does not cover nursing home, or long term care. The Nevada State Welfare Manual (June 10, 1991) defines the distinctions between skilled nursing care and intermediate care services within nursing homes, and distinguishes in detail the separate types (levels) of care within both categories. It is designed for the purpose of determining reimbursement rates, in accordance with nursing hours required for the different types of care; and to offer specific guidelines as to the facility's responsibilities in each LOC category. Type of care was identified by the majority of Clark County respondents and those from the Fredericton region, pre-SEPS, to have an impact on accessibility. The heavier level of care customer is often given very low priority for placement, usually due to staff shortages. In Fredericton, because the hospital care was heavier due to the unavailable nursing
home beds prior to SEPS, and because of the structural change in nursing home care centers, no respondents considered LOC to strongly impact placement after SEPS. The Market Model would fault governmental regulation and inadequate reimbursement rates for this constraint factor. This perspective would argue that shortages in staff cannot be rectified without sufficient capital. The Bureaucratization Model would also argue that heavy care patients are denied placement accessibility due to the governmental program rationale of cost-benefit projections for budgets and rate reimbursements. The Neo-Marxists would argue that admission rate based on level of care verses rate disbursements, is another type of cost-benefit analysis; thereby sustaining there theorem that inaccessibility to LTC in the United States, is directly related to the industry’s commodification of medicine. Chapter five will detail the constraint impact findings of each applied constraint factor.

RESEARCH PROPOSAL

This research project seeks to explain the established variance in accessibility to LTC by the indigent elderly of Clark County, Nevada, and the Fredericton region of New Brunswick, Canada; with the tentative hypothesis that Clark County’s LTC system is less accessible than Fredericton’s. For the purpose of this research, the term "accessibility" is defined as: the unconditional ability of elderly persons to acquire LTC, either in their home or the confines of a care facility, as deemed necessary and irregardless of socio-economic stratification. Ideally, associated rates of accessibility would be measured by comparing the actual percentages of elderly persons from each area, determined to need LTC, that get prescribed care. Because this data is not readily available, reliance is instead placed on the subjectively rated experiences of service providers, from among the three principle groups involved with LTC delivery to the indigent, within each of the systems.
The targeted groups were: 1) Hospitals involved with LTC discharge plans; 2) Nursing homes involved with LTC provision; 3) and Government assistance agencies involved with LTC provision and financial coverage. With respect to this study, the measure of accessibility comes to be defined by its inverse relationship to ten factors of inaccessibility.

The stated objective of this research is to measure how, and to what extent, the analytics of the three theoretical perspectives; the free Market Model, signifying how the impact of federally centralized government REGULATION acts to RESTRICT COMPETITION and INDIVIDUALISM in the marketplace; the Weberian Perspective, signifying the impact of the BUREAUCRATIZATION, and resulting OBJECTIFICATION of humankind, through the process of (INSTRUMENTAL) RATIONALIZATION of societal benefit ; and the Neo-Marxist Perspective, signifying the common forces of GOVERNMENTAL CONSUMPTION and PROFIT-ORIENTATION, as associated with COMMODIFICATION OF MEDICINE—act to explain inequitable accessibility to LTC. The following pages expound on the three perspectives' related themes, qualifying each perspective's hypothetical postulates to explain why barriers to LTC accessibility exist within the US system for provision.

**THEORETICAL HYPOTHESES**

The MARKET MODEL perspective blames government regulations and restricted competition for creating inequitable access to LTC. This model asserts that the federal government's role in the marketplace, with its restrictions on competition, is directly responsible for the unequal distribution of LTC. The Market Model ardently defends its position that, through heightened competition and government suppression, the US health care system will work itself out along a natural progression. With the principles of free-enterprise as its guidepost, this ideology declares ascendancy by the private sector to produce and distribute services more efficiently and effectively. In contrast with the Neo-
Marxist perspective, Market Model advocates strongly support profit motivations, and the conceptual view of medicine as a commodity. Crediting these elements with the procurement of socio-economic stimulation and stability, they claim inequality in material conditions to be inevitable. Further, they affirm that, through the proper functioning of free competition among the health care market, economic growth will be enhanced, the needs of society served, and social problems alleviated. With government "deregulation" as its motif, the Market Model strongly endorses the adaptation of New Federalism governance, and (federal) "decentralization" of health care to the state level. Striving to minimize the role of federal government in health care policies and service provision, this philosophy proposes to shift more costs for LTC, and other forms of health care, to the states under managed care programs. Recommending the consolidated forces of government agencies and resources, this perspective advocates for a form of the "pay or play" design for insurance coverage, with a separate insurance plan for the elderly that incorporates LTC coverage.

The Market Model hypothesizes that the least constraints to accessibility would be the result of:

1. (De-centralization) **Deregulation** - that the system with the least amount of federal government involvement in LTC provision (the more deregulated system for LTC provision) will be the most accessible, and;

2. **Private, for-profit competition** - that the system with the highest number of competing, for-profit LTC service providers and care facilities, and least amount of marketplace restrictions, will be the most accessible.

In this sense, the Market Model would attribute the source of systematic differences between the two systems' LTC distribution, to the federally "centralized" role of government in the US marketplace, and the subsequent restricted ability of LTC service providers to operate within a free-market system; in comparison to the Canadian
"decentralization" and "deregulation" of federal government within the Fredericton region’s delivery system.

To test the validity of the Market Model perspective, the aforementioned interview guide and ten identified constraints to accessibility are utilized to determine how, and to what extent, REGULATION and RESTRICTED COMPETITION have effected accessibility to LTC. Accordingly, concentration is placed on the Market Model’s perception that the basic components of the free market enterprise system, INDIVIDUALISM and profit orientation are economically correct, and should be modified only for the sake of enhanced competition and other profitable measures, including government deregulation. If the Market Model is correct, then the research should reveal:

1. That a decline in accessibility will coincide with the amount of federal government regulation in the LTC delivery system; and that accessibility to LTC by the indigent will be enhanced by a system’s decentralization, and resultant deregulation of federal government in the LTC industry; with the shifted financial responsibility and regulatory control for social health care programs to the states.

2. That a decline in accessibility will be noted in the system with decreased emphasis on "individualism" and "profit motivations" among the LTC industry; and that equitable access to LTC by the indigent will be more equitable, with a system’s expansion of competitive market forces, and greater reliance on private "for-profit" enterprise in the marketplace, including increased enrollment with "Health Management Organization" (HMO) insurance, and other forms of managed care.

The WEBERIAN perspective argues that the key dynamic in explaining differences in accessibility relates to issues of capitalism’s increased BUREAUCRATIZATION and RATIONALIZATION of society. According to Weber, bureaucracies are organized according to efficiency-based, rational principles; administrated according to a hierarchical
structure of rationally ranked offices; and operated according to the strict enforcement of rationalized, impersonal rules and procedures. This perspective points to the modern capitalistic economy in illustration of how the fulfillment of economic needs over human needs continues to be rationalized by society. Maintaining that changes in society are based on changes in the economy, this rationalization is extended to bureaucratic organizations within both the private corporate and governmental spheres; resulting in extensive criticism towards the excess consumption of financial resources by corporations and hierarchically structured welfare programs. With the accent on efficiency, the practice of rationalization, according to this perspective, naturally induces a "dehumanizing" element in their methodological operation, which inevitably leads to what Weber referred to as the OBJECTIFICATION of individuals. This perspective considers the dictates of Bureaucratization and Rationalization to not only be irrational, but inescapable.

Incumbents of this perspective propose a decrease in the financial consumption by bureaucratic agencies that are currently assisting with LTC costs for elderly recipients.

The Weberian Perspective hypothesizes that the least constraints to accessibility will result from:

1. **De-rationalization** - that the system with the least emphasis on rationalized, efficiency based service provision, will be the most accessible.

2. **De-bureaucratization** - that the system with the least amount of regulations (uncompromising impersonal rules) for LTC delivery and compensation will be the most accessible.

To test this perspective’s validity, the same interview guide and ten identified constraints to accessibility are utilized to determine how, and to what extent, BUREAUCRATIZATION and RATIONALIZATION have effected accessibility to LTC. If the Bureaucratization perspective is correct, then the research should reveal:

1. That a decline in equitable accessibility to LTC by the indigent, will be noted
among a system where both the public and private sectors prioritize emphasis on instrumentally rationalized, efficiency-based provision, based on cost-benefit projections; and that equitable accessibility will be enhanced by a system’s decreased emphasis on rationalized efficiency and the dichotomous calculation of cost-benefit.

2. That a decline in accessibility to LTC by the indigent will coincide with a system’s bureaucratic enforcement of uncompromising (inflexible) and impersonal rules, by government agencies involved with LTC delivery and compensation; and that equitable accessibility will be enhanced by a system’s decreased emphasis on pre-calculated rules and procedures, and increased emphasis on the "human" element, for provisional care.

The NEO-MARXIST perspective interprets the failures of the system to be caused by PROFIT ORIENTATION in the marketplace. Affiliates of this perspective blame the prevalence of inequitable LTC accessibility on the health care system’s subsequent COMMODIFICATION OF MEDICINE; along with the US GOVERNMENTAL CONSUMPTION of monetary resources for health care provision. With the capitalist economy’s current emphasis on profit-motives, including cost-efficiency measures, Neo-Marxist theorists proclaim that in contemporary times, this country’s health care services are administered to society as a commodity, to be bought and sold on the strict basis of buying power and profit. Building from this ideology, Lukacs describes the capitalistic society as becoming REIFIED, or COMMODIFIED, in that all societal components have come to be measured according to their estimated significance and serviceability, or usefulness.

As an offshoot of Weber’s themes, the Neo-Marxist persuasion argues that changes in the economy are based on political changes. Consequently, it professes US aging policies to be regulated by the interrelationship between economic and political
factors. Maintaining that inequality can be overcome, this perspective stresses that this issue must be attacked from a structural stance, with concentration on the basic root of the problem-public awareness. It is contended that, by raising the levels of consciousness of both the victims of inequitable medical care and other citizens, a complete transformation of the US health care system is feasible, allowing for uniform access to LTC by all economic classes. Impediments to health care reform are proclaimed by Neo-Marxists to lie within the political and economical spheres of society, and must be approached accordingly. The Neo-Marxist Model advocates for the incorporation of a single-payer system for comprehensive medical care coverage, regardless of socio-economic status, including LTC provision; and the "centralized" delivery of services.

The Neo-Marxist Perspective hypothesizes that the least constraints would result from:

1. **De-emphasized Profit Orientation (commodification)** of health care—that the system with the least amount of for-profit LTC service providers and nursing facilities will be the most accessible.

2. **Decreased Governmental Consumption**, through **Centralization** of LTC delivery - that the system with the least number of bureaucratic governmental agencies involved with LTC delivery and compensation will be the most accessible.

Again, to assess the validity of the Neo-Marxist perspective, the pre-established interview guide and ten identified constraints to accessibility are utilized to determine how, and to what extent, PROFIT ORIENTATION and cost of GOVERNMENTAL CONSUMPTION have effected accessibility to LTC, through the process of COMMODIFICATION. If this perspective is correct, then the research should reveal:

1. That a decline in accessibility to LTC will coincide with a delivery system's concentrated focus on a person's inability to pay for services or facility placement; and that accessibility will be enhanced by a system’s decreased emphasis on...
financial reimbursement.

2. That a decline in accessibility to LTC will be noted in a system where increased emphasis, by both private "for-profit" LTC operations, and government "non-profit" agencies, on "cost-containment" and "efficiency" takes precedence over provided services and placement; and that accessibility will be enhanced by a system's decreased application of the "cost-benefit" analyses for provisional care.

3. That a decline in accessibility will be directly related to the amount of layered government involved with the system's LTC delivery process; and that accessibility to will be enhanced, according to the degree of systematic "centralization" for LTC delivery.

According to Marx, the class system evolved because of the scarcity in resources. In Marx's view, capitalism took care of the scarcity problem, by introducing inequality in distribution according to buying power. While Marx spoke of commodification of society within the capitalistic marketplace, Weber stressed the increased rationalization of the modern world by society. Weber depicted the capitalistic economy as one where the precedence of political and economic over human needs had become increasingly rationalized. Lukacs related that the free market enterprise system was based on Weber's logic of instrumental rationality and the notion that modern capitalism would be best governed within an efficiency dominated bureaucratic network. However, as bureaucratic capitalism evolved in the western world, society's value of "humanism" was superseded by both individualism and material success, resulting in the replacement of "societal logic" by "market" logic. All three perspectives recognize the impact of governmental shrinkage within the realm of health care resources, identified as "scarce". Each perspective independently advocates for some form of organized coaction, with a unified purpose of societal benefit. Critics of the current government-private mixed approach to health care, indict government consumption as the cause of scarcity of resources, and
question whether the problem is really scarcity, or improper distribution.

The Market Model and the Bureaucratization Model, the Neo-Marxists all agree that the integrated roles of government in LTC would increase accessibility; however, in conflict with the Market Model emphasis on federal government "decentralization", the Neo-Marxists recommend federal government "centralization" for LTC insurance coverage and regulatory control. Each perspective acknowledges this country to be a "modified-free" enterprise marketplace, which perpetuates constraints to accessible care; yet, their perceptions of this capitalist economy, as revealed, are quite varied.

One of my stated objectives was to examine which of the three perspectives best explains the disparities in accessibility between Clark County, Nevada and the Fredericton region of New Brunswick, before and after SEPS. However, the purpose of this research is twofold, as indicated by the original premise within the abstract. The measure of constraint and, inversely, the measure of access to LTC by indigent elders within each of the sample groups, reveals a distinct variance in accessibility between the three. This disparity is measurable by the response factors of fifteen LTC providers, within both Clark County and the Fredericton region, determined to be constraints. This comparative indicator of accessibility affirms the first part of the premise, as displayed within the statistical data analysis Chapter five.

More significant to the research, was my purpose to estimate the definitive power of each perspective, to explain diversities found between the United States and Canadian systems. To this purpose, the collated responses of those groups interviewed, through which the ten factors emerged as constraints, were applied to each perspective theorem for the established degrees of influence. The summation of findings to support this research premise are exhibited for comparative analysis under Appendix III, as discussed in Chapter five.
CHAPTER 4

HISTORICAL PERSPECTIVE

HEALTH CARE MOVEMENT IN
THE UNITED STATES FOR
LONG TERM CARE

To understand the process by which the United State's health care policies were designed, it is important to understand the underlying paradox within the country's traditional health care system. Over time, governmental involvement in US health care policies and programs has evolved in stages and in varying degrees. In contemporary times the US government plays a major role in the planning, directing, and financing of health care services. As previously stated, the United States of America was founded on the ideology of free enterprise in the marketplace. Consequently, the predominant mindset of this modern capitalistic society is that the private sector is far more capable to proficiently respond to existing economic and social problems if unrestrained by the government. Much of this ideology parallels the concept of Federalism, which has trailed the evolution of politics for more than 200 years. The original definition of Federalism according to Benjamin and Lee (1988: 459) was "the constitutional division of authority between the federal government and the states". This concept initially stressed the independence of each level of government from each other and delineated the roles of each, placing the responsibility of such functions as education, police protection, and health care with what were then referred to as "regional units" of the state and local government. Separation of the state from the federal government continues to be the prevailing theme of today's society. The ideology of our young America was that free
enterprise in the market system was the most appropriate channel for the exchange of health care services, and also the best way to insure private support for public services by heeding to the interest of the health care providers. It was these ethics that paved the way for the development and maturation of capitalism and the present health care industry.

Prior to the Industrial Revolution, the American family was relatively homogenous and self-sufficient, working within what Olson (1982: 28) refers to as an “integrated production unit”, among strong family ties in a basically agrarian society. Attaining old age was a rarity, and those who did were confronted by several economic hardships, including health care provision. The attitudes associated with the term “old age” was by no means negative, as the elders were generally viewed with respect. While volunteerism, charity, and donations were popular during this time, any type of systematized welfare organization was strictly taboo. It was the contention of the majority that no one had an undefiable right to any assistance. Any support offered was strictly on the basis of need. As illustrated by Olson (1992: 28), the small number of elders who became too ill for productive labor and had no independent or family support system experienced severe economic deprivation and social sanctions.

Well into the 1900’s any provisions for the poor were administered at the local level. Based on the Elizabethan Poor Laws, our society offered two types of relief to the poor. According to Margaret MacAdam (1987: 3) "outdoor relief" referred to assistance given to the poor in their own homes, mostly in the form of food and other personal provisions. “Indoor relief” referred to care provided in “almshouses”, or poor farms, which were used primarily for aging persons. In her dissertation on nursing home admissions, MacAdam discussed how outdoor relief was considered desirable, for residents of the almshouses could be placed with employers for cheap labor. MacAdam further discusses how local administration of outdoor relief was poorly regulated and resulted in the deterioration and neglect of many recipients. The almshouses were often
quite inferior, offering little more than squalid living conditions. Yet by 1920, over 2,400 such homes had been developed across the nation. Overcrowded and understaffed, morale was low, projecting shame and indignity to those who resided within. According to Paul Starr (1982: 150), the function of the almshouse was to act as a deterrent to poverty and public assistance, with the implication that poverty was unequivocally one's own fault and responsibility. Staff contends that the legislature's objective in making this form of relief the only source of governmental aid, was to restrict expenditures for public support.

Until the 1940's, however, most of the indigent elderly resided in such poor houses, or other inadequate public facilities. Olson (1982) relates that by this time a majority of those 65 and older had become increasingly dependent on others for support. The public began to take notice that an overwhelming percentage of the residents in almshouses were elderly. Some began to reassess their philosophy regarding a person's "right" to financial and medical support, if unable to contribute to society through no fault of their own. Poverty came to be viewed as a social issue. A revised social insurance policy evolved which stressed that the government should intervene to protect those assessed to be deserving, from destitution resulting from illness, accident, or old age.

In response to the devastating reality of 3.5 million older persons deemed to be without jobs in the 30's, old age emerged as a serious social problem. As a part of President Roosevelt's New Deal, the Social Security Act of 1935 was passed, which provided for unemployment compensation and old age pensions. At the same time, the American Medical Association (AMA) successfully prevented inclusion of any health care provisions, viewing this as a serious threat to the fee-for-service system of the medical field. In fact, as Olson portrays (1982: 132), the federal government successfully evaded any responsibility for long term care and other forms of health care until 1950. In 1950, with recognition that the limited available resources were not sufficient to cover all those who were vulnerable, the federal government requisitioned the first meeting of the
“National Conference on Aging”. From this evolved the passage of an amendment to the Social Security Act with its Old-Age Assistance Program. Following enactment, this program allowed for payment of benefits to older people residing in public facilities, and privately owned Old Age facilities began to replace government institutions. The Older Americans Act of 1965 effectively managed to generate a federal, state, and local network, that exemplifies the structural elements of what Wallace and Estes refer to as America’s New Federalism.

With health care costs on the rise during the depression and the growth of a population requiring ongoing care, the health care movement was driven by the need to provide medical coverage to victims of prolonged illness, accident, or advanced age. Through the 40’s and 50’s, Congress was presented with some type of national health care bill every year. While the American Medical Association adamantly opposed such, they did relent to the enactment of a provider-controlled plan in 1945 entitled Blue Cross. Yet, according to Starr (1992: 307), this agreement was strictly in the interests of the providers and was aimed at preventing the adoption of a national health care system.

Regardless of the AMA’s incisive opposition to government intervention, the 1950 amendment to the Social Security Act did initiate provision of federal funds to the states for medical care assistance. Unfortunately, many states chose not to participate, and those that did offered varied services through very limited funding. According to Olson, a two-class health care prevailed, with the indigent continuing to receive deficient medical care. While the health care crisis for the elderly generated electrified political attention in 1950, efforts continued by the private sector to dissuade any additional components of a national old age health insurance. Under the mirage of reform, the Kerf-Mills Act of 1960 expanded federal contributions for health care to the elderly. According to Olson (1982: 44), however, all of the old age insurance provisions were merely a political ploy to control the masses and protect the interests of a monopolized capitalism, and did
relatively little to remove the hindrances of poverty among the aged. As Olson points out, the programs implemented, in actuality, tended to create dependency by the elderly on health care agencies, due to eligibility guidelines which virtually required dissolution of all acquired assets to below an arbitrary figure for qualification.

Between 1957 and 1965, Congress continued to be inundated with national health care proposals, which led to the eventual passage of a two-tiered medical welfare system; with Medicare being based on a right to medical coverage by any one connected to the Social Security system, and Medicaid being based entirely on demonstrated financial need. Medicare was established in 1965 through additional amendments to the Social Security Act. Initially scorned by the AMA and a multitude of physicians, the Medicare program was not only eventually accepted by the medical profession, but hailed as being quite the profitable resource.

As edified by Starr (1982: 369), what is now recognized as Part A of the Medicare program covers compulsory hospital charges. Its coverage is automatically applied to all those tied to the Social Security and Railroad retirement systems. Part B is a government-subsidized, voluntary enrollment insurance plan, subject to premiums, co-payments, and deductibles. It covers approved charges for physician fees, outpatient services, minimal home health care services, some durable medical equipment, justifiable ambulance services, and very limited nursing home care. According to a study conducted by the University of Nevada, Las Vegas, on national health care expenditures in 1989, only eight percent of nursing home costs were paid for by Medicare. Neither of the Medicare A or B plans cover prescription drugs outside of a hospital or other "acute" care setting, or provides for long term "custodial" care for persons with chronic conditions. (See glossary, Appendix VI)

The Medicaid program was adopted simultaneously with Medicare, but with much less popularity. It offered medical coverage to eligible impoverished aged, blind, and
disabled persons. Federally funded, the Medicaid program was established as a means-tested, state-administered project, supplemented by federally matched funds, determined annually by a formula based on a state’s per capita income (Shurtrine 1990: 1). While uniform national eligibility standards were attached to the Medicare program, the states were left with the responsibility of deciding whether they would participate in the program; and if so, how extensive their individual Medicaid programs would be. The main object of Medicaid was to offer the poor access to fundamental health care services. Because Medicare allowed the implementation of charges by physicians above what the program would pay, and Medicaid regulations forbade this practice, the acceptance of Medicaid clients was far more limited among physicians. Because neither the federal government nor the states were willing to expend the money required to effectively run a Medicaid program, according to Shuptrine, little difference was noted in regard to the actual healthfulness of the less privileged.

HEALTH CARE MOVEMENT IN CLARK COUNTY, NEVADA FOR LONG TERM CARE

In Nevada, according to Denell Hahn-Director of Clark County Social Services (CCSS), the health care movement of the 40’s and 50’s included an effort on the part of Clark County to facilitate assistance to it’s indigent residents, beginning with the administration of a general cash relief program in the early 50’s. At the time, states Hahn, all counties in the state were basically responsible for their own residents, regardless of need. In 1963, Clark County Social Service split into two agencies, with one established relief program offering commodities and means-tested financial assistance in the form of food and rent vouchers; and the other for the means-tested coverage for medical services from the Southern Nevada Memorial Hospital (now referred to as the University Medical Center). According to Hahn, this hospital was technically considered to be a poor house
for the indigent. The hospitals of the time would keep nursing home patients for required
treatment. Southern Nevada Memorial Hospital had a special wing designed specifically
for extended acute care needs and nursing home, or long term chronic care needs.

According to Hahn, prior to 1963 there were only three long term care facilities in
the county: El Jen Convalescent Care Home (still operating), which cared for private
paying nursing home patients only; Desert Retreat (now obsolete), which provided
treatment for private paying recovering alcoholics; and the Twilight Nursing Home, also
for private paying residents. Basically, all Long Term Care (LTC) services were paid for
by the counties from the early 50’s until 1967 when the Medicaid program was enacted in
Nevada. As previously alluded, participation in the Medicaid program was, and remains
today, completely optional by states, as is the extent of coverage to be offered. If the
particular state elects to participate in the program, it must then adhere to all federal
statutes and regulations set forth in the Social Security Act. However, the Social Security
Act does not dictate what services the state must offer within each of the required
categories of medical care; and therefore, each state retains great discretion as to what
medical services and procedures will be included in it’s plan, and to what income groups.
Essentially, two groups classify as indigent in regards to assistance programs. The
“categorically needy” according to the Nevada Welfare system, includes only the poorest
of the poor. With regard to elderly persons living in the community, a person is
considered “categorically needy” if their income falls at, or below, the Supplemental
Security Income (SSI) rate of $470.40. In an institutional nursing home setting the term
refers to those whose incomes fall at or below $714, though the cost of nursing home care
is far more extensive, as will be shown in the following chapters.

The term “medically needy” applies to those whose incomes exceed the above
amounts but are still considered indigent with regard to their ability to pay for nursing
home costs and extensive hospital bills. The Nevada State Welfare division (NSW)
elected to include only the categorically needy under the obligations of their assistance program. In fact, according to the Las Vegas Review Journal (November 10, 1992: 1A) Nevada has been labeled by the American Public Health Association as being the stingiest of all the states in providing care coverage to the poor. Clark County Social Services, therefore, continues to provide assistance to many who could not otherwise afford the high costs of hospitalization; and, to those who require LTC care, but do not qualify for the Nevada State Medicaid program.

HEALTH CARE MOVEMENT
IN CANADA FOR LONG TERM CARE

According to Starr (1982), Medical care in Canada and the United States shared very similar evolutions. In both countries the medical profession and health care facilities had very poor reputations until advances in the bio-medical field in the 19th century began replacing the traditional barbarous treatment methods of leaching, bloodletting, and purging with more humane and practical methods. In both countries, developments in the later half of the 19th century included the implementation of licensing laws, the formation of modern medical schools, and the creation of professional associations. In the early years of the century, hospitals in both Canada and the US assumed the primary responsibility for all health care, both short and long term.

As related by D. Coburn (1988), both countries did succeed in reducing morbidity and mortality rates with the achievements of public health measures, but did so at the expense of acquired stress between physicians and public health officials, who controlled the health management strategies. An important distinction between the medical care developments of the two nations, however, was the continuous role of regulatory agencies over the Canadian health care institutions and the lack of such in the US.

Previously communicated was the fact that, prior to 1950, opponents to a
government link to health care in the US were successful in defeating advocated legislature.. An important ingredient to this conquest was the United State’s entry into World War II. According to Starr, propaganda presented by organizations such as the American Medical Association, the American Federation of Labor (AFL), the National Association of Manufacturers (NAM), and the National Civic Foundation (NCF) assisted with the opposition by equating the idea of a national health insurance to German socialism.

In Canada, however, the actual beginnings of a public health insurance commenced in 1914 in the province of Saskatchewan under the name of the “Municipal Doctor’s Plan”. (Inglehart 1986) Coburn explains that, unlike the US, Canadian political activism against medical monopolies took a much more aggressive approach in the form of demonstrations and riots in the streets. The opponents of medical monopolies were also triumphant in gaining the public’s acceptance of a governmental compensated health insurance. Winning several seats in the federal parliament in 1921, a pro-labor party named the “Progressives” successfully advocated for the establishment of a public insurance plan. According to Coburn, the Canadian labor force had always supported governmental involvement in health care provision. In the years during, and immediately following World War II, industrial development flourished in some parts of Canada, especially in the mining industry. Canada as a whole, however, was in the process of recovering from a massive depression resulting from the war. Milton I. Roemer (1991) associates the depression to the particular devastation felt by the Canadian prairie provinces due to their reliance on the world trade market in wheat as their main economic resource.

Though available, voluntary health insurance was a rare investment among the prairie farmers who were the most predominant force in the political arena. Health care provision for the indigent was still relatively limited at the time. Out of the depression
years emerged a new anti-capitalistic party supported heavily by the working class. Called the Co-operative Commonwealth Federation (CCF), Roemer describes this party as one with great inspirational qualities. In 1944 this agrarian socialist party came into power in Saskatchewan, with “socialized health care provision” as their major platform. The CCF successfully managed to avert attention from wartime pressures to issues of health care reforms, and in 1946 the first of Canada’s “universal” hospital insurance plans was enacted in Saskatchewan. The CCF’s dynamic leadership remained in power from 1944 to 1964, with its successor being the New Democratic Party (NDP), also of socialist regime. Under the auspices of these two political administrations, several social-welfare measures were executed, with the government assuming major control. Coburn asserts that, unlike the US, where anti-Communist rhetoric squelched any proposals for a national health insurance, both the provincial and federal governments of Canada accepted the idea as a legitimate goal for reform. By 1961, all ten provinces had implemented universal hospital insurance plans, and by 1971 a physician’s insurance plan had been incorporated as well. According to Martin Pfaff (1990), the province of New Brunswick was the last to adopt the national Medicare insurance plan.

Today the success of Canada’s universal health insurance has endured strong political support by all parties. As a result of its popularity with the Canadian citizens, few politicians dare to challenge it, as evidenced by the passage of the Canada Health Care Act of 1984. Pfaff states that the vote on this act, which prohibited any form of extra billing to patients by health care facilities, physicians, or other providers, was unanimous.

Prior to 1977, Canada’s federal health and welfare organization provided for 50% of the operation costs of adult residential centers and nursing homes, then referred to as “Homes for Special Care”. This cost-sharing arrangement between the federal government and the provinces was established to assist the ten territories with the extensive cost of long term care. In April 1977, a major policy change was put in effect
which replaced the 50/50 federal cost-sharing plan with block transfers to provinces under the Canada Assistance Plan (CAP) for the provisions of extended health care services (Streich 1983: 29). With this conversion, the federal contribution to the provincial health budgets now only constitutes for approximately 35%. Consumer Reports (September 1992) reflects the possibility of an eventual goal to transfer all funding responsibilities to the provinces: a proposal quite similar to the New Federalism movement in the United States.

According to Thomas R. Burke, Department of Health and Human Services Chief of Staff (Hearing before the Select Committee on Aging-House of Representatives November 9 1987), the cost of nursing home care in Canada is now financed for the most part under the nursing home insurance section of the Canadian Health Act. Since the 1977 implementation of the block grant transfers, the provinces receive their federal share of funding, and are then responsible for designing and operating their own health insurance programs. For example, the provinces of Manitoba and British Columbia both include LTC as part of their basic health care entitlement, while the maritime provinces of New Brunswick, Nova Scotia, Prince Edward Island (PEI), and Newfoundland do not. Additionally, while both Manitoba and British Columbia allow specialized case managers and other specialized professionals to assess the need for LTC, and authorize payment for such, other provinces require a physician’s endorsement for LTC placement.

Patricia Streich (1993) explains that the block grants are distributed to the provincial treasuries each month and are deposited into the individual province’s general revenue repositories, giving the provincial governments considerable leverage in the application of the funds. Streich’s data reflects that, historically, the provinces of Quebec, Manitoba, and New Brunswick have chosen to apply the majority of their federal transfer funds for seniors; while Ontario, Nova Scotia, and PEI utilize relatively small proportions of the funding for this population. Alberta is reportedly the only province which
incorporates its own programs for the financing of nursing home and other care home development.

In addition to the federal block grants, Canada's federal government provides substantial transfers to the provinces to assist with the cost of institutional care for the elderly; along with income transfers, similar to this country's Social Security (SSA) and Supplemental Security Income (SSI) benefits, sent directly to the elderly recipients. According to Streich, in the fiscal year 1982-83, the nation's capital, Ottawa, contributed approximately $815,478 in federal funds to the provinces for LTC services alone. Additionally, through the federally funded income transfers of the Old Age Security benefit (OAS) and the Guaranteed Income Supplement (GIS), contributions to the respective care facilities are provided by all elderly residents, similar to Nevada's system.

In 1978, Section 56.1 was enacted as an amendment to the Canadian National Housing Act (NHA) in an effort to provide a single financial subsidy technique for all housing provided by public and private sponsors. According to Streich, this legislative ordinance made no provisions for health care facilities. Streich clarifies, however, that while no allowances were included for the care facilities, general NHA non-profit funding was extended for institutional construction. All LTC facility projects assisted in Newfoundland and New Brunswick have been categorized as nursing homes. Streich found that different provinces use a variety of labels to describe their nursing homes. For example, Newfoundland and Nova Scotia describe their homes as "Homes for Special Care"; PEI refers to theirs as "Homes for the Aged"; in Ontario they are called "Extended Care Homes", etc. Regardless of title, all of the provinces, except Nova Scotia, have nursing homes which provide for only low levels of medical care to residents, sending anyone who requires extensive care to the hospital. Traditionally, none of the facilities across Canada have provided for high levels of care, like those in the United States. The widely accepted policy of transferring the respective resident to a hospital setting is
implemented when any intensive care needs are required.

One myth that has been proclaimed by many sources, including Consumer Reports (September 1992), is that all Canadians are eligible for government subsidized LTC regardless of income or assets, and that no one is forced to deplete their assets to an impoverished level to qualify for support. At the 1987 hearing before the Select Committee on Aging for the House of Representatives, Chief of Staff Burke incorrectly asserted that all middle to upper income Canadian citizens who enter nursing homes have their income and assets protected. In actuality, this claim, according to Streich, is only true in those provinces that consider LTC as an entitlement and include its cost under their respective health insurance plans.

The various distinctions between the provincial systems’ funding sources and policies for nursing home placement or other forms of LTC, are dependent on two broad types of systems among the provinces:

1. **Social Service Programs**, which are delivered by the provincial Departments of Social Service, and

2. **Health Service Programs**, which are operated under the provincial Ministries of Health.

In provinces operating with the Social Service Programs, LTC is not considered an insured or entitled health care benefit and, like Nevada, involves a means-tested assessment based on income and assets. The minimum amount of contribution, or copayment required by the recipient of assistance is dependent on their respective OAS/GIS benefit, minus a predetermined personal expense allowance. If a recipient receives additional pensions or income, they are required to pay up to the full cost of the nursing home care or other LTC service. In other words, the resident’s contribution is based totally on ability to pay within this type of system, which is also similar to Nevada’s.

Under the Health Services Program system, the costs of LTC services are treated
as an entitlement or insured health care benefit, covered by the particular province’s health insurance plan. In this case, the provincial and residents’ contributions are established according to a universal rate. For residents, the rate is based on their individual OAS/GIS benefit amounts only, disregarding other income sources and any assets. LTC candidates unable to afford the minimum co-payment can apply for assistance with their local general welfare programs; however, normally the minimum amount of income benefits afforded all persons 65 or over is equal to the OAS/GIS allotment.

While the nursing homes under a provincial Health Service Program system tend to offer services to persons requiring higher levels of medical care, and tend to distinguish payment according to the level of care needed, Streich explains that those under the Social Service Program systems tend to offer one fixed, or blended, rate for a wide variety of low to intermediate levels of care (distinguished as levels one, two, and three), and tend to send those requiring more extensive care to a hospital setting. Provinces under the Health Services Program system are: Alberta, British Columbia, Manitoba, and Ontario. Those under the Social Service Program system are: New Brunswick, Nova Scotia, Newfoundland, PEI, Quebec, and Saskatchewan.

An additional distinction among the provinces is the existence of public (provincial or municipal), voluntary (charitable) non-profit homes, and private owned, for-profit homes. It is noted by Streich that, while four of the provinces primarily offer the public non-profit homes, all of the provinces, except PEI offer the voluntary, or charitable homes. In New Brunswick, for instance, most homes are either public, non-profit homes, or private, non-profit homes; with private, for-profit homes being relatively non-existent. In Nova Scotia, on the other hand, it was found that most of the care homes are private, for-profit homes, with few public, non-profit in operation. Regardless, as determined by this writer’s research, and substantiated by Streich, no Canadian senior in any of the provinces is denied access to nursing home care or other forms of LTC because of
inability to pay, assuming the services or care facilities are available. As previously acknowledged, in contrast to the US population, the overriding philosophy among the majority of Canadian citizens, advances the provision of comprehensive medical care as a given birth right. Thus, within both the Social Service Program and Health Service Program systems, whether a care home is privately owned profit bearing home or a voluntary, charitable, non-profit home, the need for LTC services or placements take precedence over the concern for payment. In most cases, the essential role the provincial government assumes is one of financing, initial development, and regulation, leaving the operation and management of direct service provision to the local licensed administering organization.

As a country with a relatively small population overall, with vast amounts of subcultures in rural community settings, the distribution of wealth and living standards in Canada has been quite diverse. In economic terms, these discrepancies have generally left the four eastern, or maritime provinces ranking the lowest. Robert F. Badgely’s research (1991) demonstrates that, while clear gains have been made with regard to uniform access to primary medical care services by all citizens across Canada, there appears to be a distinct relationship between a provincial region’s wealth and accessibility to some highly specialized services. For illustration, Badgely reveals that in 1985-86 the 4 western provinces spent an average of 18.9% more on health care per capita than the 4 eastern maritime provinces. Says Paul Pallan, Assistant Deputy Minister of British Columbia’s Ministry of Health, the intent of their provinces is to create incentives to hook people up with community based services when deemed appropriate. British Columbia’s single payer system for LTC is reputedly well suited for this task, since it gives the health ministries full reign over where to appropriate their Moines.

As previously discussed, the facilities in provinces such as Nova Scotia, that involve municipalities with medical care provision and financial backing, have customarily
tended to the needs of residents requiring low levels of care. In Nova Scotia, the nursing home policies tend to deny admittance by those requiring more than low care maintenance/minimal care attendance, and require the transfer of any resident whose care need progresses to a higher degree, to a hospital when possible. Again, no one is denied access due to a lack of sufficient income or resources. However, as Streich’s data reflects, the current trend in Nova Scotia appears to be a declining emphasis on lower level care facilities, with the incorporation of LTC facility projects offering increased access by those requiring more extensive medical care. Accordingly, Streich projects a slow, but steady, dissipation of provisionary functions by the municipalities of this province. Badgely speculates that these same economic factors may influence why none of the maritime provinces have included LTC coverage under their national health care insurance plan.

HEALTH CARE MOVEMENT IN THE FREDERICTON REGION, NEW BRUNSWICK FOR LONG TERM CARE

As illustrated, all of the Canadian provinces differ as to what LTC services are available, and how those in need gain access to such. British Columbia, Alberta, and Manitoba are regarded as the most advanced, providing all residents equal access to LTC services and placement through one single entry point. The “Single Entry Point System” (SEPS) enables a prospective client to be connected with required services by contacting one of the local Health Ministry’s offices. The Health Ministry officer, in turn expedites a case manager to assess, direct, and coordinate appropriate services for that person. Programs such as home health care, homemaking services, meals-on-wheels, day care, or nursing home placement is then initiated by the respective case-manager. Additionally, the ministry offers crisis response teams who provide immediate action when an elder requires treatment in a hospital or other emergency medical care setting.
Other provinces, including New Brunswick, have begun to follow suit in the establishment of the Single Entry Point System. According to Consumer Reports (September 1992), New Brunswick and such others are also making assertive attempts to move LTC patients out of hospitals and nursing home facilities into the community, or other less restrictive environments. Streich relates that the New Brunswick’s nursing home program is currently administered under the provincial Department of Health, having been transferred from the Department of Social Services in April, 1979. As Streich points out, however, the provision of nursing home care and other LTC services in New Brunswick are not considered to be an insured benefit, as they are in the other provinces utilizing the SEPS model. Consequently, all New Brunswick residents needing LTC continue to be assessed for ability to pay, allowing for supplemental assistance to those deemed eligible.

Streich (1983: A-21) determined the main objectives of the SEPS operation as follows: to ensure equitable distribution of nursing home beds across the province; to assess payment ability, and establish financial eligibility for the program, by those unable to pay privately; and to guarantee the maintenance and supervision of program standards in all respective facilities. At the time of Streich’s study, 70% of all residents’ incapacities in the New Brunswick nursing homes required a high level of what is officially referred to as “intermediate care”. (See Glossary) Like the Social Service Programs in other provinces, one rate of pay is designated for all three levels of intermediate care to the New Brunswick homes, regardless of the medical care needs. Previously discussed, in contrast with the other SEPS provinces, all residents in New Brunswick are required to provide a monthly contribution, based on their income, towards the cost of their care. For the indigent, the total amount of their OAS/GIS benefit, less a pre-determined personal allowance, is required. If the respective resident’s income and/or resources allow for full payment of services rendered, such is required.
Analysis of the evaluation report of the "Single Entry Point pilot project" (1991) reflected that two pilot projects were implemented in New Brunswick in the fiscal year 1989-90, following an in depth study of the LTC services within New Brunswick in 1987. The two regions selected for the projects were Fredericton and the Peninsula Acadienne. Each of the projects were essentially based on the results from experimental research and studies carried out in the United States, an evaluation of the Canadian Federal Department of National Health and Welfare, and the SEPS programs formerly executed in the provinces of Alberta and Manitoba. As outlined in the evaluation report for the Single Entry Point System (April 1991), the main philosophy of SEPS is: to reduce premature institutionalization of seniors who could feasibly remain in their homes with proper support services; to establish one point of contact, where request for assistance can be dealt with directly, regardless of the medical care need; and, to provide access to a continuum of services provided within a comprehensive network utilizing a multidisciplinary approach for problem-solving.

Recently, a third region in New Brunswick has begun a pilot program for SEPS, involving the county of Charlotte, and encompassing the town of St. Stephens. It is noted that this region along with the Fredericton region were initially chosen for study, with the anticipated goal of comparing and contrasting LTC provision for the elderly in New Brunswick to LTC provision for the elderly in Nevada.

Statistics in Canada reflect that in 1986, over 11% of New Brunswick’s 710,400 citizens were age 65 and over. It was speculated by the Department of Health and Community Services in 1987 that this figure could increase to 20% by 2021. Individuals 75 and over comprised just under 40% of the 65 and over population this same year. (Statistics Canada 1987, catalogue 93-101) Comparable figures are projected in the 1990 census from Clark County, Nevada, which revealed a total population of 741,459, with 10.5% being 65 or older, and 32% of this group ranging 75 and over. The growth trends
in both New Brunswick and Nevada, particularly Clark County, indicate the need for attention to policy makers and program developers to this age group with regard to age-specific care requirements. According to New Brunswick’s Senior Citizens Socio-demographic report (1992), the baby boomers will be reaching retirement age somewhere between 2010 and 2031. The older the adult with a disability or incapacitation, the greater the chances of the individual requiring institutional care. Considering the effects of the natural aging process on the functioning capabilities of elderly persons, a significant number have been found to need assistance of some sort, whether it be short or long term, with not only health related problems, but with routine activities of every day living. The philosophy of SEPS, according to their evaluation report, is that all seniors, regardless of the nature of their needs, should be offered one reference point to which they can turn to request assistance and be dealt with directly for access to a continuum of services.

The following chapter offers an analysis of the data derived from this writer’s research, for the comparison of each area’s LTC service delivery, and the determined cause(s) of constraints to accessibility within the Fredericton region of New Brunswick, and Clark County, Nevada.
The purpose of this study is to examine which of the three theoretical perspectives best explains the differences in accessibility to "long term care" (LTC), by comparing the United State's multi-entry, multi-payment source system with the Canadian approach of a single-entry, single-payment source system. For this study, reference is made to the two systems of Clark County, Nevada, and the Fredericton region of New Brunswick, Canada. With respect to the Fredericton region, examination is made of their LTC delivery system, both before, and after the implementation of their Single-Entry Point System (SEPS). One of the research methods employed for this measure, was the unstructured interviews of 15 care providers, within each of the regions, to discriminate factors identified most as impediments to LTC accessibility. Each of the ten factors were coded, in accordance to the respondents identification of them as having a strong, moderate, minimal, or no impact on accessibility. Accordingly, the ten major constraint factors were again coded, for equated relevance to constructs of the three perspectives. While this technique is an admittedly subjective indicator of accessibility, I believe the results to be relevant, and it allows for the categorized distinction of response patterns. Along with the interview data, the content analysis of governmental documents, including each of the regions' Medicare Handbooks, Nevada State Welfare manual, Clark County Social Service Manual, Single-Entry Point System manual, and Evaluation, the Fredericton region's Department of Health and Human Services manual, and the Extramural Hospital Manual, reflected many systematic distinctions which are discussed in following section. These distinctions were
then examined, to the extent that they revealed differences in degrees of government regulation, bureaucratic rationalization, and profit orientation, among these two diversified LTC delivery systems.

To evaluate the response data transposed on the following pages, the Kruskal-Wallis one-way analysis of variance (ANOVA) was incorporated, for the measured comparison of long term care accessibility, between two economically diversified sample areas: Clark County, Nevada, and the Fredericton region of New Brunswick, Canada. For this ANOVA, the measure of accessibility was determined according to the rated experiences of service providers, across three targeted groups of LTC service delivery for the indigent, from within these two parameters. To further examine accessibility, data was actually calculated among three distinctive sample populations for LTC delivery: Clark County, Nevada; the Fredericton region of New Brunswick, prior to the Single-Entry Point system; and the Fredericton region, after SEPS. Specific to this analysis is the hypothesis that: the LTC delivery system in Clark County is significantly less accessible than the Fredericton region’s system, before the inception of the SEPS; which is significantly less accessible than the Fredericton region’s system, after the inception of SEPS.

CLARK CO>FREDERICTON BEFORE SEPS>FREDERICTON AFTER SEPS

To measure accessibility among the three populations, data variance was analyzed with respect to ten factors, as related by the target groups to most frequently indicate constraints to LTC accessibility. Qualitative responses were subsequently encoded onto an ordinal scale, with numerics ranging from 0 to 3; “3” signifying a strong impact, “2” signifying a moderate impact, “1” signifying a minimal or unclear impact, and “0” signifying no impact. The qualitative data was thus transposed into quantitative data,
through the rated use of this coding scheme. To substantiate the above hypothesis, the
Kruskal-Wallis "H" test was applied to estimate population variance. In this instance, the
sampling distribution is "x2" with two (k-1) degrees of freedom. (The reader is referred to
Charts 1, 2, and 3, in Appendix III, to review the supporting data.)

Using this analysis procedure, the calculated value of 'H' is determined to be 11.99, with a
corresponding critical value of 9.210; chronologically displayed as follows:

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<tr>
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Based on the above results, the "H" value is found to exceed the critical value, at the .01
level of significance; demonstrating statistical evidence to support the alternative
hypothesis that: Clark County's LTC delivery system is, in fact, significantly less
accessible to the elderly, than the Fredericton region's system of New Brunswick. More
importantly, the data indicates the substantial impact of ten major constraint factors, on
(LTC) accessibility by indigent seniors in Clark County; and the considerably less impact
of these same constrains, on (LTC) accessibility by indigent seniors in Fredericton, both
before SEPS, but most significantly, following SEPS. It is therefore concluded that LTC
inaccessibility is directly related to identifiable constraint factors; and that the
incorporation of the SEPS program did have an inverse effect on constraints to LTC
access by financially challenged elders. The applied objective of this analysis is to now
ascertain why this is so.

Three theoretical perspectives are proposed to explain why accessibility to LTC is
so inequitably distributed in Clark County; and why the distribution rates are so diversified
among the three sample populations. Ideally, in this respect, the validity of each
perspective's explanatory evidence would be tested according to a measured level of
association with the ten constraint factors. Unfortunately, it was difficult to assess which
theory best applies, from this data; only that variance does exist between the three
population samples. It is noted that, while no definitive measure of association could be derived from the data; the three perspectives were paralleled with the ten constraints, to examine each one’s relative association to the hypothesis. The interpretive results of this comparative analogy will be discussed in greater detail within the next chapter. This next section first quantifies the collectively rated responses from among 15 LTC service providers, within each of the respective delivery systems, to compare the associated impact of accessibility constraints, most experienced by professionals omniscient to the field. Accordingly, this section offers a brief interpretive association between each constraint factor and the three perspectives.

INDIVIDUAL EXAMINATION OF THE TEN IDENTIFIED CONSTRAINTS

Upon individual examination, the calculated rate of impact on accessibility, by each of the constraints is displayed as follows:

1. **Application Process for LTC Placement Assistance:**

   For review, this constraint relates to the application process required by each of the two apply for either LTC provision in the community, or LTC placement costs. The independent analysis of this constraint factor generated mixed results. While 13 out of 15 Clark County respondents considered the application process for assistance to have a major impact on accessible LTC by the indigent; only 4 believed this factor to strongly influence accessible care in Fredericton-prior to SEPS; and none considered this factor to be of major influence after SEPS. It should be noted that all respondents in Clark County associated this factor most, to the lack of financial payment during the pending process for assistance. In contrast, only one of the Fredericton respondents made any reference to the financial aspect of the application process; and stated that this was showing
marked improvement. Other respondents from Fredericton associated inaccessible LTC, mainly to the lack of alternative LTC services, prior to SEPS; and to the assessment time frames involved for nursing home consideration by the multidisciplinary panel, post-SEPS. A number of the participants expressed discontent with the fact that the SEPS panel would completely shut down if any committee member went on vacation; which would result in delayed placements. Because of the Clark County respondent's emphasis on both bureaucratic and profit-oriented issues, with little or no association of this factor to the federal government's role or restricted competition, it is maintained that this constraint factor's causal explanation most clearly relates to the Weberian and respective Neo-Marxist Perspective.

2. **Time Limits for Required Information:**

For review, this constraint refers to the amount of time allotted for an applicant to gather and provide information, as requested by each system's respective welfare agencies, to determine eligibility for LTC provision and assistance. This factor was considered to have a strong impact on LTC accessibility by 13 of 15 Clark County respondents, with only 1 person giving an "unsure" reply; and that person being from one of the two assistance agencies. This rating was assessed to be especially strong among respondents from the "for-profit" nursing facilities and hospitals; as, the failure of an applicant to provide all agency required information by the due date, will inevitably result in denial due to strict agency rules. Consequently, the cost of provisional LTC often goes unpaid. As with constraint number one, it appears that this factor would best be explained by the Weberian and Neo-Marxist Perspectives, due to the respondents' strong implication to both bureaucratic and profit-oriented issues.
3. **Multiple-Agencies for LTC Financial Coverage:**

This constraint refers to the assessed impact of having more than one agency involved with the provision, and financial coverage of LTC placement and services to indigent elders, based upon the applicant’s income status. This factor again produced strong impact responses in Clark County. While 13 of 15 respondents acknowledged at least a moderate associative impact on accessibility, 11 of the 15 expressed this to be a strong deterrent for accessible LTC. In fact, the majority of respondents from Clark County’s for-profit hospitals and nursing homes, indicated they were glad to have two assistance agencies involved with financial coverage, to cover the costs of LTC for both, the indigent patients awaiting LTC placement or services who have no resources, and the nursing home residents who have exhausted their resources and are not eligible for Nevada State Medicaid. In Fredericton, again, this factor was again not viewed to have any impact on LTC accessibility, either before or after SEPS; as it was not applicable to their system. Respectively, this constraint also seems to be best explained by the constructs of the Weberian and Neo-Marxist Perspectives; with little association to either the effects of centralized government regulation or restricted competition, as proclaimed by the Market Model.

4. **Population Need of Indigent Elders Requiring LTC:**

This constraint relates to the number of indigent elders that require LTC, and the corresponding size of applicant caseloads within government assistance agencies. All respondents from Clark County, and the Fredericton region-prior to SEPS, claimed population size to strongly influence accessibility to LTC placement by seniors. Where the two systems differ is in how population size effects accessibility. In Clark County, the effect of population size on accessibility rates is related directly to the "supply and demand". Consequently, in Clark County, an
indigent senior has a much higher chance for LTC admission to a LTC facility if their bed capacity is low. In Fredericton, however, population size was determined to act as a constraint to all seniors in need of nursing home placement, prior to SEPS; relative to the scarcity of vacant bed space. However, it is indicated by the collated response patterns of the health care respondents, after the inception SEPS, that this program acted to completely neutralize any impact on LTC placement by the population size factor, through the increased provision of less restrictive, alternative LTC service programs to seniors. It may be said that this constraint essentially applies to all three perspectives: 1) The Market Model, with its claim that accessibility would be vastly improved if we could minimize the costly regulation of the LTC industry by governmental bureaucracies, and remove government sanctions on facility expansion, subsequently affording a higher bed ratio for indigent elder admissions; 2) The Weberian Bureaucratization Perspective, which refers to the extensive periods of "pending" time involved with each applicant’s eligibility process, as a determinant to their timely access (noted to be a cost-containment tactic); the associated emphasis on cost-containment procedures by governmental bureaucracies, including budget cut backs, high volume caseloads; and other tactics for applicant depersonalization. In this sense, it could be said that accessibility to affordable LTC by financially strapped elders, is significantly restricted by the bureaucratic LTC delivery system; and, 3) The Neo-Marxist Perspective, which would equate this constraint to the practice of capped admission rates of indigent elders by the "for-profit" LTC facilities in Clark County.

5. **Waiting Period for LTC Placement From an Acute Setting:**

This factor refers to the length of time imposed on hospitals discharging indigent patients to LTC facilities. In Clark County, 9 out of the 15 interviewed found the
waiting period required to establish LTC placement for elders, to signify a strong impact on the elderly without sufficient payment resources. Four Clark County respondents indicated no impact by this factor with respect to LTC placement; however, it is noted that these providers represent the two hospitals that offer payment up front to the facilities, for seniors applying for government assistance. A strong impact was also indicated by Fredericton respondents before SEPS, with a nullified effect after SEPS. This constraint appears most compatible with explanations by the Weberian and Neo-Marxist perspectives, in that, if one has the financial resources to contract for LTC services, accessibility is high. Accordingly, if one lacks the financial resources to contract the same, accessibility is low; and requires the application to a government assistance agency, causing its own constraints. The Market Model constructs of government regulation and restricted competition do not appear to apply.

6. Bed Availability:

This determinant factor explicitly refers to the admission rate of seniors, to LTC facilities with available openings (bed space), who are waiting approval for government assistance. Once again, 13 out of 15 Clark County respondents indicated this factor to cause severe delays in placement by indigent elders without the means to provide payment. Those interviewed did indicate that when bed availability opens up, the senior with sufficient resources to cover the cost of care is given far more consideration for admittance than the senior awaiting approval for financial assistance. This factor, again, relates to bed ratios. In close association to Factor four, if a facility's bed vacancies are high, more consideration is given to the senior without a payment source. Comparatively, all respondents from the Fredericton region referred to bed availability as causing major constraints to access before SEPS; but relative to all seniors requiring placement, and not just the
poor. After the institution of SEPS, and the consequential LTC community service delivery, this factor was related to have no impact. In conjunction with Constraint four, relative association is applied to the explanations of all three perspectives: 1) the Market Model’s proclamation that if LTC facilities were allowed unrestricted expansion by the government, more beds would be available to better accommodate the indigent; 2) the Weberian Perspective’s reference to the extensive application and eligibility process for government assistance; 3) the Neo-Marxist Perspective’s implication towards capitalistic profit-motives, and analogous distinction of medical care as a commodity.

7. Method of Payment for LTC:

Reference to this factor involves the particular type of payment resource available to the prospective LTC recipient. (e.g.: private resource provision; Medicare or other insurance coverage; established state Medicaid assistance or Clark County Medical Assistance; or pending government assistance with the state or county agencies.) Although this writer anticipated this component to illicit a stronger impact response rate in Clark County, only 3 out of 15 respondents indicated this to be so. Deciphered a bit further, it was determined that 8 of the respondents applying a “moderate” impact were either from the hospitals offering payment up front to the facilities during the welfare assessment process; or from the two government assistant agencies themselves. Of the four nursing homes sampled in Clark County, one of the facilities was acknowledged to better accommodate the indigent, while another professed to do the same. Therefore, it stands to reason why these respondents might consider payment source, or lack of, to only have a moderate impact on LTC placement; while the other respondents consider the impact of this constraint to be strong. Apart from those pending a payment source, it appears from the data that, overall, one’s method of payment is not a
strong constraint factor. However, emphasis is placed on those pending
government assistance; for this group is not considered to have a method of
payment, by this LTC industry’s private sector. In comparison, payment source
had absolutely no bearing on LTC placement within the Fredericton region’s
system, either before or after SEPS, as payment is not a concern. While this
identified constraint factor appears to be weak, at most; the following theoretical
associations are applied. It appears that what minimal impact this constraint has
on LTC accessibility, could technically apply to all three perspectives: 1) the
Market Model’s assertion that LTC provision is more equitably distributed when
more reliance is placed with the private sector; relative to those pending
government assistance; 2) the Weberian Perspective’s assertion that LTC
inaccessibility is directed related to governmental bureaucracies, "rationalized"
distribution to the elderly. 3) Relative association appears to be strongest,
however, to the Neo-Marxist Perspective; with its accented emphasis on profit, as
evidenced once again, by the lack of accessible community services availed to
seniors without an established payment resource.

8. Waiting Period for Community Services:
This category refers to the availability of community LTC services to those who
cannot pay. The responses calculated for this perceived constraint projected a
relatively small impact in Clark County; though implications were made to suggest
otherwise. Respondents from the government assistance agencies expressed
indecisiveness about this issue, as did one nursing home respondent. The
remainder of nursing home respondents, along with those from the hospitals,
signified no impact; in reference to several different community programs now
available for indigent and near-indigent seniors. Contrary to the above ratings,
however, this factor was distinguished by the majority of Clark County service
providers to have caused serious constraints, prior to the expansion of community services. According to the majority, this factor would often force nursing home placement over less restrictive alternatives for indigent elders in the recent past, due to inaccessible community service programs. In correlation, this constraint factor appears to associate most closely with the Market Model, almost disputing the other two perspectives. The Market Model professes that through enhanced reliance on the marketplace, LTC distribution will become more equitable. Several respondents acknowledged private operations, most frequently church affiliated, for the expansion of LTC community services. This would fit with the Market Model’s affirmation that volunteerism will be stimulated automatically through enhanced reliance on the private sector. In conjunction, because both the state and county have reportedly expanded community service provision to indigent elders, Weber’s Bureaucratization Perspective does not appear to apply. The Neo-Marxist Perspective is deemed to be somewhat applicable, in that the provision of community services by private health care operations is still inaccessible to those without a payment source; thus reflecting the private sector’s commodification of LTC. However, while this perspective does address the presence of inequitable accessibility, it affords minimal explanation for the expansion in community services, by both private and public sectors.

9. Establishment of a Physician, to Follow Institutional Care:
This constraint factor refers to the ability of securing an attending physician to provide medical care in a nursing facility, for those without an established payment resource. In Clark County, 9 out of 16 respondents considered this element to pose, at least, a moderate constraint with regard to accessibility; with four defining it as strong. An additional four rated the impact of this factor to be minimal, with two being unclear. Categorically, this factor is considered to have the strongest
impact among those without a payment resource. It was related by several that establishing physician care in a LTC facility, can also be more difficult for recipients of Clark County Medical Assistance; as the county does not pay for physician’s care. Additionally, due to the low reimbursement rates provided by Nevada State Medicaid, and the extensive time frames involved for payment recovery, many physicians also shy away from the LTC Medicaid recipients, and completely deny services to patients who are pending Medicaid. Correspondingly, this factor displayed no impact with regard to Fredericton’s LTC system, either before or after SEPS. Theoretically, the Market Model’s reference to government regulation, and related cost-containment policies, could be applied to explain why physicians are reluctant to assume the care of an indigent elder; there verifying the concept that medical care is indeed a commodity to be purchased, and that inaccessible care is directly related to insufficient compensation by the government. In accordance, the Weberian Perspective could be applied in association with government bureaucracy’s rationalized cost-containment’s policies. More appropriately, however, this constraint factor appears to be best explained by the Neo-Marxist Perspective; and the associated proclamation that denial of doctoral care is directly related to the private sector’s emphasis on profit, and the sequential commodification of medicine.

10. Type or Category of Required Care:
This last constraint factor refers to the nature and severity of one’s medical care need as it effects accessibility to LTC. The type and severity of one’s medical problems was indicated to be a strong factor of constraint to accessible LTC, in both Clark County, and the Fredericton region prior to their implementation of SEPS. In Clark County, 11 respondents considered one’s level of care (LOC) to strongly impact accessibility for LTC placement. The additional four respondents
indicated moderate impact. In Clark County, this factor was associated to nursing home staff shortages, and the subsequent inability to provide for heavy care patients. Indicative of the structural change in the nursing home placement process, and the increased LTC alternative services within the Fredericton region's system, no impact was indicated in relation to medical need, following the SEPS implementation. In comparative association to this constraint factor, each of the three perspectives offer valid assumptions for its strong impact on accessibility. The Market Model would implicate governmental regulation of expenditures, and inadequate reimbursement rates for this constraint factor. The Market Model would argue that shortages in staff cannot be rectified without sufficient capital; and consequently, associate inaccessibility by heavy care patients directly to governmental disbursement rates. The Bureaucratization Perspective would also argue that heavy care patients are denied placement accessibility due to government rationalized cost-containment policies. The Neo-Marxist Perspective would argue that the admission rate of heavy care patients to for-profit facilities, is determined by profit-oriented considerations, rather than provision of care; thus substantiating the Neo-Marxist assumption that inaccessibility to LTC in the United States, is directly related to the delivery system’s commodification of medicine.

Summarily, the data collected with respect to the above individual constraint factors, and their associated impact on accessibility to LTC by indigent seniors, is displayed as follows. From the data, it appears that nine out of the ten factors indicated a high percentage of, at least, a moderate impact; with seven of the nine rated as strong by 80-100% of the Clark County sample. Of the ten constraint factors, the "waiting for community services" was assessed to have the least amount of impact on access to LTC provision. The reader is reminded that, though the ratings for this constraint were low,
the majority of Clark County respondents from the private sector did reference this factor to have caused strong constraints in the recent past, often forcing nursing home placement of the senior who could go home, but could not afford community service costs, currently in excess of $20 dollars an hour. It is questioned what a longitudinal study might conclude regarding this factor, due to increased budgetary cutbacks by both state and federal government bureaucracies.

In comparison, sample data from the Fredericton region indicated only five of the ten constraint factors to strongly impact LTC accessibility, prior to the Single-Entry Point System. On the other hand, subsequent to SEPS implementation, none of these constraint factors were considered to cause a strong impact on accessibility to LTC; with only three constraints suggested by, 27%, 13%, and 40% respectively, to have even a moderate impact on LTC accessibility, subsequent to the implementation of SEPS.

Most significant to the research conclusions, and not reflected at face value by the calculated data, is the determination that none of the four constraint factors were reflected by the Fredericton region to have any associative relationship with governmental restrictions or regulations in the marketplace, and little to do with profit motivations. Quite the contrary, of the factors indicated by the Fredericton region to have a strong impact on LTC prior to SEPS: 1) the application process for establishing LTC assistance, 2) population size of seniors in need of LTC, 3) the waiting period for LTC placement, 4) facility bed vacancies and, 5) type of care required, all five were reflected by the research to relate most to governmental, or bureaucratic, constraints to provisional LTC service in the community, and the consequential limited openings by nursing homes. In accordance, of the three constraint factors implicated following SEPS: 1) the application process with respect to SEPS intake evaluation, 2) the waiting period for community LTC services, as it effects hospital patients' discharge, and 3) population size in need of LTC provision, none were found to have a strong impact on LTC accessibility; and the impact of all three,
though insignificant, are considered to still apply most to bureaucratic constraints by the Fredericton region's governmental system.

In sharp contrast, of the nine factors determined to most significantly impact accessibility in Clark County, the co-relationship of eight reflect to be most closely associated to Neo-Marxist concerns on profit orientation, commodification of medicine, and government waste. Correspondingly, seven of these factors reflect the commensurable association with Bureaucratic determinants of rationalization. In comparison, only one of the ten constraint factors reflects its most relative association to Market Model, and restrictions on competition. In conclusion, it is maintained that accessibility to LTC is highly impacted, by numerous constraint factors within the Clark County system for LTC delivery, as revealed by the data. It is further maintained that the above data calculation does infer an inverse effect on constraint factors by the established Single-Entry Point System for LTC in the Fredericton region. Chapter six will explain why.

**COMPARATIVE INDICATORS OF INFLUENCE**

According to Marx, the class system because of the scarcity in resources. In Marx's view, capitalism took care of the scarcity problem, by introducing inequality of distribution according to buying power. While Marx spoke of the "commodification" of society within the marketplace, Weber stressed the increased "rationalization" of the modern industrialized world by society. Weber's conception of the capitalistic economy was one where the precedence of political and economic needs over human needs had become increasingly rationalized. Lukacs depicted the free market enterprise to be based on Weber's logic of instrumental rationality, and the notion that modern capitalism would be best governed within an efficiency dominated bureaucratic network. However, as
bureaucratic capitalism evolved in the western world, society began to supersede acts of “humanism” with self-serving acts of “individualism”. With increased emphasis on material success, “societal logic” became “market logic”, thus prompting government regulation, and the expansion of bureaucracy for instrumentally efficiency.

All three perspectives recognize the impact of governmental spending and shrinkage, within the realm of health care resources identified as “scarce”. Each perspective independently advocates for some form of government organized coalition, with a unified purpose of societal benefit. Critics of the current government - private mixed approach to health care, indict governmental consumption as being a cause of resource scarcity, and question whether the problem is scarcity or distribution. Theorists of the Market Model, Bureaucratization, and Neo-Marxist persuasion all agree that an integrated role by government in LTC would increase accessibility; however, in conflict with the Market Model emphasis on federal government decentralization of regulation, the Neo-Marxists advocate federal government centralization of LTC insurance coverage. Each perspective acknowledges this country to be a “modified-free” marketplace enterprise, which perpetuates constraints to accessible care. Yet, their perceptions of this capitalistic economy, as revealed by the research, are quite varied.

As stated, one of my stated objectives for this study was to examine the relative validity of each perspective’s hypothetical frameworks in explaining disparities in accessibility between the two sample regions. More importantly, it was my purpose to estimate the degree of explanatory power offered by each of the three theoretical perspectives with regard to the disparities found between each sample group. In order to establish measurable degrees of influence by the perspectives, pertinent to this study of inaccessibility, it was necessary to establish numerical values for: 1) constraint level within each sample group, 2) percentage factor of each individual constraint, #1-10, as contributory to the sample group constraint level; and then, by way of verifiable methods,
apply a theoretically defined "degree on influence" for each perspective, which would in turn be applied to the constraint levels. It was speculated that, by this method concrete numerical indicators would point to the perspective which best explain inaccessibility, or accessibility, level factor, and also illuminate an approach beneficial to LTC service within all three sample groups. For the sake of clarity and formula construct, the sample groups, while encompassing two regions in two separate countries, were given a letter of identity.

A) = Clark County
B) = Fredericton region of New Brunswick, prior to SEPS
C) = Fredericton region of New Brunswick, after SEPS

Using the raw data displayed in Appendix II - Chart #1, which was constructed from the field research responses given by those questioned, numerical values of constraint were acquired for each sample group. The following method was applied. The responses of those interviewed were given a numerical value of 3, 2, 1, or 0, as indicating a strong, moderate, minimal, or zero impact, on each of the constraints identified within the two areas, to impact accessibility within their respective system for LTC. Within each sample group the response to each of the constraints was given a quotient. To establish a sample group quotient, it was determined that each group could have a total of "450", as its highest level of constraint. By compiling each of the sample group’s numerical responses for identified constraint impact, a calculated percentage of impact that each constraint could have on that group, was obtainable.

\[
\begin{array}{ccc}
A & B & C \\
450/334 & 450/214 & 450/24 \\
=.74\% &=.47 &=.05
\end{array}
\]

This formula was use to establish levels of constraint for each sample group. For evaluation, these levels were considered valid evidence, as they were the result of values applied to the constraints, by the service providers most involved with LTC. Next, the
individual constraints within each of the sample groups was assigned a value, employing the same method. (See Appendix III - Chart #2)

EXAMPLE: Constraint # 1 Group A  \( \frac{45}{42} = .93 \)

These individual constraint values were then used to measure group constraint "similarities and differences", by numerical comparison. The result factored a sample group level of constraint, and an individual constraint factor of participation, applicable across each sample group. The next step was to operationalize the theoretical constructs of each perspective, to obtain a numerical value for each for comparative analysis. As done with the sample groups, each of the perspectives were assigned a letter of representation.

<table>
<thead>
<tr>
<th>Market Model</th>
<th>Weber's Bureaucratization Model</th>
<th>Neo-Marxist Model</th>
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</thead>
<tbody>
<tr>
<td>X</td>
<td>Y</td>
<td>Z</td>
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The operationalization quotient for each perspective is defined by the measured influence of 10 theoretical concepts, as integral to each perspective: X, Y, and Z. Using each perspective's theorems as measurable parameters of perspective influence, or explanatory power, each perspective is assigned a value of impact on the constraints. In this way, the three perspectives come to define themselves, through the inclusion or rejection of each theoretical construct, as displayed at the end of this chapter. This perspective value formula utilizes a Yes/No definition, with Yes = 1, and No = 0. By asking each perspective to define itself according to the ten concepts, with regard to the ten constraints for degree of influence in each sample group, indicator degrees were obtained. (See Appendix III) For this purpose, reference is given to the following theoretical constructs: federal regulation, restricted competition, and individualism from the Market Model; bureaucratization, rationalization, and objectification from the Bureaucratic Model; and profit orientation, governmental consumption, and commodification from the Neo-Marxist Model. Further association is applied by each perspective independently, with regard to their perceptive influence of centralization.
Example: X is given a .5 degree of influence because it defines itself by concept view, with 5 of 10 concepts being applicable to constraint number 1, within sample group A, we now have a "degree of influence" factor for each perspective, for each constraint, for each sample group. By addition of each degree of influence, of each perspective, to each constraint, the total degree of influence of that perspective is known.

<table>
<thead>
<tr>
<th>Market Model/CC</th>
<th>Weberian Model/CC</th>
<th>Neo-Marxist Model/CC</th>
</tr>
</thead>
<tbody>
<tr>
<td>X/A = .53</td>
<td>Y/A = .66</td>
<td>Z/A = .87</td>
</tr>
<tr>
<td>Market Model/Pré-SEPS</td>
<td>Bureaucracy/Pre-SEPS</td>
<td>Neo-Marxist/Pre-SEPS</td>
</tr>
<tr>
<td>X/B = .27</td>
<td>Y/B = .38</td>
<td>Z/B = .06</td>
</tr>
<tr>
<td>Market Model/Post-SEPS</td>
<td>Bureaucracy/Post-SEPS</td>
<td>Neo-Marxist/Pre-SEPS</td>
</tr>
<tr>
<td>X/C = .0</td>
<td>Y/C = .0</td>
<td>Z/B = .06</td>
</tr>
</tbody>
</table>

If the levels of constraint factors which are identified with inaccessibility to LTC, are inversely used for percentage of accessibility within the sample groups, the following indicators can be figured. Inversely related, the Clark County (sample "A") percentage of access to Long Term Care by the elderly equals 26%. In the Fredericton region of New Brunswick, prior to the implementation of the "SEPS" pilot program (sample "B"), the percentage of accessibility is 53%. In the Fredericton region, following SEPS initiation, the accessibility for the client-in-need to obtain LTC is assessed at 95%. The results of this comparative association are illustrated under Appendix III.

Sample group C, the Fredericton region of New Brunswick after SEPS, a Single Entry Point System of access to LTC for the indigent elderly, registered a 95 percentage of access for this population at risk; a substantial increase of availability. Within this group, the Market Model perspective indicated a zero impact factor of explanatory evidence for the increased rate of accessibility, as indicated by Chart #1. Interestingly enough, Weber’s Bureaucratic Perspective was evaluated to have zero impact on sample group C. However, this would seem to be consistent with the pilot system of SEPS,
which virtually eliminated all forms of bureaucratic constraint from LTC access, as indicated by the confirmed reduction of constraint values (Appendix III), and the increase in percentage of the population most at risk for LTC service by the SEPS program in sample group C. The summation of findings to support the twofold premise of the research can be reviewed in Appendix III.
CHAPTER 6

COMPARATIVE ANALYSIS

SIMILARITIES AND DIFFERENCES

A review of the applicable literature, documents, and interview data yielded the following similarities and contrasts between the Fredericton region, with a single-entry, single payment source system for long-term care delivery, and Clark County, with a multi-entry, multi-payment source delivery system.

1. Population Comparatives:

There are 15 counties in New Brunswick, with 7 operating as “Health Care” regions and 12 operating as “Family and Community Social Service” regions. Although there are 17 counties in Nevada, statistics reflect that the entire population of New Brunswick could fit within the parameters of Clark County. The total population in the Fredericton region is 113,625, as recorded by the 1992 census, with the "over 65" group being 11,645 (10.2%). According to the New Brunswick Nursing Home Services 1992 annual statistics report, there is a cumulative total of 839 intermediate care level beds among the nursing homes in the Fredericton region. In comparison, statistics reveal the 1992 Clark County census of those over 65 to be 296,906, or 34.1% of the total population, with 1,927 available nursing home beds, apportioned for both skilled and intermediate "levels of care" (LOC). (Nevada State Division of Health-Bureau of Licensure and Artification 1992) Only two homes in Clark County offer intermediate care exclusively, with a combined total of 210 beds. These figures indicate a bed ratio
disparity of 7:1, with regard to the age group most likely to require Long Term Care (LTC). Considering that Clark County is home to three times the number of elderly residents in Fredericton, this distinction is considered quite significant.

For a senior to have absolutely no support system in the Fredericton region, and most parts of New Brunswick is a rarity, unlike Clark County with the influx of seniors, migrating from their home territory and family structure. Consequently, only one percent of the Canadian population, is in a nursing home or other LTC facility, whereas in the US, the nursing home population accounts for three to four percent, a difference of over one half million people, according to Estes and Gerard (1984).

2. Governmental (Budgetary) Structure:

Both the United States and the Canadian provinces formally employed a 50:50 cost-sharing approach to health care, between the federal and state, or provincial, governments. With consideration to the costly expenditures for the hospitalization of "chronic" care patients, prior to Single Entry Point System (SEPS), the Canadian federal government now offers block transfer payments to the provinces, for a more "centralized" delivery of LTC. In the Fredericton region, the block grant transfers have allowed for more LTC services in the community, and the deinstitutionalization of many seniors back to their homes, under the SEPS program. Similarly, the US federal government has followed suit with increased federal block grant transfers to the states; however, the responsibility for "custodial" LTC, still remains divided among two levels of government, the county and the state, and the allocated grants have done little to enhance community services or deinstitutionalization of seniors.

Both the Fredericton and Clark County systems are bound by federal mandates and regulations, and are struggling with limited resources. The trend with both
systems is for "federal decentralization" of LTC delivery funding. Neither the Canadian national Medicare system, or the US federal Medical system cover the cost of custodial LTC in Fredericton or Clark County. The major issue of today for both systems is "cost-containment", which has caused the most acrimonious political and public debates over how to pay for all health care, both acute and long term. The ongoing debates involve both providers and consumers. While cost controls in the US are left largely to market forces, in Canada cost measures are managed strictly through a political process between the provincial and federal governments. Nevertheless, the crunch on financial resources has hit, causing both system’s to take a harder look at who can pay for their own care and who cannot. Taxpayers on both sides of the border are saying that they cannot pay anymore.

3. Operational Structure:
Each of the 10 Canadian provinces, like each of the 50 United States, basically operate their own programs for the disadvantaged elderly population. Each of the provinces are different, as are the states, due to demographics and overall diversities of each area. With the exception of the enforcement of cost-sharing rules, however, in the Fredericton region there is no federal government involved with LTC delivery or provision. Unlike Nevada’s system, all decision making for nursing home placement and assistance in New Brunswick is determined at the regional level, as opposed to the provincial level of government. In contrast, with respect to the Nevada system for LTC coverage, clients in need of LTC are differentiated, between the state and county government levels, according to income; and between the federal (Medicare), state (Medicaid), and county (Clark County Social Services) levels, according to level of medical care need.

Similar to the Nevada system for "community LTC provision" the New Brunswick
system requires that a recipient be diagnosed with an "active", or "acute", medical care need, to receive services by a registered nurse in the community under (federal) Medicare coverage. Prior to the SEPS program in the Fredericton region, however, the regional government was forced to contract out for LTC community services, with both private, for-profit and government, non-profit agencies. Following the inception of SEPS, the for-profit companies were all but eliminated, due to the subsequent employment of regional government staff for provisional services, at a much less costly rate.

4. **Pre-Admission Screening Process:**

Both systems utilize pre-admission assessment tools for nursing home placement. The Nevada State Medicaid LTC screening process (referred to as "PASSAR"), is actually employed to rule out "active mental illness or retardation", as a criteria for admission. The respective screening packet is only three pages long. As stated, the screening packet for the SEPS system is 47 pages long, yet renders a more detailed medical assessment, for the intended establishment of a "least restrictive treatment" setting. In contrast, the financial eligibility form applied in Fredericton for LTC assistance consists of two pages, compared to Clark County's 11 page Social Service application, and Nevada State Welfare's 15 page application. Due to the high rate of denial by Nevada State Welfare, most nursing homes in Clark County require some type of "guaranteed" payment backup for admission of those pending Medicaid eligibility. This responsibility is most usually deferred to the Clark County Social Service agency, which requires a duplicative screening process.

It was determined that nursing homes in both Clark County and New Brunswick will consider admission of a person diagnosed with mental retardation or mental
illness, as long as the medical care needs outweigh the mental health care needs. However, the research displayed far less barriers to LTC by residents in Fredericton with mental health problems, both before and after SEPS, than those of Clark County. When a nursing home resident of New Brunswick requires mental health treatment, they are simply transferred to a hospital in St. Johns; a distance of less than 35 miles. Payment for such is provided by the federal Medicare insurance hospital plan. In opposition, the state-operated mental health system of Nevada does not consider those in need of nursing home care to "fall under" its criterion for mental health treatment, and does not provide payment for such. If a resident requires mental health treatment in Clark County, they are transferred to a Nevada state mental health institution. In Nevada, the budgetary sources for state and county operations are completely autonomous and discriminate, with expenditures being heavily guarded at the administrative level. As a consequence of Nevada's currently limited state resources, mental health services have become increasingly less accessible to the nursing home resident inflated with severe mental health care needs.

5. Government Reimbursement Rates:
The governmental operations in both the Fredericton region and Clark County offer negotiation with their nursing homes, on either a yearly or bi-yearly basis, to establish agreeable reimbursement rates. The definitions attached to the "intermediate levels of care" (LOC) types 1, 2, and 3, are quite similar in New Brunswick and Nevada (See Appendix IV), and did not change with SEPS. The payment structure of each system varies dramatically, however, with the New Brunswick regional governments paying a flat rate to nursing homes for all levels of care. In Nevada state and county reimbursement rates differ according to each LOC. Additionally, in New Brunswick nursing homes are basically paid the same
rate for care by the government, as by residents paying privately. With the larger homes, the Fredericton rate averages around $80-90 per day. In contrast, the present average rate of pay by state and local governmental agencies in Clark County for nursing home care, ranges from $49 for Intermediate Care Level "1" (ICL 1) residents, $62 for ICL "2" residents, and $82 for ICL "3" residents. For compensation, the average rate of pay by the "private resource" resident in Clark County is $95 for all levels of intermediate care. The New Brunswick system provides for wheelchairs, oxygen, transportation costs, visual care, and some dental care for the LTC resident. In Clark County, all of these items are now considered by state and county government, to be "facility items", placing the responsibility for their provision on the nursing home provider.

6. Nursing Home Level of Provisional Care Distinction:
The Fredericton system maintains that all "skilled care" services (see Glossary) should be cared for in hospitals; whereas the Nevada system refers most skilled care patients to nursing home facilities, subsequent to the exorbitant cost of hospital care. As a rule in New Brunswick, all tube feedings and intravenous therapies are also administered only by hospitals facilities. No ostomy care of any type is allowed in a nursing home, nor is dialysis, unless the patient is able to administrate this care independently. It was determined that many of the New Brunswick hospitals have developed "extended care wings" similar to Nevada’s, for the treatment of unstabilized, chronic care patients. According to the Department of Health and Community Services, however, these hospitals are now pushing for the transfer of chronic care patients to nursing facilities, which has long been the practice in Nevada. It was reflected that this issue could eventually present a significant impact on New Brunswick nursing home placements.
In both study areas, it was found that the "hard to place" patients with extensive nursing care needs, are given the least priority for placement, regardless of who is paying. In this area the establishment of SEPS has had relatively little impact.

In contrast with Clark County’s system, the Fredericton region also requires hospitalization for the treatment of decubitus ulcers, or pressure sores, as opposed to nursing home placement. If a decubitus ulcer forms in the nursing home, and progresses to a critical stage, the person is considered to be in need of intensive treatment, and thus transferred to the hospital. While skin breakdown is a frequent occurrence among nursing home residents in Clark County, often times severe; this condition was noted by the Fredericton region’s Nursing Home Unit to be rare within their system; identifying only three serious incidents of decubitus ulcers over the past seven years, and all related to hospital stays.

Also in contrast with Nevada, nursing home beds in New Brunswick can be held up to 30 days, with continued governmental support while a resident is hospitalized. An additional extension of up to 30 days can be requested, and is usually approved. Neither Nevada State Welfare (NSW) or Clark County Social Services (CCSS) allow for this type of coverage. Consequently, each time a nursing home resident of Clark County is hospitalized, they stand to lose their bed space, in what has become their living environment.

7. **Financial Eligibility Guidelines:**

The United State’s Social Security system offers a Supplemental Security Income (SSI) to the elderly that assures a minimum of $470.40 to a person living in the community. In New Brunswick all persons over 65 are entitled to a minimum Old Age Security (OAS) benefit plus a Guaranteed Income Supplement (GIS), together equaling $825; the OAS being universal in the amount of approximately
$300, and the GIS being calculated according to other pension benefits. All
nursing home residents in New Brunswick are allowed $88 per month in personal
expense moneys by the Department of Income Assistance, while Nevada State
Welfare and Clark County Social Services allow only $35 per month. New
Brunswick allows the recipient of financial assistance up to $4,500 to prepare for
their burial, but only a maximum of $500 in savings. In contrast, Nevada allows
for up to $1,500, exempting the cost of a burial plot, to prepare for death; and a
maximum allowance of $2,000 in assets, both liquid and non-liquid, to be retained
by the client.

In respect to client assets, a recipient of LTC assistance in New Brunswick is
technically allowed to keep one house, and up to one attached acre of land,
although the sale of additional land is seldom enforced. With regard to spousal
impoverishment, New Brunswick allows for the splitting of assets, with one-half of
the institutionalized spouse's income being retained by the spouse at home, if
indeed the institutionalized person's income is higher. If the spouse remaining at
home receives a higher income, that person is allowed to keep the entire amount.
The philosophy behind this approach is that, New Brunswick does not wish to
impoverish the independent spouse and cause them to both require assistance.
Liquid assets are split equally as well, if they are in both names. The government
cannot force the sale of any property held jointly, regardless if it is non-residential
property or not. On the other hand, in Nevada the spouse remaining in the
community is allowed by the state to retain $70,470 in liquid assets; with Clark
County allowing a maximum of $20,000 in available assets. In neither study area
is a person allowed to sell any property for less than its fair market value. Nevada
State Welfare allows one to keep their primary residence and all surrounding land,
provided that their intent is to eventually go home. On the contrary, Clark County Social Services requires the sale of all property, including one's primary domicile, to qualify for assistance.

The rule of thumb in regard to "disposal of assets" in New Brunswick is presently determined to extend retroactively back to 24 months for financial eligibility, meaning that if one has transferred an asset into another name during this period, the client may not qualify for assistance. In Nevada this time period has been increased from 24 months to 30 months. Financial assistance is terminated automatically in both areas if it is discovered that the family and, or, client has withheld financial information.

One predominant difference between the Fredericton region and Clark County is the large amount of exploitation against the elderly in Clark County. According to one respondent with the Department of Health and Community Services, no cases of exploitation could be recalled in Fredericton within the last ten years. In Fredericton it is considered a serious offense to falsify financial information or exploit another of their resources, both offenses being subject to high fines or, imprisonment, under the Canadian Social Welfare Act. All persons applying for assistance sign a declaration acknowledging this fact. In contrast to the Fredericton region, exploitation is not recognized by Nevada State Welfare as an "acceptable divestiture" of the client’s assets; and is not given any consideration for the eligibility process. In other words, whether someone stole a person’s money, or it was given away; the bottom line is, if one had assets over $2,000, and they are now gone, financial assistance for LTC is not granted by NSW.
8. **Nursing Home Entry System:**

Still another important distinction revealed is that, while people requiring LTC in Clark County either in the community or a facility, have no one single point of entry to access services unless they can afford to pay, the Fredericton region does. Within the Fredericton region and other regions utilizing the SEPS program, where the Health Ministry dispatches case managers upon referral to establish and arrange for the appropriate level of care—be it home health care, day care, or nursing home placement, LTC is very accessible to all seniors, and based on medical care need rather than monetary reward. In significant contrast, indigent seniors in Clark County must first have a doctor certify need for LTC, be assessed by the state for type (category) and severity of LTC, and then locate a nursing home or community service provider that is willing to serve them without an established means of payment. Again, for those awaiting nursing home placement or community services not provided under (federal) Medicare, who have applied for state Medicaid assistance but now face the average pending period of three months; as a general rule, a second application is required to Clark County Social Services for a backup payment source in the event of state Medicaid denial.

9. **Distinction in Overall Philosophy:**

Most significant to the research was the distinction that all nursing homes within Clark County are "for-profit", whereas the majority of nursing homes in the Fredericton, and other New Brunswick regions are "non-profit". The only "for-profit" nursing homes in the Fredericton region were formerly grandfathered in compliance to guidelines of the old system, and may soon be phased out, as most do not have a registered nurse on staff 24 hours a day, which they will need to provide for the heavier care patients, to be competitively selected from the "SEPS pool". Research, firmly supported by all respondents within Fredericton region,
including the administrator and staff of the privately owned, "for-profit" nursing home in Gagetown, New Brunswick, that profit did not take priority over their level of provisional care. This respective private operator stated she was prepared for the changes anticipated by the SEPS implementation.

In accordance, one significant difference between the two study areas related to New Brunswick’s prevailing belief in universal rates of payment, equitable treatment, and placement of LTC for all citizens as deemed necessary, regardless of one’s ability to pay. From the material examined and the collective statements of all respondents, it is apparent that in New Brunswick, the placement of a person in need of LTC occurs first, with consideration of a payment source coming second, which is usually established within 30 days. Additionally, private rooms are made equally available to both private paying and government supported residents alike, based on a waiting list. From the material examined and the collective statements of all respondents, it is apparent from these distinctions alone, that the New Brunswick’s system places far more focus on the client than the monetary reward.

According to Gerard, the Canadian Union of Public Employees (CUPE) does not believe that profits should be made by nursing homes at the expense of an ill, frail, or incapacitated person. Remarkably, considering the "for-profit" orientation of Nevada, over 50% of the Clark County respondents, including the nursing home operators themselves, had similar beliefs. The CUPE maintains that the private, "for-profit" nursing homes are a national shame and describe them as profit hungry enterprises which offer nothing more than a warehouse for the elderly. Also, according to Gerard, CUPE claims that the nursing home workers in Canada are
less concerned with better pay and shorter hours, than in providing quality care to their patients. The question that again arises is, why? Concern was voiced, that this philosophy of patient care could change in regions such as Fredericton, as the SEPS program expands and the nursing home population becomes increasingly sick and frail, and require more intensive care. The concern was suggested that this philosophy could change in regions such as Fredericton, as the nursing home population becomes increasingly more sick and frail, and require more intensive care. This certainly could be the subject of future research.

All persons interviewed in the Fredericton region expressed an overall satisfaction with their system for LTC, while 80% of those interviewed in Clark County expressed a considerable amount of dissatisfaction with the current LTC delivery system. All respondents involved with governmental application for assistance preferred to work with the Clark County Social Services rather than the Nevada State Welfare Department, although, the majority believed it to be the state’s responsibility to fund LTC placement for indigent seniors. Interestingly enough, the majority of those interviewed in Clark County believed that, should a national health care insurance system be implemented, LTC should be included. Among those in Fredericton, the majority believed that their system should remain the same, in that those persons who can afford to pay for extended care should do so, and that those who cannot pay have an unconditional right to assistance. According to one Fredericton respondent, society may just be going through a phase right now with the maturation of the "baby boomers", and that this trend could one day reverse itself, so why change the system. To this person, one has no legal or moral responsibility to leave money to their offspring, so if the client can pay for their LTC needs, they need to.
CHAPTER 7
OVERALL FINDINGS

One of the stated objectives of this paper was to validate each perspectives' explanatory reasoning for the systematic similarities and distinctions among the Fredericton region and Clark County. To this purpose, theoretical association is applied by the Market Model, Weberian Bureaucratization Model, and the Neo-Marxist, Profit-Orientation model, to each of the allegorical distinctions. In reference to the allegory first discussed, comparing "elderly population size" and nursing home "occupancy", the reader will recall that, as a Long Term Care (LTC) constraint factor, the "elderly population need" was unanimously rated to have a strong impact on accessibility, in both Clark County and the Fredericton region, prior to Single Entry Point System (SEPS). Comparatively, the population size of those in "need" had virtually no impact on accessibility in Fredericton, following SEPS; this being an extremely positive indicator that the goal of the SEPS program was achieved, with the delivery of LTC in Fredericton now being proportionate to senior need. Advocates of the Market Model blame nursing home bed shortages on government restriction, theorizing that if the US government dissolved the present "certificate of need" requirement for the expansion of nursing homes, more than ample space would become available to the indigent. The credibility of this theorem is difficult to assess, however, from a speculative point of reference. Considering the high percentage of indigent nursing home candidates in Clark County, and the numerous constraints to accessible LTC, association is made with the Weberian analytics of (government) rationalized bureaucracy, as it effects accessibility. Due to the extensive
"pending" period of Nevada State Welfare's (NSW) eligibility process for Medicaid coverage, and the strong possibility that NSW will deny assistance to the resident at the expense of the respective nursing home, indigent clients are not considered to be "financially lucrative", resulting in their diminished priority for placement. In this sense, the Neo-Marxist analytic of "profit-oriented", "commodification of medicine" equally applies, with respect to indigent seniors’ and their restricted placement options.

The second comparative distinction involves "federal" governmental expenditures for LTC. Several theoretical concepts are offered to explain the differentiated "funding sources", including federal de-centralization (of funding), state or provincial centralization (of funding), federal deregulation, limited resource options, cost-containment procedures, and the political economic process. Research indicates the mutual dominance of the "funding source" theme, among all governmental programs within the Clark County system; which could engage the causal implications of all three perspectives. To explain this systematic distinction, the Market Model would point to the enormous cost of government-layered regulation, being directly absorbed by US taxpayers; and accredit the success of SEPS to the decreased role of federal government. The federal deregulation of health care has long been proposed by the Market Model, which aims to limit governmental restrictions on free-market competition, and government stifled rates of reimbursement for LTC. Recognizing the "financial" necessity for a government, private mixed approach to LTC, within this country's "modified-free" economy, the free-market model promotes the deregulated authority of LTC provision to the states; not so much for centralized delivery, but rather to revitalize a "democratic capitalism". The Market Model would give no credence to government restricted competition in the marketplace.

In the Fredericton region, prior to SEPS, their system also involved a government, private mixed approach to LTC, which was all but eliminated after SEPS. The reader will
recall that the operation of "multiple governmental agencies" for LTC provision and assistance in Clark County, was interpreted by 60% of the respondents to be a strong constraint to accessibility; while the Fredericton region reflected this factor to have no impact, either before and after the implementation of SEPS; thus implying the impact of both "multiple private agency" involvement, and "bureaucratic" constraints.

The Weberian Perspective would associate the US created, "bureaucratic structure" of its government, with instrumentally rationalized budgetary allotments by the US federal government, to differentiate the systems. Neo-Marxists would parallel Weber's instinct for socio-economic distinctions in health care provision, in reference to the strong influence of US politics on federal government funding for social welfare organizations. In acknowledgment of the SEPS achievements, the Neo-Marxists would point to the New Brunswick, Canada's adherence of centralizing funds, for LTC delivery.

There are other identifiable factors, relating to the operational structure of each respective LTC delivery system. Unlike the US, all Canadian provinces are independently governed, and operate their own intrinsic programs, particular to that provinces' demographics. Prior to SEPS, the federal role in health care was more predominant, due to the extensive Medicare coverage of chronic care for hospitalized patients awaiting nursing home placement. The private for-profit enterprises were also more predominant in the LTC industry. The role of the federal government is now minimal in the Fredericton region, and the for-profit operations have slowly dissipated; a sharp contrast to the Nevada system. Essentially, this issue is relative to the intrinsic structural components of centralized government versus decentralized government. All three perspectives, separately fault operational structure of US government, for the failures in health care delivery. The Market Model blames the present US health care crunch, on over-sized governmental regulation, and advocates for the "decentralized role" of federal government, and the delegated responsibility for health care to the states. In respect to a
limited government approach, they might consider the SEPS system to be more productive (efficient) than Nevada's, but would harshly ridicule the governmental restrictions on for-profit enterprise. The Neo-Marxist acolytes also fault the structure of government's health care system, but for the interest of equitable care, rather than competition. In opposition to the Market Model, they advocate a "centralized" health care system. While the Neo-Marxists would consider the SEPS system to be more equitable, less political, and less wasteful of government resources, they would still question the exclusion of LTC coverage under their nationalized health insurance. The Weberian theorists would equate the effects of the US "bureaucratization" of the health care system, and the inefficient, cost-benefit analyses of government operations; though simultaneously equating federal government deregulation, with federal government (budgetary) cutbacks. The Bureaucratization dictum, though not necessarily promoting the centralization of health care, does firmly support the active moderation of change, within the present structure.

Still another distinction refers to the LTC pre-admission process of each system. The Nevada State Welfare's "PASSAR" screening packet is used to discriminate mental health needs from nursing care needs, and to isolate the level of care for, both the placement category, and the appropriate funding source. The assessment packet is 10 pages long, as opposed to the SEPS program's 47 page application. It is noted that "level of care" (LOC) issues and "method of payment" were both rated as strong constraints in Clark County. Though LOC was most certainly a concern in Fredericton before SEPS, it had nothing to do with financing; only nursing home vacancies and is no longer applicable. For comparison, the Market Model would acknowledge the market system's monetary interests, but offer no apologies for the market system's capital interests, interpreting this to be the "American way". The Weberian theorists would strongly argue that bureaucratic rationalized procedures indeed effect health care delivery in the US. The
Neo-Marxists would equally associate the cost-containment priorities of competitive capitalism, to the equally strong commodification of health care, respective only to Nevada.

Each system’s governmental payment structure and respective reimbursement rates for LTC were varied, as well; with a flat rate of pay for LTC in New Brunswick, and the considerable diversity in rates of payment in Clark County. The constraints which apply to the former statements, are again, directly related to "LOC" and "payment source". The Market Model would relate this distinction to the free-market "fee-for-service" philosophical approach to health care provision in the US, in correct explanation of inequitable distribution of care within the US. In a meeting of minds, Neo-Marxists equate capitalism’s "commodification of health care" with the Weberian indictment of "depersonalization" in human welfare, to explain current policies and procedures in US health care.

The category of provisional care, at the nursing home level in New Brunswick, and in Clark County also differed dramatically between the systems, with the mean level of residential care being far less extensive in Fredericton. In Fredericton all "skilled care" provision (acute care) is diverted to hospital facilities, contrary to the Clark County facility provision of both "skilled" and "intermediate". This has been the operational procedure for decades, and did not change with the inception of SEPS. The distinction prior to SEPS relates to the backlog of "chronic care" hospital patients awaiting nursing home placement. With the lack of community LTC services, pre-SEPS, the nursing homes were also at capacity, with many residents who could otherwise go home. The Fredericton region nursing homes administer only "intermediate care", with the transfer of all chronic "heavy care patients", whether categorized as "intermediate" or "skilled". Differentially, in Clark County, nursing home facilities provide for all levels of "chronic" care, and a selective provision of "skilled care", with the hospital’s transfer of a patient as soon as the
degree of acute care need is resolved, and the coverage of federal Medicare is terminated. This identified systematic distinction is, again related to "payment source" and "LOC" as they effect placement; both indicating strong "bureaucratic" constraints within the Clark County system. In the Fredericton region, they emphasize provisional care, rather than payment ability. In Clark County, however, the emphasis is on cost savings, in direct association to payer source for the exorbitant costs of hospital care. The Neo-Marxist theorems equally apply, with reference to the US private enterprise system's profit interests in LTC, and the commodification of care, which are reflected by nursing home staff shortages, and a "fast-food" approach to health care delivery.

The research disclosed systematic distinctions in financial eligibility guidelines to have a strong impact on "equitable" LTC accessibility in the US. In identic relation to both "rationalized bureaucratization" and "reified commodification", evidence of government resource consumption is illuminated among the three-tiered governmental approach to both acute, and long term medical needs. In Clark County both governmental assistance programs have defined limits for allowable assets to nursing home recipients, and their policies for "disposal of assets" apply equally as harsh. The distinction between these two systems lies with the elevated length of inflexible, ineligible time restraints imposed by the Nevada State Welfare system, for "senior victims of exploitation". Although Clark County Social Service is more approachable and accommodating in this circumstance, this form of asset "diversion" still requires investigation, and thus, still impacts accessibility; which is in complete contradiction to the Fredericton region's LTC operation, which allows for uninterrupted service provision.

The point of nursing home entry is considered to be one of the most contrasting distinctions between the two systems. In Clark County, the systematic point of entry involves three government layers, to discriminate both placement and payer source. In the Fredericton region only one level of government is involved, with the Single-Entry Point
system for LTC. This paramount and substantial association is connected to all ten of the identified constraint factors, and to all three perspectives: 1) the Market Models' diversification of decentralized government, 2) the Weberian application of "multi-agency structured" bureaucratic constraints, 3) and the Neo-Marxists' profit oriented commodification of medicine.

Significantly, the most dominant systematic distinction discerned by the research, is relative to dominant overall philosophy within each areas' political arena. The "for-profit: verses "non-profit" enterprise systems are clearly indicative of the provision for long term medical care as a "right", or a "privilege". Over 50% of the respondents in Clark County believed profits should not be made at the expense of the ill. Yet, in complete contradiction, the Fredericton region revealed a stronger reliance upon private resources for LTC, than did the Clark County respondents, in respect to nationalized health care coverage. This salient point appears to either relate to, all of the constraint factors, or none, due to the reversed reaction among respondents. Still, in Clark County, the "for-profit" orientation and "commodified" medical care distinctions most clearly relate to the Neo-Marxist perspective. In Fredericton, however, where profit is not a concern, this issue appears to apply more to the "bureaucratized rationalization" of limited resources.

**SYNOPSIS OF COMPARISON**

The two countries, containing the regions used in this study, were both an outgrowth of one country, England. While the United States ended this association in 1776, Canada continued to be part of this commonwealth. As a geo-political factor, this divergence was significant to both Canada, and the United States approach to health care, from both a historical and theoretical perspective. Health care began within the confines
of the Market Model perspective, nurtured by a free enterprise marketplace. The original theorems of the Market Model advocated for societal benefit, as tailored by the private enterprise system. Profit orientation without competitive restrictions would produce increased quality of health care, citing "selectivism" as a natural method of growth. As the US industry grew in size and impact, it necessitated a bureaucratic structure which as Weber theorized would increase societal benefit by making the Market Model's delivery system even more efficient, which still was humanistic in its desire. However, as growth was produced, the bureaucratic structure began to lose more of its formerly personalized approach, through the use of instrumental rationale to verify its methodology. Weber began to question this new approach in relative association to objectification of the individual it was founded to serve. As the bureaucratic model grew, rigid guidelines began to appear, thus endangering the Market Model's theorized societal benefit, due to restricted competition. Neo-Marxist thought was interpretive of this trend, and indicted the profit orientation of the Market Model, as polarized recipients of service into classes, which were externalized through the objectification process reinforced by the instrumental rationality of the bureaucratic model.

With this background in mind the reader is asked to recall the two questions, principally indicated in Chapter three to be most significant to this researcher's cause:

1. What contributing factors most strongly impact accessibility to LTC by the elderly residents of Clark County? By elderly residents of the Fredericton region? Is one system more accessible than the other?

2. How can we best compare the LTC operational approach of Clark County's Multi-Entry, Multi-Payment source system, and the Fredericton region's Single-Entry, Single-Payment source system, with their mutually prescribed functionary objective to promote independence of seniors, through the provision of requisite care within the least restrictive environment, and enhance accessibility to LTC by
disadvantaged seniors?

The United States has always embraced the free enterprise marketplace as the backbone of capitalism, and utilized this philosophy in its approach to health. Capitalism freely embraced the "market model" motif of profit orientation through competitive market forces, projecting that the marketplace, if left to its own accord will best serve society. As business is good for the "free-market" economy, commodification of health care is inevitable. In Canada, health care has always been viewed as a human right, has never been abandoned, and as Wolfe states, "they should be proud of their development of a national health care insurance plan for the entire populace". The Canadian Federal Medicare program, as with the US Medicare system, makes no provision for "custodial", or "chronic" LTC. One important distinction between the US and Canadian policies is that, if the LTC resident in Fredericton becomes "acutely" ill they are transferred to a hospital setting under federally funded Medicare coverage. However, the SEPS pilot program initiated in the Fredericton region of New Brunswick, was this researcher's third sample pool, to answer the two primary questions of accessibility, as measured through responses of providers directly involved with LTC. The comparative analysis of the two regions comprised a background, for the impact of the Fredericton region's SEPS program, in significantly increasing accessibility for LTC service to the elderly indigent.

The 15 local respondents strongly indicated the ineffectiveness of Clark County's health care approach, by their collated data of the 10 constraints. While Clark County defines their system, in regard to funding, as a government-private mix, with private pay being considered as a significant portion of this approach, it is illusionary. Those who can pay will, and those who cannot, fall into the governmental side of the funding assistance process.

For comparative measures in regard to question #1, the reader is reminded that nine of the ten identifiable constraints were assessed to cause, at least a moderate impact.
on LTC accessibility in Clark County. Of the nine constraints, eight were highly definitive with explanatory evidence as applying to Neo-Marxism. Seven of these eight, also reflected the commensurate association of Bureaucratization, while only one constraint was proven to be most clearly defined by the Market Model’s conception of "deregulation". "How accessible is Clark County’s system for LTC, in comparison to the Fredericton region’s?" Relying on the data acquired, five of the ten constraint factors were considered to have strong impact on accessibility in the Fredericton region, before SEPS, and only three constraints were moderately active, after SEPS. In response, Clark County does not appear to be very effectual in their health care approach. Of the five associated constraints before SEPS, and the three indicated to have any effect after SEPS, all were deemed to be most applicable to the "bureaucratic structure" conceptualized by Weber, in the absence of any profit orientation, political influence, or commodification of care.

In regard to question #2, ‘How do we best compare the two systems, and their mutually prescribed objective to enhance accessibility to LTC provision in the least restrictive setting, by all seniors?; "Why is the Fredericton regions’ LTC delivery more equitably distributed?" This is the most significant question that the research proposed to answer. Again, seven of the nine constraints that tested strong in Clark County, were found to be highly associative to both Weberian and Neo-Marxists dialects, with only one "most relative" association to the Market Model, and its perception of "restricted competition".

The answer to question #2, with regard to the significant disparity between accessibility in Clark County to Fredericton after SEPS is twofold. While funding for both region’s Medicare systems is centralized at the Federal level, with SEPS the five person panel responsible for service to the client in need, is a single entity; while Clark County remains a multi-agency, multi-tiered system, with the perpetuation of inefficient health
care delivery. While the Market Model advocates project profit orientation within a non-restrictive free enterprise marketplace, as developing cost-efficient, societally beneficial health care through selective evolvement, this rationale does little to explain the similarities or distinctions between Fredericton’s level of access and Clark County’s level of access, as measured by the raw data appendix. The valid assumptions of Weber’s Bureaucratic and the Neo-Marxist perspectives appear equally effective in explaining the disparity of Clark County and Fredericton in accessibility. They cannot be separated. Understandably, while the strength of bureaucratic constraints on the US long term care delivery system are clearly bureaucratic, their impact takes place within the profit-oriented, capitalistic context, hence a "modified-free" enterprise system of health care. It is maintained by this writer that the analytics of EFFICIENCY, COST-BENEFIT, SCARCITY OF RESOURCES, and PROFIT-ORIENTATION all interact to explain some similarities between Canada and the United States. However, as previously questioned, is the problem really related to "scarcity of resources", "instrumental rationality", or "improper distribution"? A consideration of the answer lies in the background of each country, while their respective health care policies evolved to the present day. In Canada, health care as a basic right, has always influenced their health care system with humanism. For the US, health care has become a "business or industry" within the free enterprise marketplace of capitalism. Legislature and policies have evolved from this background. With the Market Model citing scarcity of resources as hindering the efficiency of their distribution of service, the Neo-Marxist model proffers that scarcity in resources is a fallacy, resulting from free market enterprise "fetishism of commodities". Weber’s bureaucratic structure was originally theorized in the absence of any profit-orientation, political influences, or commodification of care. This utopian theorem is not in alignment today. While profit-orientation in accordance with the Market Model is not part of the Bureaucratic model, budgetary competition between government agencies, and
departments, is rampant. No governmental agency or interdepartmental unit is willing to surrender their space in the hierarchy of bureaucracy, or a dime of their budgetary funding for the cause of societal benefit. The first love of bureaucracy is their own rules.

And, while it appears that the US system's problems may have once been related to "scarcity", due to the lack of professional doctors and other medical practitioners, the solution to this problem was addressed through the introduction of capitalism and inequitable distribution. Yet, the current costs of health care, including LTC, are astronomical. One problem feeds on the other. BUREAUCRATIC CONSUMPTION and EFFICIENCY-BASED cost-containment policies, have resulted in the increased cost of medical care by respective providers, to bridge the gap between financial loss for provisional care, and the lure of PROFIT.
CHAPTER 8
CONCLUSIONS AND POLICY IMPLICATIONS

Without dispute it is the general consensus that the United State’s implementation of the Medicare and Medicaid programs has increased access to various forms of medical care by the indigent elderly and other disadvantaged groups. However, it is Olson’s contention that these programs have actually only been superimposed to create an “ineffective and unresponsive, privately controlled medical care market” (1982: 134). She points to severe inadequacies and shortcomings with both programs, stating that they have erroneously ignored preventative care and sufficient home-health services, while promoting increased institutionalization of the elderly, while allowing the exploitation of illness for profit. In her view, despite the numerous governmental resources that have been poured into Medicare and the Medicaid systems, little improvement has been made in regards to health care services and related problems. The argument over which bureaucratic system should pay for the indigent continues to unnecessarily stagnate health care provision for the elderly.

According to Olson, (1982: 128), our current American health care system has basically been shaped, both economically and politically, by those whose interests lie in increased profits, enhanced status, and the control mechanisms of this framework. The providers of health care, in Olson’s opinion, desire conformity of medical provision to suit the needs of capitalism; or as Marx would phrase it, the means of production. This philosophy, while undergoing some transformation as more of the population is affected,
is still prevalent in the ethics of today. Olson contends that our American culture has
tunnel vision, focusing its attention on economic perspectives at the expense of moral and
ethical considerations. Health care as a human right is the backbone and guiding principle
for countries like Canada with national health care systems, where medical services are
essentially provided on a non-profit basis.

The American ideals of individualism and libertarianism, have enculturated an
emphasis on self-reliance for all adult age groups, freedom of choice and the freedom
from societal and governmental intervention on health provision. Health care managed as
a commodity has apparently justified the unequal distribution of health care delivery in
accordance with ability to pay. Olson theorizes that socially-created fallacies of aging as a
problem, and alleged "fiscal crisis" within all levels of government, have amplified
organizational constraints and structural deficiencies in the United States. These fallacies
have created an impediment to the adoption of a universal health care program.

According to Olson, people in lower income groups are far more apt to
enter nursing homes and remain there due to the requirements by the state and local
assistance agencies to impoverish oneself in order to qualify for support. In addition
Olson states this conclusion is verified by the fact that only one-third of all residents in
institutions pay privately. Parallel to Olson, Robert J. Blendon (1986) claims that our
current public policies have virtually commodified health care by treating it as if it were
simply another private sector enterprise within the general economy. Blendon
acknowledges Olson’s declaration that fiscal pressures on federal and state
governments have resulted in a drastic decline in Medicaid’s coverage to our nation’s
poor and near-poor elders. He refers to the payment dilemma for the costs of
extended care or community care for the elderly as the “American middle-class
disease”, indicating that the middle class has historically absorbed higher payments for
their health care in order to subsidize coverage for the poor in the form of increased
private pay rates. This practice is extremely apparent in the Long Term Care (LTC) industry of Nevada by comparing charges to private paying residents with the reimbursement rates offered by Nevada State Welfare (NSW) and Clark County Social Services (CCSS).

In Nevada, as in other states, the Medicaid program’s reimbursement rates are severely inadequate to cover the actual cost of delivered care, according to the providers interviewed, resulting in the loss of money to hospitals and nursing homes on their "Medicaid admissions". Many health care providers are reportedly refusing to accept a patient who has yet to be approved for Medicaid, making the patient’s access to needed care nearly impossible. There are many local nursing homes that have initiated legal steps in a battle against NSW, for what they consider to be unreasonable reimbursement rates. According to the Las Vegas Review Journal, as of June 9, 1992, the Nevada nursing homes have been successful in recovering $1.3 million dollars from the Medicaid program, though $15 million was demanded originally.

It has been this writer’s experience that only a handful of nursing homes will accept a person who is pending approval of Medicaid coverage, and none will consider admission without some type of guaranteed payment insurance, placed on the Medicaid application. Medicaid processing time, according to those externally involved with the Medicaid determination procedures, average a minimum of three months for determination of eligibility, with some cases taking over a year. In the interim period no one gets paid - neither the nursing home, the physicians, those who are providing transportation, pharmacies, or other providers.

The Clark County Medical Assistance program pays a nursing home one dollar a day more per patient for an Intensive Care Level (ICL) 1 or ICL 2, and two dollars a day more for the ICL 3 resident, though the purpose of this additional allotment is actually to pay attending physicians, since the county does not provide direct payment to physicians.
The research discovered that many nursing homes and physicians in Clark County are unaware of this policy and, as a result, many physicians go uncompensated for their services. For the majority of patients, one or two dollars a day more is far from adequate to compensate the physician’s charges for those services rendered.

With the implementation of Medicare’s Diagnostic Related Groups (DRG) system within the United States, patients are being discharged sicker while still requiring far more intense medical care. As hospital clientele changes, so does the nursing home population. Through the studies of the two regions in New Brunswick, it appears that a similar trend is developing, towards the discharging of chronically ill patients to other types of LTC facilities, and the focused concentration on acute illnesses. While this may possible indicate a shift in philosophy, nothing has been set in motion to date. With the inception of the Single Entry Point System (SEPS) program in New Brunswick, a change in nursing home dependents has indeed resulted, as those requiring a lower level of care are returned to the community, and those with higher levels of care are being admitted.

If current demographic trends continue, according to the General Accounting Office (GAO), we can expect an increase of widowed elderly by 33% as we approach the year 2000. The GAO also predicts that the elderly among the upcoming generation will have fewer siblings and children to offer support, thus causing in a higher rate of nursing home placements. This potential burden on the Medicaid program is likely to increase in two ways. First, a significant increase in the population at risk of institutionalization is anticipated, and secondly, the intensity of services required by the older, sicker, more frail population with increased dependencies will give rise to increased nursing home admissions.

Though many experts argue that we are just undergoing a "phase" in demographics, and that our population will eventually balance out again, these two trends could have important policy implications for the Medicaid and local government
programs in the near future. Considering such indicators as longer life expectancies, the "over 75" group being the fastest growing segment of our population, early discharges from hospitals and the resulting increased admissions to nursing homes, Blend warns that the question of, "who will pay for the LTC cost of our elderly", will confront us with alarming momentum in the coming years.

According to Don Burroughs (1992), the current movement toward privatization has stirred up bureaucrats to the realization that their "monopoly" on social services may be threatened. He stressed that the public sector may be faced with the option of learning from the private business sector, or being replaced by it. Burroughs relates that a recent Times poll reflected that 70% of Americans believe government run programs to be inefficient and wasteful. One of the recommended solutions is to weed out layers of administration, while allowing more decision making by the lower level employees, which may be more effective in eliminating the gridlock in the system.

Samuel Wolfe (1991) foretells of similar trends toward privatization in some areas of Canada, as well as restrictions on their universal entitlement programs. These prevalent themes in both Canada and the United States have been coupled with what Wolfe describes as a neo-conservative political philosophy which advocates the capping of state and provincial budgets for social programs, and stresses more responsibility be held at the local level in order to meet their own basic social needs. If Wolfe is correct, he fears the movements could increasingly lead away from equity among the classes, and instead amplify social disparities in both countries. According to Wolfe, as a result of the regressive excise and sales taxes imposed in Canada between 1984 and 1989, along with an exemption on capital gains, the proportion of tax on income contributed by the lower income earners doubled, while the higher income group taxes remained the same. In regard to the free trade agreement between Canada and the United States, there is speculation that this may lead to a Canadian shift in the country's tax structure to favor
the rich, thus weakening ties between the east and west provinces, while strengthening ties between Canada and the United States. Wolfe feels strongly that this will occur. He further envisions a more regressive health care system within a more segregated class structure.

When all proposed reforms are analyzed, no clear cut policies present themselves as integral to the redistribution of income, or the diminished inequity of health care, or the increased longevity among the socially disadvantaged populace, which Wolfe states will always remain the same, as long as the issues of poverty and associated health statuses remain masked by the policymakers of both Canada and the United States. Because of the dispute over our diminishing resources and where they should be allocated, and the ongoing struggle between the federal, state or provincial, and local county or regional programs in both Canada and the United States, Wolfe is convinced that whether we prefer private or public action is a moot point, because every level of government, whether local or federal, is united in giving credence to its own form of de-bureaucratization, in competition for influence and continuation, none of which will succeed in correcting the imbalance at their own expense. In defense of the Canadian system, Wolfe points out that they should take pride in the successful establishment of a universal public payment system for general health care within a private practice enterprise, while 37 million Americans go completely uninsured for any type of medical care. It is hoped that the key prevailing philosophies of universality and medical care as an inalienable right, are not influenced by the aforementioned trends.

How does all this pertain to long term care? According to Wolfe, the present trend of placing greater emphasis on rehabilitation and ambulatory care, community-based care, prevention and health maintenance, will continue in Canada. This same emphasis continues to be encouraged in the state of Nevada. Wolfe submits that such a move should afford assurance of a more cost-effective and efficient distribution of health and
human resources in Nevada.

In the majority opinion of the canvassed providers of New Brunswick, the SEPS program has achieved its projection of service for LTC. Of the 15 respondents interviewed in the Fredericton region all but one were encouraged by the SEPS program and felt it to be both cost-effective and efficient, with only some minor adjustments being necessary. It is clearly evident that all the respondents believed the SEPS program to have had a positive effect on accessibility to LTC, especially within a nursing facility. Whether SEPS will act adversely on the nursing home environment, due to the increased admissions of those in a clinical state of deterioration, will be left to future research.

As the population of the US and Canada ages with growing survival rates, the need for a more compelling LTC policy becomes crucial, whether funding stems from federal, state, provincial, regional, or county government. However, policymakers have long avoided LTC issues for a number of reasons. According to Harrington et al, several sources indicate one major factors is, that a substantial portion of people involved with LTC policy, do not consider LTC to be a federal responsibility in an era of limited resources. This holds true both in Canada and the United States. With a growing interest in decentralization in New Brunswick, the financial aspect of this transference from the federal to the provincial level has not yet appeared to present a problem, with sufficient transfer funds continuing to be dispersed to the province, and in turn to the respective regions. Whether this will change or have any eventual impact, is undetermined at this point.

Harrington believes that a transfer of responsibility from the federal to state level of government within the United States, will ultimately result in one-half of the nursing home expenses being paid out of pocket, and the remainder to be covered by the virtually exhausted and ineffective Medicaid, or other public systems. The shifting of financial obligation, from one level of government to another, would not necessarily pose a problem
according to Lee and Benjamin, if at least two conditions were satisfied. First and foremost, the respective level of government that assumes this obligation, must be afforded the financial means to fund the responsibilities ascribed to them. Secondly, the respective administrative framework must be on line to assure appropriate regulation and financial accountability. It is the contention of Lee and Benjamin that the United States federal government has created conditions that limit the ability of the states to properly respond to Medicaid cutbacks, and that the result has led to the inaccessibility of proper care by those who are most in need.

In regard to state level funding of LTC, it is argued that the states do not tax as heavily as the federal government and, therefore have a limited ability to generate revenue. This pertains especially to the state of Nevada, which does not requisition a state tax at all. Considering a state level framework for the operation of LTC, there is apprehension that state and local governments may lack the political flexibility to make decisions in the best interest of the public and the consumer. Lee and Benjamin offer evidence in support of predictions that vast inequities would develop if the states were disconnected from federal standards for LTC, with some providing excessive provisions and others providing extremely narrow and inadequate assistance, due to the wide disparities across our nation.

The debate on both sides of the US, Canadian border between centralization and decentralization has not yet been resolved. Arguments in favor of centralization, with the maintenance of certain powers and functions under one central point of control, as Lee and Benjamin point out, include assured equality, guaranteed rights, better efficiency, competence, uniformity, and stronger unity. In line with Reagan’s plug for a "New Federalism" approach, opposing arguments in support of decentralization of health care, claim greater diversity, political sovereignty, limited federal power, better accountability and increased competence, as the benefits of their reform.

The "New Federalism" ideology severely limits direct federal involvement in health
and welfare programs which, according to Estes and Wallace, dismisses any societal obligation to support our nation’s basic human needs with regard to health, income, housing, or the overall welfare of our society. Yet, according to Lee and Benjamin, several states have already enacted drastic policy changes, which have severely deflated reimbursement rates to physicians, hospitals, and nursing homes; and have effectively transferred the financial burden for the indigent onto local governments.

At the 1987 hearing before the Select Committee, Representative Ron Wyden from Oregon advised that his state had developed a plan, which incorporates both the state and local government bodies to assist elderly people who require LTC, in staying in their homes at a lesser cost than nursing home facilities. Wyden recommends that the federal government change its rules, to allow the state and local governments the ability to jointly run these community based programs.

According to Harrington et al, there are 80 federal programs currently operating in the United States, which offer LTC financing including Medicare, Medicaid, the Department of Veteran’s Affairs, the Older American’s Act, and Title III and Title XX of the Social Services Act. This multitude of diverse programs, in Harrington’s view, not only produces disparities and tremendous gaps in regard to accessibility and coverage, it also creates massive confusion by those seeking assistance, while inflating administrative costs and, in essence, encourages a system grossly out of balance. Harrington’s proposes a plan that would offer universal access to a comprehensive, administratively efficient, and "user friendly" health care system. Under a federal mandate, this plan would arrange for a state LTC Planning and Payment Board, to work within a network of local public agencies, that would act as entry points to LTC. The local agencies in turn would establish a multidisciplinary approach with a specialized panel of social workers, nurses, therapists, and physicians responsible for assessing and coordinating a service plan.

Equipped with this plan the local LTC assistance agency would summarily assume
responsibility for distributing the available funds to cover operating costs of approved community providers, while the state LTC Planning and Payment Board would be responsible for the allocation of payment for all of the LTC services to each respective local agency from a budget formulated in accord to the overall population, using the actual number of elderly and disabled residents, and the price of living as parameters. Ironically, this proposition closely resembles the SEPS program which is beginning to spread across the Canadian provinces.

Like the SEPS program, should such a plan be implemented in the United States, each institutional provider would negotiate with the local LTC assistance agency for service costs and operating provisions on a yearly basis. A comprehensive budget would be mutually agreed upon with consideration given to past expenditures, service utilization, and projected changes in services, wages, and other related factors. Mirroring the Canadian system, this proposal would offer either a fee-for-service option to physicians, or a salary arrangement from institutional providers. All physicians and other care providers would have to agree to accept the prenegotiated public reimbursement as payment in full and not bill additional charges for their services.

As in Canada, the federal and state apportionments for LTC would be kept separate from those funding sources for acute care. Harrington et al, proposes that this health care design would consolidate all funds from existing public programs at the local, state, and federal levels; and then combine them with new federal revenues raised through a progressive taxation system. The coverage under this proposal would be extended to all income groups requiring assistance with at least one Activities for Daily Living (ADL) deficit, without any means testing. Although based solely on need, with the previous financial barriers removed, it is anticipated that LTC service will demand increased implementation, as demonstrated in Saskatchewan, Alberta, and New Brunswick; however, utilization could be expected to level off over an approximate three year period,
as theorized by Harrington.

It is the contention of Harrington and her associates that LTC is a right, not a privilege, with accessibility based on need rather than financial ability to pay. Of the 16 persons interviewed in Clark County including LTC providers, acute hospital administration, and assistance agency personnel, 56% would agree with this philosophy. Not surprisingly, 100% of those interviewed in New Brunswick stressed the importance of LTC as an inalienable right, even though it is not part of their National Health Care Insurance Plan.

As the director of Clark County Social Services, Denell Hahn agrees full heartily that our counties should be able to tailor their programs to meet the needs of their residents, because the Nevada counties are so diversified. To absorb all of the costs of LTC for the entire Clark County population, however, the county would have to be able to access comparable funding mechanisms which the state currently has, including federally matched funds. Hahn states that this goal could be attained through a more cooperative effort on the part of all governmental agencies at the federal, state, county, or local levels to work together, combining their energies to minimize bureaucratic waste, accelerate client services, and allocate our limited resources where they belong, to the best interest of those we are attempting to assist.

According to Brandon et al (1991), the United States government, though faulted for its inefficiency, is far more effective in administrating health care coverage than the private sector. To justify his claim, Brandon reflects that only 2.3% of Medicare claims go towards administrative costs. Ideally, if our system could be designed to decrease excess administrative expenditures, we could feasibly provide more medical services to those in need without increasing overall costs. It is apparent, in this writer's opinion, that our existing health care system within the United States for, both short and long term care, must be radically altered from the wasteful, patchwork system currently in force.
It is obvious that all services paid for through general funds in the United States are subject to cuts, usually at the mercy of politicians. The gradual Medicare and Medicaid budget cutbacks over the years have resulted in payment of less and less to doctors, hospitals, and nursing homes, frequently offering less than the actual cost of delivered care. There is an ongoing struggle over who should pay for what services for our indigent. Patients in Clark County continue to be shuffled around among hospitals and nursing facilities in accordance with their payment source, without regard to their humanity, as personally witnessed by this writer. It is also evident that as the emphasis on payment sources and profit increases, accessibility to equitable services by all income groups decrease. Yet, with the creation of the "welfare state", the above providers have become dependent on the state Medicaid and federal Medicare programs for continued operation. Attempts to manage the health care system a piece at a time have been ineffective. Physicians and long term care facilities charge privately paying persons more, in an effort to make up for the Medicare, Medicaid fee restrictions. With our "band-aid" philosophies, the solutions have inevitably become the problems.

With all of the red tape and volumes of paperwork involved with billing for services, our inequitable system of reimbursement has raised the cost of medical care for the total population, insured and uninsured alike. In order to preserve the mirage of a private system we have created the most bureaucratic, over-regulated, resource consuming system in the industrial world, reflects David Mechanic, Director of the Institute on Health Care Policy at Rutgers. (Consumer Reports July 1992: 448) Private providers and public agencies alike have been forced to hire additional staff to help cope with the increased demands of third party review, regulations, and paperwork. This same article portrays that out of the estimated $817 billion will be inappropriately distributed toward overpriced, unnecessary treatment, and a bloated bureaucracy, with $163 billion alone going to administrative costs.
As the political economical approach to aging dictates, we must begin to analyze the "problem" of aging from a structural point of view, incorporating the broader spectrum of our social, political, and economic environment as it interrelates to affect the aging process. One main argument posed by political economists is that aging has been stereotyped as a problem by those who devise social policies. The result is that social policies and programs established for the elderly are, in essence, contributing to an "aging enterprise" which creates dependency and perpetuates poverty and class differences. According to the political economy approach, these socially created programs and policies have been developed for the purpose of social control and tend to fit the needs of a capitalistic society as opposed to benefiting the elderly. Many of the programs are regulated by bureaucracies which have as their primary aim, in the view of political economists, the continuation and legitimization of their existence rather than the provision of aid to the elderly, perpetuating limited access to equable medical care by our indigent elderly. It is this writer's contention that too much time, expense, and energy is wasted between the county, state, and federal levels of government in the United States, disputing over whose responsibility it is to assist with the short and long term medical needs of this population. It is suggested that the combining of services and programs under one central agency would curtail costly overhead and administrative expenses, thus redistributing "new funds" to those in need. At the very least, as suggested by Hahn, a serious effort must be given by the three-tiered governmental system in Nevada, to offer a more coordinated, cooperative, and efficient delivery of services. The pooling of resources could generate a more effectively run system, with application of the redeemed capital to the care of the elderly, disabled, and other disadvantaged groups, where it can really make a difference.

It is believed that the taxes collected to pay for a health care system, should be based on a progressive tax rate, or flat tax, which would include the assets and resources
of the taxpayer, as well as income; and that the distributive share would be accrued proportionately across class lines, so that the middle class currently carrying this burden, through mandatory, regressive payroll tax schedules, could witness some reprieve.

In accordance to Marx and the political economy approach, the owners of the "means of production" will always have more power to influence policy over the welfare of society. But, in our day and age, as more people become informed or affected by the inequities of our current health care system, our society could collectively advance great influence over policy formation. Through proper education, health care should come to be viewed as a human service, conductive to an overall healthier society; as opposed to a commodity, measured by a "bottom line". As we learn to blend our business ethics with our health care ethics, through critical analysis and reeducation, positive results can be achieved.

LIMITATIONS OF THE STUDY AND SUGGESTIONS FOR FUTURE RESEARCH

Previously indicated was the fact that this writer’s employment has resulted in a close association with all of the hospitals and nursing homes in Clark County, as well as with both Nevada State Welfare and Clark County Social Services over the past seven and a half years, which may or may not be construed as an intervening variable in regard to securing an unbiased sample. Utilizing face to face unstructured interview methods, according to some authors can be highly susceptible to interview bias. While it is true that this writer is familiar with every person interviewed, an avid attempt was made to decrease bias by addressing this specific issue at the beginning of each interview. Each of the Clark County respondents was asked to bypass the fact that they knew me or the agency I am affiliated with, and to assume that my knowledge of the subject matter in question is
limited. Also, the questions were phrased in such a way as to promote unsolicited or unbiased responses. This technique appeared to be effective, and credible.

The use of a tape recorder with each interview conducted could possibly be misinterpreted by some as creating reactivity, and placing limitations on the reliability of the information given by respondents. However, the approach implemented to counteract this prospect was to assure each resident that any sensitive information offered would be held in the strictest of confidence, and that their anonymity would be maintained if they so desired. As already discussed, it was explained to the respondents that the tape recorder would provide for a smoother interview process, assuring less errors with the interpretation of their responses, and save time due to their busy schedules and my time allotment. I firmly believe that the tape recorder did allow for a more free-flowing interaction, resulted in less errors of recording data, and did not appear to have any noticeable effect on the interview.

Though anonymity to the respondent was very difficult to assure, considering the fact that the cover letters within the appendix do specify who was contacted, not to mention the small sample units they were selected from; fortunately this did not appear to pose a problem for any of the respondents. According to Lofland and Lofland (1984), some researchers argue that when studying large organizations or certain subject matters, the guarantee of anonymity may be deemed unnecessary, or even inappropriate.

Because of the relatively small sampling size to choose from in both research areas, random choices were difficult, and all but impossible within some spheres, as previously acknowledged. As with all non-probability sampling, including convenience, purposive, and snowball sampling techniques, the researcher cannot claim that those selected for interview are representative of the larger population. Therefore, the ability to generalize is severely limited. It is believed, however, that the accuracy lost in convenience sampling is offset by conservation of time and money; that the information received through purposive
sampling is valid and reliable, coming from those most knowledgeable to the intent of this study; and that the snowball sampling technique used for New Brunswick allowed for informants to identify others who should be included in the study so as to leave few, if any gaps in data collected.

It should be noted that with the random sampling process utilized to select hospitals within the Clark County area, this researcher fortunately chose the one non-profit institution, and the one for-profit institution that extends "guarantees" on their Medicaid applications, (in addition to the Clark County Social Services guarantee earlier discussed), causing their respective discharge delays to be far less than the majority of hospitals that do not provide the same when complex cases and financial matters occur. A more extensive comparison study with respect to all nursing homes and hospitals and their discharge delays could also prove to be beneficial for further research.

It is recognized that throughout the research conducted for this thesis, this writer was prone to look for literary evidence to support the purported ineffectiveness of our current welfare system, aware of the possibility that this might lead to a rejection of discrediting material. It is maintained, however, that the reliability of this study would be authenticated, in that, should the same subject matter be studied by others using the same population results, they would be consistent. It should also be found by other researchers that the majority of the articles written about our welfare system clearly describe our system as being inept, inefficient, filled with bureaucratic waste, discriminatory in relation to the elderly indigent’s access to equitable services, and in dire need of reform. Additionally, it is believed that those interviewed provided sufficient credence to the claim that the poor and near-poor elderly without an established payment support system, do not have equal access to LTC as those that do.

The lack of accurate data regarding the length of time patients use private resources before converting to Medicaid continues to limit consideration of many public
and private policies on nursing home care, although nationwide studies conducted by the GAO indicated that approximately 50% of private paying residents took an average of six months for conversion over to Medicaid, which indicates a strong relationship between nursing home use and the risk of welfare dependency within a relatively short length of placement. The GAO has acknowledged the fact that there are major gaps in information on the most basic components of Medicaid’s support provisions for nursing home care, causing serious difficulties in their efforts to access programs across the states. One past measurement used by the GAO to determine access difficulties experienced by Medicaid and potential Medicaid clients, was to analyze the length of waiting time for placement in hospitals. The GAO further acknowledges that their data on the needs of the persons under consideration of placement, and on actual patient discharge delays in acute care facilities and the related expenditures, are now antiquated and current ones have yet to be compiled, placing the reliability of their reports in question.

Essentially, there is evidence from the majority of sources, that the patients’ individual characteristics and care needs, accented by a shortage of available beds, and our current state Medicaid policies have acted to reduce accessibility to LTC for both Medicaid eligible and potential Medicaid recipients; although the true extent to which these access problems exist is still difficult to assess. A lack of nationwide data hinders the ability to determine how the same problems compare statewide, or how effective federal and state wide statutes and regulations have been in alleviating the identified problems. This issue might also be addressed in further research studies, however, that topic falls far beyond the realm of this particular thesis project.

In the US, additional comparative studies could be conducted between one of the more progressive states, such as Hawaii or Florida, who have revised their health care plans to reportedly include relatively universal medical coverage for acute and long term medical care, with a state that has not; or compare a state offering Medicaid coverage to
the medically needy and the categorically needy. In this country's profit oriented alignment of cost versus benefit, it may also prove significant, or at least interesting to compare and contrast cost effectiveness between a country such as Canada, offering a single payer system, with the United States, which operates a multiple payer system.

Comparison studies in Canada might include researching the provinces which offer the SEPS program to those who don't, with special consideration given to the accessibility to LTC. Additionally, one could compare the presence or absence of SEPS, between provinces which provide LTC coverage as a component of their national health care program with one that does not. Needless to say, the issue of medical care and coverage is very prevalent in both Canada and the United States today, and any reform measures will require extensive analysis to assure the proper utilization and distribution of our proclaimed, invaluable and severely limited resources.
APPENDIX I

CONDENSED INTERVIEW GUIDE

GENERAL QUESTIONS FOR GOVERNMENT ASSISTANCE AGENCIES
SELECTED FROM THE INTERVIEW GUIDE, WHICH ARE SPECIFIC TO THE
IMPACT OF CONSTRAINTS TO ACCESSIBILITY TO LONG TERM CARE.

1. What is your agency’s function in regard to nursing home placements, group care
or special home placements, and in provision of community care services for the
(indigent) elderly?
(FOR FREDERICTON ONLY) Has your agency’s function changed since the
implementation of the Single Entry Point System (SEPS) pilot program? If so,
how? Please explain.

2. How many (on-line) staff are in your Long Term Care (LTC) unit? What are their
functions? What is their average caseload size?
(FOR FREDERICTON ONLY) Has your agency staff’s function, size, or
clientele changed any with the implementation of SEPS? If so, how? Please
explain.

3. From what sources do you receive your referrals for assistance with LTC?
(FOR FREDERICTON ONLY) Has this aspect changed since the
implementation of SEPS? If so, how?

4. What is the size of the population you serve for LTC? (How many people
currently receive your agency’s assistance with LTC?) With nursing homes or

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other LTC facilities? In the community?

- Is there a limit on the number of people your agency is prepared to serve?
  If limited, by what means do you determine which people to assist?
- How many applicants are currently pending assistance with your agency?

(FOR FREDERICTON ONLY) Has the population at risk changed (in any form) since the implementation of the SEPS program? If so, how? Please explain.

5. Please describe your agency’s application process for LTC service provision and placement. What criteria do you use to determine the applicant’s eligibility for service? Please explain.

- How does your agency determine validity of financial information regarding income or assets of applicants?
- What time frames are allowed for the applicant to produce required information for eligibility determination? Please explain.
- What is the capacity of your agency able to assist applicants who are unable to provide information for eligibility due to mental or physical incapacitation?
- What of those applicants who are unable to access their resources?
- What of those applicants who have been exploited?
- What if the applicant is not able to provide all required information by the before the allotted timeframe deadline? Please explain.
- Does your agency have the capacity to recover assets if they are later discovered?
- What provisions are made for a spouse remaining in the home? (e.g. income, resources, assets, joint bank accounts, etc.)

(FOR FREDERICTON ONLY) Has your agency’s eligibility criteria changed in any way since the SEPS program was implemented? If so, how? Please explain.
6. What is the average amount of time it takes to process an application for service eligibility?

- What factors would you say most effect the processing time?
- Does your agency provide payment to the LTC facilities while eligibility of a resident is being established? If not, who pays during this time?

(FOR FREDERICTON ONLY) Has the application processing period changed since the implementation of SEPS? If so, how? Please explain.

7. What criteria is used by your agency to determine a client’s Level of Care?

- Please explain your LOC screening process.

(FOR CLARK COUNTY ONLY) Do the agency (LOC) guidelines differ between the state and the county? Does the screening process differ? If so, how? Please explain.

(FOR FREDERICTON ONLY) Has the criteria or screening process changed with SEPS? If so, how?

- What LOC factors do you find to most effect the types of services and medical care facilities available to the indigent elderly in need of LTC? Please explain.

8. What are your agency’s guidelines to establish provisional LTC services within the community as opposed to LTC facility placement?

- To what extent does your agency provide LTC community services? Please explain.

(FOR FREDERICTON ONLY) Has the implementation of SEPS effected your agency’s guidelines for provisional care? If so, how? Please explain.

9. How many nursing home facilities do you have in your area?

- Do you contract with all of the facilities?
• What is the function of your agency in regard to the licensing or regulation of LTC facilities? Please explain.

• What is the occupancy rate of each facility?

• What levels of care are provided in these facilities?

• What criteria is used by the nursing facilities to determine LOC? Please explain.

(FOR FREDERICTON ONLY) To what extent has the implementation of SEPS effected the nursing home population? Please explain.

10. What is your agency's current rate of reimbursement to the nursing homes for each LOC medical need?

• How is the reimbursement rate determined?

• How do you determine what medical supplies and provision will be covered as a "facility item" or "agency item", in regard to financial payment?

(FOR CLARK COUNTY ONLY) Does the rate of reimbursement vary between the state and the county? If so, how? Please explain.

11. What is the average length of time an elderly welfare recipient remains on a waiting list for nursing home placement from the community in your region? For community services?

• What types of problems are encountered in your attempt to arrange LTC services from the community for the indigent elderly client? For LTC placement? Please explain.

• What factors or variables do you find most effect the waiting period for LTC community services? For LTC placement from the community? Please explain.

(FOR FREDERICTON ONLY) Has the implementation of SEPS had any impact
on your agency's ability to arrange for LTC placement or service provision for the community elder in need of LTC? Please explain.

12. What factors do you find most effect an indigent elder's accessibility to LTC facility placement from an acute care setting? Accessibility to LTC in the community from an acute care setting? Please explain.

(FOR FREDERICTON ONLY) Placement accessibility from acute care, before SEPS? After SEPS?

13. When one of your ongoing clients is being discharged from an acute care setting, who determines the level of care needed by the patient? What is the normal procedure for the hospital's discharge plan of your client? What is your agency's role in the discharge plan? Please explain.

14. What about the hospital patient who has no payment source? What is your agency's role in discharging these patients? What other government agencies are involved with the discharge plan for LTC provision and assistance to elder indigents? Please explain.

15. In your experience, what is the average length of time an indigent elder without an established payment source remains on a waiting list for nursing home placement from the acute care setting?

   - For placement in the community with LTC services?
   - What factors would you say most effect hospital discharge processing time for the indigent client in need of LTC services or placement who does not have an established payment source?

(FOR FREDERICTON ONLY) Has the implementation of SEPS had any impact on the discharge processing time for the elder in need of LTC? Please explain.

16. When an indigent client requires nursing home placement or LTC community services, what is the procedure for establishing a physician to follow the care of
the recipient of LTC assistance with your agency? For the patient who does not have an established payment source?

- Does the establishment of a physician have any impact on the type of LTC services or placement available to the indigent elder? Please explain.

(FOR FREDERICTON ONLY) Impact of establishing a physician, before SEPS? After SEPS?

17. What is your agency’s budget allowance for LTC community services and facility placement of indigent elders?

- Would you consider your agency’s budget to be commensurate with the elderly client need in your area? Please explain.

(FOR FREDERICTON ONLY) Has the implementation of SEPS had any impact on the budget allowance for LTC provisional care? Please explain.

18. We have discussed a lot of factors which appear to impact an indigent elderly person’s ability to access LTC services and facility placement. Can you think of anything we have not covered?

- Of the following indicated factors, which would you say pose the most constraints to LTC placement for the indigent elder? For community service provision?

- How would you qualify the impact of these factors: strong impact, moderate impact, minimal impact, no impact?

(FOR FREDERICTON ONLY) Impact before SEPS? After SEPS?

19. On a scale from 1 - 10 (with 1 being lowest and 10 being highest) how accessible would you say LTC provision is to those who are unable to pay privately for services? Please explain.

(FOR FREDERICTON ONLY) Accessibility before SEPS? After SEPS?

20. On a scale of 1 - 10 (with 1 being the lowest and 10 being the highest) how
satisfied are you with your current LTC system for the indigent? Please explain.

(FOR FREDERICAON ONLY) How would you rate your satisfaction with the system before SEPS?

21. (FOR CLARK COUNTY ONLY) There has been a lot of talk this election year about devising a national health care plan. Should such a plan be implemented, do you believe that national coverage should include provisions for LTC delivery? Please explain.

22. (FOR FREDERICAON ONLY) Can you explain why LTC nursing home placement and services have not become part of your national health care (Medicare) plan. How do you think the cost of LTC for the indigent should be paid for? Please explain.
GENERAL QUESTIONS FOR HOSPITALS SELECTED FROM THE INTERVIEW GUIDE WHICH ARE SPECIFIC TO THE IMPACT OF CONSTRAINTS ON ACCESSIBILITY TO LONG TERM CARE.

1. What services does your hospital provide to the elderly? From where does your hospital receive it's funding? What is this hospital's bed capacity?

2. What is your hospital's function in regard to nursing home placements, special care homes, community service provision, and other discharge planning responsibilities to the elderly in need of LTC?
   - How many discharge planners/coordinators are employed by your hospital?
   - What are their functions in this regard?
   - What is the average size of their caseload?

(FOR FREDERICTON ONLY) Has this function changed in any way since the implementation of the SEPS pilot program? And, if so, how? Please explain.
   - Has the caseload size changed any with the implementation of SEPS? And, if so, how? Please explain.

3. What criteria is used by your hospital to determine a patient's Level of Care?
   - Please explain your LOC screening process.
   - What LOC factors do you find most effect the types of LTC services or facilities available to the indigent elderly? Please explain.

(FOR FREDERICTON ONLY) Has the LOC criteria or screening process been effected in any way by the implementation of SEPS?

4. How many nursing home facilities are there in this region? What is each one's bed capacity? What levels of care are provided in each of the facilities?

(FOR FREDERICTON ONLY) Has the number of nursing home facilities or bed capacity been altered as a result of the implementation of SEPS? And, if so, how? Please explain.
5. When you receive an order for LTC placement of an elderly patient, please explain your assessment process from the onset of the discharge order to actual discharge.

- Who actually determines that LTC is needed?
- What factors are involved which determine what LTC services or facilities are available to the respective patient?

(FOR FREDERICTON ONLY) How has this discharge process changed since the implementation of SEPS? Please explain.

- What factors most effect your capacity to discharge the indigent elder in need of LTC provision? Please explain.

6. When you receive an order for LTC placement or services for a patient who lacks the resources to pay for this care, what is your normal procedure for discharge planning?

- What methods are used to determine the patient’s resource availability for payment? Please explain.
- What methods are used to establish a payment source for those without resources to cover the cost of LTC? Please explain.
- If the elder in need of LTC requires governmental assistance for LTC, who initiates the application process with the respective government agency? Who follows the application after the patient is discharged? Please explain.
- How many governmental agencies are involved with the payment of LTC for the indigent elderly? If more than one, how does your hospital determine which agency to approach for assistance? Please explain. If more than one, how does each agency’s guidelines and screening processes, rates of reimbursement compare? Please explain.
- What factors (variables) are involved which most effect your capacity to establish a payment source for the indigent in need of LTC? Please
(FOR FREDERICTON ONLY) How has this discharge planning function or capacity changed, with regard to the indigent elderly, since the implementation of the SEPS? Please explain.

7. What percentage of your hospital’s elderly patients would you say are placed in a LTC facility as:
   - Private paying resident?
   - Under Medicare or other insurance coverage?
   - Whose care is subsidized by a government assistance program?
   - Who have not yet been approved for government assistance? Please explain.

8. What percentage of the elderly patients requiring LTC are returned to their home with community services:
   - Who pay privately for provisional care?
   - With service provision under Medicare or other insurance coverage?
   - With service provision being funded by a government assistance program?
   - Who will be pending governmental assistance for their LTC coverage? Please explain.

9. What is the average length of time it takes to discharge an elderly patient, still in need of LTC in some sort after the acute care need is resolved, and the doctor’s discharge order is received, to a nursing home, special care home, or own home with community services, for the elder who is:
   - Paying privately for care.
   - Under Medicare or other insurance coverage?
   - The ongoing recipient of government assistance for care?
   - Pending approval for government assistance? Please explain.
• What factors have you found to influence this discharge waiting period most? Please explain.

(FOR FREDERICTON ONLY) Has this waiting period been effected in any way by the implementation of SEPS? And, if so, how? Please explain.

10. What types of community services are available to the patient in need of LTC in the home who will be paying privately for provisional care?

• For the patient under Medicare or other insurance coverage?
• For the patient receiving ongoing governmental assistance for provisional care?
• For the patient who is pending governmental assistance for provisional care?
• What factors do you find most influence the availability of LTC community services to the indigent elder? Please explain.

(FOR FREDERICTON ONLY) Has the implementation of SEPS effected LTC community service provision in any way? And, if so, how? Please explain.

11. What is your procedure for establishing a physician to follow the long term medical care of an elderly patient who is:

• Paying privately?
• Under Medicare or other insurance coverage?
• The recipient of ongoing government assistance?
• Pending approval for government assistance?
• What factors are involved which most effect ability to establish a physician to follow a patient’s care? Please explain.

(FOR FREDERICTON ONLY) Has the implementation of SEPS in any way effected the process of establishing a physician to follow? And, if so, how? Please explain.
12. Does the establishment of a physician to follow the long term medical needs of a discharged patient have any impact on the type of LTC service or placement availability to the indigent elder? Please explain.

(FOR FREDERICTON ONLY) Has the implementation of SEPS impacted this factor in any way? And, if so, how? Please explain.

13. We have a lot of factors which appear to impact an indigent elderly person's ability to access LTC placement and services. Can you think of anything we have not covered?

- Of the above indicated factors, which would you say most impact accessibility to LTC placement by the indigent elder? Accessibility to LTC services in the community setting? Please explain.

(FOR FREDERICTON ONLY) Before SEPS? After SEPS?

- How would you qualify the impact of these factors: strong impact, moderate impact, minimal impact, no impact?

(FOR FREDERICTON ONLY) Before SEPS? After SEPS?

14. On a scale of 1 - 10 (with 1 being lowest and 10 being highest) how accessible would you say LTC provision is to the elderly who lack the resources to pay for services? Please explain.

(FOR FREDERICTON ONLY) How would you rate accessibility to LTC before SEPS? Please explain.

15. On a scale of 1 - 10 (with 1 being lowest and 10 being highest) how satisfied are you with the current LTC delivery system for the indigent? Please explain.

(FOR FREDERICTON ONLY) How would you rate your satisfaction of the system before SEPS? Please explain.

- Why do you believe the costs of nursing home care and other LTC services
have not become part of your national health care (Medicare) insurance plan? What is your personal opinion regarding the coverage of LTC costs? Please explain.

(FOR CLARK COUNTY ONLY) There has been a lot of talk this election year about devising a national health care plan. Should such a plan be implemented, do you believe that national coverage should include provisions for LTC delivery? Why or why not? Please explain.
GENERAL QUESTIONS FOR NURSING HOME PROVIDERS SELECTED FROM THE INTERVIEW GUIDE WHICH ARE SPECIFIC TO THE EFFECT OF CONSTRAINTS ON ACCESSIBILITY TO LONG TERM CARE.

1. Please explain your admission criteria. From where do you receive your referrals? (FOR FREDERICTON ONLY) Has the admission criteria changed in any way since the implementation of SEPS? Please explain.

2. Do you accept both private and government subsidized residents?
   - If yes, what percentage of the residents currently cover the cost of care with private resources? With Medicare coverage? With government subsidies?

   (FOR FREDERICTON ONLY) Has this percentage changed in any way with the implementation of SEPS? Please explain.

3. What is your facility’s overall bed capacity?
   - What levels of care do you provide for within your facility?
   - What is your bed capacity for each LOC?
   - What criteria is used to determine the level of care required?

   (FOR FREDERICTON ONLY) Has your facility’s occupancy rate or LTC criteria changed in any way with the implementation of SEPS? Please explain.

4. What is your daily per diem rate? Please explain.
   - What is the daily reimbursement rate paid by the government for their clients’ care?
   - Does Medicare cover the cost for any of your services? If yes, what are the reimbursement rates provided by Medicare?
   - What percentage of your residents pay privately for their care? Receive governmental assistance? Have no established payment source?
(FOR FREDERICTON ONLY) Have these percentage rates changed in any way since the implementation of SEPS? Please explain.

5. How long is your waiting list for admission of a prospective resident paying privately? Who is subsidized by the government? Who has no established payment source? What is your facility policy regarding the establishment of a person’s payment source prior to admission?
   - Please explain what factors are involved with the waiting list for placement.
   - How many private rooms do you have? How long is your waiting list for a private room?
   - Please explain what factors are involved with the waiting list for a private room.

(FOR FREDERICTON ONLY) Has the waiting list for placement or private rooms changed in any way with the implementation of SEPS? Please explain.

6. How does your facility establish a physician to follow a residents care who is paying privately? Receiving governmental assistance? Pending governmental assistance?

(FOR FREDERICTON ONLY) Has this factor changed in any way since the implementation of SEPS? Please explain.

7. When a private paying resident depletes their resources, how does this effect this facility’s ability to provide for ongoing care?
   - What is your procedure for assisting residents in need of governmental assistance for nursing home costs? Please explain the process involved.
   - How many governmental agencies are involved with this process? If more than one, how does your facility determine which agency to approach?
   - How does your facility establish what care items are to be included within the resident’s rate of reimbursement and what items are to be covered by
the respective governmental agency subsidizing care?

(FOR FREDERICTON ONLY) Has this process changed in any way with the implementation of SEPS? Please explain.

8. What is the average length of time it takes to process an application for governmental assistance for a resident? Please explain what factors influence this process most.

(FOR FREDERICTON ONLY) What was the average length of processing time before the implementation of SEPS, and what factors influenced the process most?

9. What is your facility procedure for discharging a resident back to the community, or to a lower level of care facility when nursing home placement is no longer required, but some form of LTC is still needed?

- What factors are involved which most impact this process? Please explain.
- How long is the average waiting period to establish community LTC provision for the elderly patient without any established resource to pay?

(FOR FREDERICTON ONLY) What was the facility procedure for discharging the resident, before the implementation of SEPS? What factors were involved which most impacted this process? Please explain.

10. What is the average length of time involved with a resident's discharge to a lower level of care facility? To a community placement? Please explain what factors are involved with this process and how they effect discharge.

(FOR FREDERICTON ONLY) What was the average length of time involved before the implementation of SEPS?

11. We have discussed a lot of factors which appear to impact an elderly person's ability to access LTC provisional care. Can you think of anything we have not covered?
• Of the above indicated factors, which would you say impact accessibility to
LTC coverage and provision the most?

(FOR FREDERICAON ONLY) Which of these factors would you say impacted
accessibility most, prior to the implementation of SEPS?
• How would you qualify the impact of each of these factors: strong impact,
moderate impact, minimal impact, no impact?)

(FOR FREDERICAON ONLY) How would you qualify the impact of these
factors, prior to the implementation of SEPS? Please explain.

12. On a scale of 1 - 10 (with 1 being lowest and 10 being highest) how accessible
would you say LTC is to those without the resources to pay? Please explain.

(FOR FREDERICAON ONLY) How accessible would you say LTC was to
those without the resources to pay, before the implementation to SEPS? Please
explain.

13. On a scale of 1 - 10 (with 1 being lowest and 10 being highest) how satisfied are
you with the current LTC system for the indigent? Please explain.

(FOR FREDERICAON ONLY) How satisfied were you with the LTC system
before the implementation of SEPS? Please explain.

14. (FOR CLARK COUNTY ONLY) There has been a lot of talk this election
year about devising a national health care plan. If implemented, do you believe it
the plan should include provisions for LTC? Why or why not? Please explain.

15. (FOR FREDERICAON ONLY) Can you explain why LTC nursing home
placement and services have not become a part of the national health care
(Medicare) insurance plan?
• Do you believe that the national health care plan should cover the cost of
LTC? Why or why not? Please explain.
APPENDIX II

Chart 1

RAW DATA SHEET
ACCESSIBILITY RATINGS

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187
## Chart 2

### CUMULATIVE DATA SHEET

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\[ R_1 = 215.5 \quad R_2 = 168.5 \quad R_3 = 81 \]

\[ N = 30 \]
Chart 3

ACCESSIBILITY RATINGS

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APPENDIX III

Chart 1

TOTAL IMPACT OF CONSTRAINTS WITHIN SAMPLE GROUPS

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SAMPLE GROUP CONSTRAINT VALUE  \( A = .74 \)  \( B = .47 \)  \( C = .05 \)

INDIVIDUAL CONSTRAINT VALUE BY SAMPLE GROUP

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DEGREE OF INFLUENCE CHART FOR THREE PERSPECTIVES

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Total Influence Degree By Each Sample Group

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**Total Influence Degree for Each Sample Group**

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**Total Influence Degree for Each Sample Group**

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Sections 501.1 through 506.1 of the Nevada State Welfare (NSW) Manual (June 10, 1991) defines the distinctions between skilled nursing care and intermediate (custodial) care services within nursing homes, and distinguishes in detail the separate type (levels) of care within both categories. According to one local nursing home operator, the term "level of care" is a state welfare creation designed for the Purpose of determining reimbursement rates in accordance with nursing hours required for the different types of care, and to offer specific guidelines as to the facility's responsibilities for each category. Like New Brunswick, the Nevada nursing homes charge a flat rate for all persons requiring intermediate care. Said rates, however, only apply to private paying residents. The same practice is applied to private paying residents in Nevada who require skilled care, which the reader will recall is not offered in the New Brunswick nursing homes as a rule.

According to the NSW Manual, skilled nursing and skilled rehabilitation services are those which are ordered by a physician who also offers specific directives, needed on a daily basis, and are required to be administered on an inpatient basis in a skilled nursing facility. Skilled care would include services such as gastrointestinal feeding, IV therapy, treatment of decubitus ulcers (bed sores), etc. A skilled nursing facility (SNF) is defined as one specifically qualified to provide skilled nursing care or rehabilitation services only by, or under the supervision of licensed nursing personnel or a professional therapist based...
on doctor's orders. According to the 1990 and 1992 Medicare handbooks, most nursing homes in the United States are not skilled nursing facilities, or do not participate in the Medicare program, which is certainly not the case in Southern Nevada. The majority of the nursing homes in Clark County accept both skilled and intermediate care clients and do participate in Medical.

Intermediate care level (ICL) services are defined as health-related services provided to individual who require at least some assistance with their everyday affairs, referred to as "activities of daily living (ADL)"; such as bathing, dressing, eating, ambulating, toileting, transferring from a wheelchair to bed, etc. These individuals do not require the intense care which a hospital or skilled nursing facility is able to provide, but do require certain services due to their mental or physical condition.

An ICL 1 patient or resident is relatively independent. they are able to ambulate without personal assistance, although they may require the aid of a cane or a walker. They may require reminders to go to the dining room for a meal and encouragement to teach, or minimal assistance and/or supervision with grooming, hygiene, dental care, bathing, or toiletings; but again, they are basically independent. The ICL 2 patient/resident possesses all the attributes of their level one counterparts, but require considerably more assistance with items such as cutting up their food, supervising their food and liquid intake, personal and oral hygiene, transferring from one place to another, toileting, ambulation, and other everyday activities.

The highest level of intermediate care is the ICL 3 category. Generally a person at this level is essentially dependent on facility staff for most of their care. Often totally bedfast, these individuals needs extensive hands-on care. Those that aren't bedfast require the support of at least one other attendant to transfer. Many need to be hand fed if not able to participate in a feeding program, and require complete assistance with grooming and hygiene maintenance. The bedfast patients must be observed closely and repositioned...
frequently to prevent decubitus ulcers (bed sores), and monitored for fecal impaction. The above intermediate levels of care represent the great percentage of the medical care provided in the Clark County nursing homes. The majority of the recipients of these types of care are persons with chronic, long term illnesses or disabilities. This care is also referred to as the previously defined term "custodial care".

Like the intermediate levels of care, skilled care, according to the Nevada State Welfare criteria, is also separated into three categories. A Skilled Nursing Level (SNL) 1 patient necessitates extensive treatments and medical procedures on at least a daily basis. Procedures included under this category would include wound dressings, catheter care, tube feedings, and simple colostomy, or tracheostomy site care with minimal routine suctioning. (Note: in layman's terms, a colostomy bag is used for bowel elimination and a tracheostomy tube allows for artificial airways.)

As the number of nursing care hours increase, so does the classification of skilled care. The manual explains that nursing hours are calculated by added the total number of minutes required for skilled care provision to the respective patient and then dividing that total by 60 to indicate the actual number of nursing hours per patient day. A skilled nursing level 2 would require a minimum of 4.5 hours and a maximum of 6.25 hours. According to one of the nursing providing assessments, skilled nursing care at a 3 level is a rarity and usually involves a patient who is totally dependent on artificial means, such as a ventilator, for survival.

**LEVEL OF CARE DEFINITIONS**

**NEW BRUNSWICK, CANADA**

In 1973 a Federal/Provincial Advisory Committee submitted a report on patient care classifications which standardized five broad types, or levels of care. These level of
care definitions have been adopted by the majority of the Canadian provinces, including New Brunswick.

Classifications of these five types of care are summarized as follows:

1. **Type I Care**: is that required by a person who is ambulant and/or independently mobile, who has decreased physical and/or mental faculties, and who required primary supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. The period of time during which care is required is indeterminate and related to the individual condition. Type I is equivalent to residential care with minimal nursing care services.

2. **Type II Care**: is that required by a person with a relatively stabilized (physical or mental) chronic disease or functional disability, who, having reached the apparent limit of his recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital, but who requires availability of personal care on a continuing 24 hour basic, with medical and professional nursing supervision and provision for meeting psycho-social needs. The period time during which care is required is unpredictable, but usually consists of a matter of months or years.

3. **Type III Care**: is that required by a person who is chronically ill and/or has a functional disability (physical or mental), whose acute phase of illness is over, whose vital processes are stabilized, and who requires a range of therapeutic services, medical management, and skilled nursing care plus provision for meeting psycho-social needs. The period of time during which care is required is unpredictable, but usually consists of a matter of months or years.

The major difference between Type II and Type III Care is that under Type II Care, the resident requires personal care under professional nursing supervision; while
under Type III Care, professionally qualified nurses carry out direct provision of care. As we will see, the definitions of Type I, II, and III Care are quite analogous to Nevada State Welfare's intermediate care levels. Unlike Nevada State Welfare's program, however, New Brunswick's Department of Health and Community Services allocates one flat rate of payment for all three levels of care, with the government paying basically the same rate as a person with private funds.

4. **Type IV Care:** is that required by a person with relatively stable disability such as congenital defect, post-traumatic deficits or the disabling sequelae of diseases, which is unlikely to be resolved through convalescence or the normal health process, who requires a specialized rehabilitative program to restore or improve functional ability. Adaption to this impairment is an important part of the rehabilitation process. Emotional problems may be present and may require psychiatric treatment along with physical restoration. The intensity and direction of this TYPE OF CARE is dependent on the nature of the disability and the patient's progress, but maximum benefits usually can be expected with a period of several months.

5. **Type V Care:** is that required of a person:

   A. who presents a need for investigation, diagnosis or for definition of treatment requirement for a known, an unknown, or potentially serious condition; and/or,

   B. who is critically, acutely, or seriously ill (regardless of diagnosis) and whose vital processes may be in a precarious or unstable state; and/or,

   C. who is in the immediate recovery phase or who is convalescing following an accident, illness, or injury and who requires a planned and controlled therapeutic and educational program of program of comparatively short duration.
Level I Care is synonymous to acute care for the critically ill. Type IV and V are most usually transferred to a hospital for treatment. (Streich 1983: Appendix 1 and 2)

According to the Directives Manual for Nursing Homes (May 1987), those excluded from nursing home placement include the following:

1. Psychiatric/behavioral problems including:
   A. uncontrollable dementia
   B. uncontrolled aggression
   C. acute psychiatric illness
   D. threat to self/others
   E. moderate/severe depression or agitation

2. Notifiable communicable disease as listed in Reg. 84-283 under the Health Act.

3. Dialysis required to be performed by care staff, i.e., dialysis is a responsibility of the patient to perform.

4. Residents whose status changes frequently, thus requiring frequent admission to hospital. The following are offered as examples. Each situation will need to be considered on an individual basis:
   A. Brittle diabetic who needs frequent insulin adjustment and strict diet control.
   B. Those who have unstable or poorly controlled congesting heart failure (CHF) with resultant episodes of acute pulmonary edema.
   C. Residents with progressive debilitating disease who have frequent exacerbations, i.e., multiple sclerosis.
   D. Residence with chronic bronchitis or emphysema who have frequent respiratory crisis, and who may require oxygen therapy rather than by oxygen concentrator.
   E. Those with serious and severe peripheral vascular disease, i.e.,
gangrene.

F. Residents with severe asthma.

G. Cancer victims who are terminally ill and, because of the site of the cancer and/or metastases, become frequently obstructed (bowel and bladder); those unable to retain nourishment and require close supervision to ensure adequate intake and output; those who require frequent hypodermic injections for the control of pain.

H. Residents who require drug therapy and close medical attention to stabilize a condition, i.e., extremely confused and agitate patients; the uncontrollable diabetic in need of diet or insulin adjustment, etc.

I. Residents experiencing frequent seizure activity.

5. Residents who require constant medical monitoring (tube feedings, oxygen by other than concentrators, or intravenous therapy).

6. Frequent blood work by nursing home staff.

7. Onsite ECG testing by nursing home staff.

8. Daily anticoagulant testing and/or subsequent medication adjustment by nursing home staff.
### APPENDIX V

#### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ADL</td>
<td>Activities for Daily Living</td>
</tr>
<tr>
<td>AFL</td>
<td>American Federation of Labor</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>CCSS</td>
<td>Clark County Social Services</td>
</tr>
<tr>
<td>CUPE</td>
<td>Canadian Union of Public Employees</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnostic Related Groups</td>
</tr>
<tr>
<td>GAO</td>
<td>General Accounting Office</td>
</tr>
<tr>
<td>GIS</td>
<td>Guaranteed Income Supplement</td>
</tr>
<tr>
<td>GNP</td>
<td>Gross National Product</td>
</tr>
<tr>
<td>ICF</td>
<td>Intermediate Care Facility</td>
</tr>
<tr>
<td>LOC</td>
<td>Level of Care</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>NAM</td>
<td>National Association of Manufacturers</td>
</tr>
<tr>
<td>NCF</td>
<td>National Civic Foundation</td>
</tr>
<tr>
<td>NSW</td>
<td>Nevada State Welfare</td>
</tr>
<tr>
<td>OAS</td>
<td>Old Age Security</td>
</tr>
<tr>
<td>SSI</td>
<td>Supplemental Security Income</td>
</tr>
<tr>
<td>VA</td>
<td>Veteran's Administration</td>
</tr>
</tbody>
</table>
1. **Accessibility** - the unconditional ability of elderly persons to acquire long term care, either in their home or the confines of a care facility, as deemed necessary and regardless of socio-economic status.

2. **Acute Care** - refers to care or treatment of short-term illness or condition that has the potential of being fully reversed.

3. **Activities of Daily Living** - refers to the functions of everyday life, such as bathing, dressing, toileting, ambulating, and transferring (i.e., from a bed to a wheelchair).

4. **Bureaucratization** - the process in which a formal organization increasingly takes on the characteristics of a bureaucracy, with departments or bureaus, officially managed according to strictly enforced formal rules; emphasized rationality and impersonal procedures. A central aspect of this process is the formalization of rules under a hierarchical apparatus of control.

5. **Centralization** - A) an ecological process in which businesses, industry, or services are clustered in a limited area or focal point. There term refers to the tendency for types of service facilities to congregate in a central and readily accessible section or urban area. B) the (centralized) power or authority of government.

6. **Chronic Care** - refers to ongoing care and treatment for a long term ailment or condition that shows little chance of recovery.

7. **Commodification** - process by which human beings become dehumanized and,
instead viewed as products of the system.

8. **Competition** - the pursuit of goals by individuals or groups, the objects of which are limited according to supply and demand; an indirect, impersonal process in which individuals or groups of individuals attempt to satisfy their needs, seeking the same limited resources within a given environment.

9. **Custodial Care (Intermediate Care)** - refers to treatment or services primarily for the purpose of meeting personal needs that can be provided safely and reasonably by a person not medically skilled or trained. This category includes persons with chronic, long term illness and/or disabilities (Medicare Handbook 1990).

10. **Decentralization** - A) an ecological process in which business, industry, or services tend to be dispersed away) from one central focal point, when costs become high and congestions becomes too great, B) the movement towards secondary centers or subcenters, C) the (decentralized) power or authority of government.

11. **Diagnostic Related Groups** - refers to the Medicare reimbursement rate system by which the hospitals are paid a flat rate for each diagnosis a patient is admitted for, regardless of severity of the illness or the length of stay.

12. **Federalism** - according to Benjamin and Lee, the term refers to the constitutional division of authority between the federal government and the states (1988: 459). In essence, it delegates responsibility for several social function onto local government.

13. **Fetishism of Commodities** - products of human labor as they are produced for use or for exchange, and how the value of the products produced through human labor becomes externalized and transformed from production for personal or universal use to production for exchange in the marketplace.

14. **Individualism** - the doctrine that individual freedom in economic enterprise should not be restricted by government or social regulations laissez-faire; the doctrine that
self-interest is the proper goal for all human actions.

15. **Group Care** - refers to those who do not require any medical services. This level of care is for persons who, because of age or disability would not be able to carry out their own household needs and require someone in attendance in case of emergencies. All persons of this level must be able to take their own medications. Group care facilities provide only rooms, meals, some personal care, laundry, and 24 hour non-medical assistance (CCSS Manual 1988: X111.1.0).

16. **Long Term Care** - according to Estes and Lee, LTC refers to a range of services that addresses the health, personal care, and social needs of individuals who lack some capacity for self care on an ongoing basis. LTC enables the chronically impaired to be maintained at their maximum levels of psychological, physical, and social well being.

17. **Medicare** - refers to the federal health insurance program offered to all persons 65 or older and certain disabled persons who are attached in some way to the United States Social Security system. Part A of the program provides partial payment for acute care in a hospital, skilled nursing facility, or hospice center. Part B helps cover physician's services, outpatient services, and other medical services as deemed appropriate.

18. **Medicaid** - United States federally funded, means tested, state administered program established in 1965 to provide medical coverage to "eligible" impoverished aged, blind, or disabled persons.

19. **OAS/GIS** - Old Age Security is a benefit that all Canadian senior citizens are entitled to after age 65. The Guarantee Income Supplement is also an entitlement benefit for any Canadian citizen whose income falls below the established poverty line.

20. **Rationalization** - the development of greater standardization, consistency, and
coordination in organizational structure; the operational provision of apparently reasonable justifications for approval of conflicting social norms or values; the practice of guiding one's actions and opinions solely by what seems reasonable.

21. **Reification** - process where people come to view humanly created social forms as natural, universal, and absolute; and that the resulting social structures are unchangeable and outside the realm of their control/ process where individuals come to see themselves, and be seen as external to the process of production (creation) of such.

22. **Skilled Care** - refers to nursing care provided on a 24 hours basis under the supervision of a professional registered nurse, or the provision of skilled or intensive rehabilitation services. Skilled nursing care must be ordered by a physician.

24. **SSI** - Supplemental Security Income is the United States' replica of the Canadian GIS benefit for those whose income falls below a minimum amount.
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