Vulnerable Populations: Assessment of Community-Level Barriers

Name

College

Date
Previous work has provided the explanation of vulnerability of mothers and children, as well as underlined the relevance of focusing on their social needs in terms of the healthcare program. As it was mentioned before, there is an environment of restricted social and health resources, but to meet the principle of democratic equality, it is crucial to actualize the needs of those who deserve such benefits at most. Still, the integration and adoption of the proposed health care program deal with the obvious community-based barriers which complicate the proper distribution of benefits between mothers and children. The given paper is going to analyze the barriers of micro-level, macro-level, and ethical level to derive some potential solutions to the complex problem.

Evidently, micro-level barriers include mainly individual impediments toward proper integration into the program. Such aspects as socioeconomic and financial dimensions become the triggers for establishment of relationships with community and related health care services. When mothers and children are involved in the process of individual resource allocation, they face a problematic context of disproportionate sharing of benefits. Thus, the men have enough strength and privileges to handle their resource dependence; the women and specifically mothers are lacking of such individual capacities in most cases, because of social functions and obligations to handle child-bearing and child raising (De Chesnay & Anderson, 2008). At the micro-level, mothers are compromised by duty to keep her children: it relates to spending on the food, clothes, education services for their kids, etc. In the meantime, the rest conditions of well-being such as expensive and quality health care, technologies of human development and self-realization, and social comfort are restricted at the individual level, because resources of mothers are directed to the primary needs of children. Unsurprisingly, families with lone mothers are
considered as critical at-risk group, as children may miss some important social benefits which are acceptable only through the micro-level and financial regulation.

Macro-level analysis has identified a broad specter of barriers associated with state budget regulation. The current situation concerning funding for care of mothers and children is even more complicated than the situation at the federal level. In fact, the community legislators and state governors have a constitutional duty to balance their budgets annually, and there are no political shortcuts to avoid this legal obligation. According to estimations of experts, health care spending embraces from 20 to 25 of community and state budgets, and it also relates to the Community and State Children's Health Insurance Program as well as Medicaid (Ferguson, 2007). Obviously, governors of our community emphasize on total spending and engage financial cutbacks within the community-based programs. In common, the growing rates of keeping health care for mothers and children – which are the most popular and dense vulnerable groups in the community – becomes extremely problematic, as other areas of spending surpass the health care services for these populations.

The ethical aspect of providing specialized assistance to the vulnerable group – mothers and children – is complicated by complex minority-majority jurisdictions. The main concern is that integration of specialized health care program develops and promotes the gap between formally “deserving” and “undeserving” populations with the same social needs. For instance, why mothers and children should be more privileged than the elderly population or people with disabilities? In this sense, ethical restrictions hamper the distribution of health care benefits and cause inter-communal and inter-agency conflicts, because it is difficult to stay in the same jurisdiction by meeting the needs of particular vulnerable population.
In a way, solutions can be derived basing on the analysis of main community-based barriers. To cope with micro-level and individual financial barrier, the program should include a comprehensive approach to family health management. As for independent options, there must be extensive consultations with mothers to shed the light on how to reduce family costs and organize family economy. In the meantime, special intervention and prevention medical measures have to be performed for free to young mothers. Of course, the strategy of supporting mothers and children would require integrated options of funding, and the program proposes to rely on the target spending pattern (Shi & Stevens, 2010). It involves family-based (micro-level) projects in investing in the health future.

In order to handle macro-level barrier of funding, there should be organized a system of independent investments. For example, to mitigate excessive state spending on other areas of care, a special donation system to keep lone mothers and orphan children can be arranged to collect funds. In the meantime, it is rational for community and governmental leaders to test new treatment modalities and financing mechanism to keep mothers and children: some new cost-efficient care management models or delivery systems should be implemented to reduce health costs at the community-based level (Ferguson, 2007). The attraction of investors from private health sector is another option.

Unfortunately, ethical barriers and biased are one of the most hard-to-eradicate, because they lie within the awareness and stereotypes of community members. However, to meet the interests of mothers and children, who are considered as the main demographic reproductive force in the community, the program proposes to manage expectations of vulnerable populations. There should be a balance between deserving and most deserving groups, accordingly.
References

