SOCIAL EQUITY AND HEALTH CARE FOR CHILDREN AND INFANTS

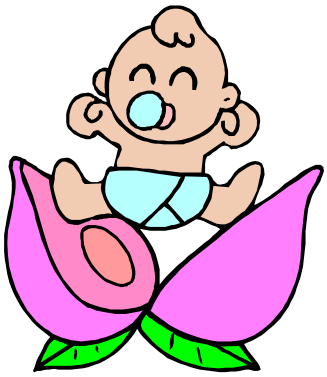

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Table of Contents

INTRODUCTION:

"An individual's "right" to health care is hotly debated at every level of the political system and throughout this country's social structure" (Cypher, 1997, p.25). More recently the accessibility and healthcare policy regarding senior citizens has been in the forefront of discussions (Wholey, D., Burns, L. & Mourey, R. 1998; Outshoom, J. 2002; Stallard, Decker, & Sellers 2002). This paper however centers on the issue of equitable infant healthcare. Dalton and Springer (2001) found in their study that there is a "persuasive" correlation between government health spending and positive birth and infant health outcomes. A related study by Frances Althaus in 1998 revealed, "Instances of low birth weight (an indicator of infant mortality) decreased due to improved access to prenatal care and non-clinical support services.

This paper will focus on the equity of infant healthcare in Richmond City Metropolitan area including Chesterfield, Hanover, Henrico, Richmond City, and Petersburg). The paper is divided into four sections to thoroughly discuss the idea of social equity and infant/child healthcare. Section I begins with an overview of social equity and governance. This overview will include a discussion of the origins, definitions, and existence of the concept of social equity. Section II outlines national public healthcare policies and statistics related to infant healthcare programs (i.e., SCHIP and FAMIS). Section III examines the Richmond Metropolitan area's statistical data regarding infant healthcare. This section will also discuss indicators of potential inequity in infant healthcare. Section IV introduces strategies and recommendations to ameliorate potential social inequities in the provision of infant healthcare to recipients in the Richmond Metropolitan Area. Finally the paper concludes with a summary of the information and issues discussed in Sections I-IV.

SECTION I:

SOCIAL EQUITY AND GOVERNANCE

The importance of social equity within government and its relevance within the field of public administration is irrefutable. How it is actually addressed, implemented, and administered is another issue. The actual development of social equity within the foundation of public administration is the culmination of hundreds of years of work toward a democratic nation. In order to have a better grasp of social equity and governance, we must first have a clear understanding of its history and origins, its fundamental concepts and the range of difficulties in addressing the array of issues it encompasses.

HISTORY AND ORIGINS

Svara and Brunet (2003), contend that although social equity issues have been discussed in a vague sense for many years, it is difficult to narrow down when they came to the forefront within public administration. The Classical Approach of the late 1880's to 1940's focused more on efficiency within government as its major goal; during which time a strong commitment to democracy. Although this era was primarily normative, social equity was not a major value. The Behaviorists view of the late 1940's has focused on a more rational, efficient form of government that relied strongly on making organizations more efficient but again, social equity was not at the forefront of its paradigm (Greene, 2003). Rutledge (2002), state that social equity can be traced back to the writings of Aristotle and Plato while others suggest social equity as a practical tool in public administration can be trace to the Minnowbrook Conferences of the 1960's. The Minnowbrook Conference papers developed a concern for values within the field of public administration and contended that social equity was "The reduction of economic, social,

psychic suffering and the enhancement of life opportunities for those inside and outside an organization"(Denhardt,2000,p.?). Others maintain the 'new public administration' paradigm of the late 1960's has brought with it an awareness of social equity within government that steered away from efficiency and economy and added the concern for equity. Svara and Brunet (2003), suggest that during this 'new public administration', scholars began considering the redistribution of resources as a way to address inequality. Frederickson (2002) also focused interest squarely on social equity in governance as a fundamental responsibility within the public administration profession.

Throughout the years, government has attempted to mandate social equity using legislative actions. The legislation covering child labor laws, affirmative action, Title IX, voting rights etc. are just a few measures that attempt to address social equity issues through governance. Shafritz and Russell (1997), contend public administrators have an obligation to advance social equity. They suggest this done through administering of laws in a fair manner, feeling compelled to proactively advance social equity within our own domain and providing moral leadership in the area of social equity. The new Refounding Period (late 1980's – current) is a blending of a framework that focuses on a 'results' orientation rather than a 'process' orientation and seeks to make government more efficient and accountable (Greene, 2003). Whether this is a dramatic shift away from social equity issues remains to be seen.

DEFINITION/ESSENCE

The definition of social equity has many variations, from 'simple fairness' and equal treatment to redistribution and reducing inequalities in society (Svara and Brunet, 2000). Shafritz and Russell contend that social equity is "fairness in the delivery of public services, it is egalitarianism in action – the principle that each citizen, regardless of economic resources or

personal traits deserves and has a right to be given equal treatment by the political system" (1997, p. 449). Frederickson suggests that social equity in public administration is a 'third pillar' for public administration, holding the same status as the values of efficiency and economy" (Wooldridge, 1998). Frederickson (2002) further contends that social equity is achieved by doing what one can within the constraints of law and policy to implement policy by a method that is fair and just. A NAPA panel created a preliminary set of criteria that provide an operational meaning to social equity that divided the criteria to ensure social equity into four areas: procedural fairness, access – distributional equity, quality – process equity, and outcomes, (Svara and Brunet, 2003). Social equity has also been defined by NAPA as "The fair, just, and equitable management of all institutions serving the public directly or by contract, the fair, just and equitable distribution of public services and implementation of public policy, and the commitment to promote fairness, justice, and equity in the formation of public policy." (Svara and Brunet, 2003). Another conceptual thought on social equity is that it should be base on equality, need, demand, preference, and willingness to pay ("Equity and Service Distribution", Wooldridge, 2003).

Over the years, the nature and description of social equity has grown. "Equity is now more broadly defined to include not just race and gender but ethnicity, sexual orientation, certain mental and physical conditions, language and variations in economic circumstances" (Standing Panel on Social Equity and Governance, 2000). The panel also recognized that social equity takes on multiple structures: simple individual equality, segmented equality, block equality, unequal distribution of resources to achieve equality and values of equality. Several forms of social equity come together to make the distinction between equality and equity and the "task of public administrators is to organize, manage and lead in such a way as to make the processes and

the results of those processes as equitable as possible. Social equity is, then, the balancing of the various forms of equality." (Standing Panel of Social Equity and Governance, 2000)

John Rawls, in his book entitled A Theory of Justice (1971), argued how government is able and obligated to guarantee social justice and equity through his 'Justice as Fairness Theory', that is often characterized as a philosophical foundation for the welfare state. He maintained that each person had a right to the most extensive basic liberty of others and inequalities in the distribution of wealth and power are just only when they can be reasonably expected to work to the advantage of those who are least advantaged.

At a 1998 roundtable discussion on globalization and social governance held in Europe , a paper was presented that stated that equity was more than the distribution of income and wealth, it was about the distribution of human capital such as health and education and the distribution of opportunities for participation in social and economic life. Delivery of services a fair and equitable manner within the public sector is an area of concern for public administrators who attempt to focus on social equity. Wooldridge (1998), states, "There is no question that judgments about service equity require judgments about values, but the distribution of services is at the heart of policy-making". Svara and Brunet (2003), suggest, "Equity cannot be a defining value of the field unless it is tied to a commitment to act to advance equity." (2003) The role of public administrators in the governance of social equity is now understood.

ADDRESSING SOCIAL EQUITY ISSUES

Although social equity and its relevance in governance may be extremely complicated, its importance to public administrators should not be overlooked. The difficulties in ensuring social equity in governance are problematic for public administrators. While we must be constantly aware that the needs of the citizens are to be reviewed prior to implementation of a policy or

project, often how this is done in a fair and equitable manner is difficult to implement. In addition, the concept of governance, particularly in a democratic society, brings with it a wealth of issues as it relates to social equity within the population we serve.

The term 'governance' itself is derived from the Greek work "kybernan", "kybernetes", and means "To steer and to pilot or be at the helm of things" (Urban Governance Initiative, 2002). Malhotra (1998) offers that the term governance means different things to different people. He provides that it encompass the functioning and capability of the public sector, and the rules and institutions that design the framework for the conduct of public and private business. In broad terms, governance is about the institutional environment in which citizens interact among themselves and with government agencies/officials (Malhotra, 1998). Gurung (2000) suggests the result of good governance is development that gives priority to poor, advances the cause of women, sustains the environment, and creates needed opportunities for employment and other livelihoods". Gurung (2000) also proposes that governance is good and effective when it subscribes to the following nine characteristics: participation, strategic vision, rule of law, transparency, responsiveness, consensus orientation, *equity* building, effectiveness and efficiency and accountability. How we use this good governance to achieve social equity will always be a continuous goal of those in public administration. Rutledge (2002) argues that although the issue of social equity and governance was "Joined some 35 years ago, the profession still does not have good answers or acceptable strategies for policy implementation due to the failure as a profession to develop the quantitative tools, indicators and benchmarks to define objectives and measure progress in pursuit of social equity".

Shafritz and Russell (1997), state government organizations have a special obligation to be fair and just as well as to pursue social equity with their employees and the public – because

they represent the citizenry. Although solutions to ensure social equity are always evolving and continue to be explored and researched, we as public administrators must ensure we keep the issue clearly within the forefront of our consciousness.

SECTION II:

NATIONAL PUBLIC HEALTHCARE POLICY

The healthcare system has been undergoing a surmountable amount of criticism since the early 1990's. After the Clinton, administration's plan to revamp the health care system was dismissed by Congress healthcare concerns and the issues remain a focal point for the American public. Employees are now relegated to managed-care programs, such as health maintenance organizations (HMOs). These types of health carriers cover the 100 million Americans who can afford health insurance. The managed-care system has taken away the flexibility patients once enjoyed. Whether a person has, access to health insurance is dependent upon the jobs they hold and their age. The two-thirds of Americans who have health insurance are covered through their employers, while those elderly citizens, 65 and older are covered under the government Medicare health plan. According the U.S. Census Bureau (2001), citizens in low-wage jobs or work for small businesses are the ones who cannot afford health insurance. Both adults and children in this segment of the population experience inequities in healthcare.

An article recently published in The Voice newspaper reported that approximately 75 million Americans under the age of 65 were uninsured sometime in 2001 and 2002 with over 52 percent of the uninsured population falling in the category of non-Hispanic whites.

There are serious medical implications for persons without insurance; uninsured women diagnosed with breast cancer are more likely to show a decrease in their survival rates as well as

men diagnosis with colon cancer. Uninsured pregnant women are more likely to deliver lower birth weight babies as compared with women who have health insurance. Statistics gathered by the Public Agenda show persons earning less than $25,000 a year make up 22.7% percent of the uninsured population, whereas children living in homes where both parents work fulltime is 49.4% uninsured rate.

Socioeconomic inequalities in healthcare seem to be widening rather than narrowing. Recessions, job loss, corporate downsizing, and lack of availability of jobs all contribute to the inequities uninsured persons are experiencing. Public policies concerned with equity and justice in healthcare should explore ways to reduce healthcare inequalities. The poor citizens usually feel the impact of these inequities in healthcare. Since the poor lack, the economic means to purchase health insurance the mortality rates are higher than for those persons with health insurance. Wagstaff points out, "…it is not just the loss of income associated with poor health-it is also substantial financial costs of the medical treatment necessary to restore health" (Wagstaff 2001). The healthcare implications of poverty are demonstrated in the following chart.

Characteristics Of the poor	Poor Health outcomes	Diminished income
- Inadequate service unhealthy, sanitary and practices, etc	- ill health - malnutrition - high fertility	- loss of wages - costs of health care - greater vulnerability to catastrophic illness

Caused by:
- lack of income knowledge;
- poverty in community social norms,
- weak institutions, and infrastructure bad environment
- poor health provision – inaccessible, lacks key inputs, irrelevant services, low quality
- excluded from health finance system – limited insurance, co-payments (Wagstaff, 2002).

The cost for healthcare should not hinder a family's ability to maintain an appropriate standard of living. Out of pocket cost for health insurance should not drive households into further economic poverty, nor should the cost exceed a reason percentage of a family's income

(Poverty and Health, 2002). Workers without health insurance through their employer's have few options other than the public health insurance plans. These plans, Medicaid or Medicare have eligibility requirements that address the very poor and needy. Many uninsured citizens fall into the category of "working poor"; their salaries exceed the poverty level, yet cannot afford to purchase basic health care insurance.

INFANT HEALTHCARE

Recent state expansions of coverage for children dramatically increase the availability of health insurance for low-income children in working families. However, for those children's parents is extremely limited. The eligibility levels for child-only coverage are the highest levels for coverage of children through age 18 in the states, although sometimes infants and younger children are covered at higher levels. The levels include income disregards, for example, income not counted when the state calculated eligibility. In many states the eligibility level shown is for a separate state SCHIP program, which may provide a more limited benefit package than Medicaid, may require families to pay premiums or co-payments, and may not be consistently open to new enrollment (Families USA, 2002). Children who are uninsured are less likely to received basic medical care because of the absent of health insurance. Holl and Szilagy state "uninsured children are found among all age groups, and while the likelihood of being uninsured is slightly higher among black children, most uninsured children are white. Annual family income is below $20,000 is strongly associated with children lacking health insurance".

A study published in the *American Journal of Public Health*, 1988, discusses the effects of WIC (Women Infant and Children) on infant mortality. The study revealed that WIC participants during pregnancy appear to reduce both endogenous and exogenous infant deaths (AJPH 1988).

SCHIP-STATE CHILDREN'S HEALTH INSURANCE PROGRAM

SCHIP is a partnership between the federal and state governments that helps to provide children with the health coverage they need to grow up healthy and strong. SCHIP requires that states use their allotted funds to cover uninsured children - and not replace existing health coverage. The program also includes important cost-sharing protections so that low-income families are not burden with heavy out-of-pocket expenses (U.S. Department of Health and Human Services). The critical issue of uninsured children was address by Congress in 1997 under Title XXI of the Social Security Act. Which expands health coverage to uninsured children whose families earn too much to qualify for Medicaid but too little to afford private coverage (U.S. DHHS) State Medicaid plans are the building blocks to covering the 40 million low-income individuals, which includes 20 children? SCHIP provides to those families that are at or below the 200 percent federal poverty level. The states are required to ensure the health benefits offered meet the equivalent benchmark insurance plans through out the country. The standard Blue Cross Blue/Blue Shield Preferred Provider Option offered by the Federal Employees health Benefit Program; a health benefit plan offered by the state to its employees; or the HMO benefit plan with the largest commercial enrollment in the state. (U.S. DHHS)

Approximately 3.5 million low-income children were enrolling in SCHIP by December 2001. Although the enrollment of uninsured children was successful, a large number of children continue to remain uninsured. Several factors influence the reduction of the SCHIP funding, the funding previous allocated to the states are in jeopardy of being reverted the U.S. Treasury. Many states are experiencing budget crises and the needed funds to share the 80/20 split may not be available. These budget crises have an impact on the reduced enrollment and increase number of children who remain uninsured. It is estimated the enrollment in SCHIP will drop

by 900,000 between fiscal years 2003 and 2006; the problematic fiscal outlook in the states suggests that this projection may underestimate those losses (FamiliesUSA, 2002).

SCHIP was enacted in 1997; 10 million children in the U.S nearly 14 percent of all children under 19 years old were uninsured. Although the vast majority of uninsured children has a parent who worked 75 percent lived with a parent who worked full-time and almost 90 percent lived with a parent who worked full- or part-time.

States began to move quickly after the passage of SCHIP, to design and implement expanded health coverage for children. Ultimately, all 50 states, plus the District of Columbia and the U.S. Territories, opted to participate in SCHIP. As a result, the program experienced steady enrollment increases from year to year (FamiliesUSA, 2002).

The National Center for Health Statistics released a report from the Department of Health and Human Services that found the percentage of children without health insurance declined from 13.9 percent in 1997 to 10.8 percent in 2001, largely because of enrollment growth in SCHIP. Enrollment in health coverage can have a dramatic effect on children's access to health care. One study found that, after being enrolled in a children's health insurance program for a year, the percentage of children reporting an unmet health care need or having delayed health care fell from 57 percent to just 16 percent (FamiliesUSA, 2002)

Although, SCHIP eligibility levels are set at 200 percent of the federal poverty limit or $30,040 in annual income for a family of three, five million children still are uninsured. These five million uninsured children are in jeopardy of ever receiving insurance because of the outside factors that may hinder continued state funding. To sustain steady progress in reducing the number of uninsured children is in jeopardy. The Bush Administration's proposed 2003 fiscal year budget and the Office of Management and Budget (OMB) estimated that SCHIP enrollment

would decline by 900,000, about one-quarter of the current enrollment between 2003 and 2006 (FamiliesUSA, 2002).

Three major problems lead to the drop in SCHIP enrollment. First, the amount of federal SCHIP funds made available to the states in fiscal year 2002, 2003, and 2004 is considerably lower than the amount that were made available in the four previous years. Second, almost $3 billion of previously allotted SCHIP funds are scheduled to be taken away form the state and will be reverted to the U.S. Treasury - $1.2 billion on September 30, 2002 and $1.6 billion on September 30, 2003. Third, the states are experiencing significant budget crises that are causing them to reduce their commitments to low-income health coverage (FamiliesUSA, 2002).

First, it was presumed in 1997 that the federal budget would be in worse shape in fiscal years 2002-2004. Then in recent years immediately preceding and immediately following that period. For each of the first four years SCHIP implementation, starting with fiscal year 1998, the programs block grant funding provided roughly $4.3 billion to states. In fiscal years 2002-2004 SCHIP funding to the states reduced by 26 percent and reduction s of $1.125 billion per year (FamiliesUSA, 2002). The Center on Budget and Policies Priorities listed 32 states the will received lower SCHIP allocations for fiscal year 2003. Second, along with the reduction of federal support states are facing a loss of approximately $2.8 billion in previous federal allocations for the program. The loss of funds is due mainly to the way Congress scheduled the 10-year distribution to the states. Congress allocated more funding to the states in each of the first four fiscal years of the program implementation than it did for any of the succeeding five years (FamiliesUSA, 2002). Congress did not take into consideration that states had to first past legislation to start the program and then had to develop the program administrative infrastructure.

Since state programs needed time to design and implement this new program, many of the states did not expend the large amounts of funding allocated upfront. States had three years to spend all allocated funds or run the risk of losing the federal funding. Calculations completed by Families USA reveal that $2,814,800,00 will be reverted back to the U.S. Treasury, $3,282,000,003 in funding will be lost between 2002-2004, with $6,096,800,000 lost overall for the states.

Third, with the current state budget crises these shortfalls will have an impact on the number of children enrolled into the SCHIP program. This could not have come at a more inopportune time when families will need to rely on Medicaid and SCHIP for health coverage. The lost of jobs and the increase of employer-sponsored health insurance will increase the need for the continued federal insurance plans.

Three strategies that affect enrollment are: (1) freezing enrollment or limiting periods during which children can enroll; (2) increasing family premium requirements, thereby making program participation less affordable; and (3) undoing eligibility and enrollment simplifications that make it easy for families to enroll, and stay enrolled, in SCHIP (FamiliesUSA, 2002). It remains that 4,745,600 low-income children are uninsured.

FAMIS – FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN

FAMIS legislation was enacted by the General Assembly in 2000. It directed the Department of Medical Assistance Services to amend the Virginia Children's Medical Security Insurance Plan (VCMSIP) as authorized under Title XXI of the Social Security Act. The health insurance plan was then renamed FAMIS and eligibility requirements changed to reflect poverty levels at or below 200%.

{§ 32.1-351. Family Access to Medical Insurance Security Plan established}

A. The Department of Medical Assistance Services shall amend the Virginia Children's Medical Security Insurance Plan to be renamed the Family Access to Medical Insurance Security (FAMIS) Plan. The Department of Medical Assistance Services shall provide coverage under the Family Access to Medical Insurance Security Plan for individuals, up to the age of nineteen, when such individuals (i) have family incomes at or below 200 percent of the federal poverty level or were enrolled on the date of federal approval of Virginia's FAMIS Plan in the Children's Medical Security Insurance Plan (CMSIP); such individuals shall continue to be enrolled in FAMIS for so long as they continue to meet the eligibility requirements of CMSIP; (ii) are not eligible for medical assistance services pursuant to Title XIX of the Social Security Act, as amended; (iii) are not covered under a group health plan or under health insurance coverage, as defined in § 2791 of the Public Health Service Act (42 U.S.C. § 300gg-91(a) and (b) (1)); (iv) have been without health insurance for at least six months or meet the exceptions as set forth in the Virginia Plan for Title XXI of the Social Security Act, as amended; and (v) meet both the requirements of Title XXI of the Social Security Act, as amended, and the Family Access to Medical Insurance Security Plan. (1997, c. 679; 1999, c. 1034; 2000, cc. 824, 848; 2001, cc. 238, 735, 756; 2002, c. 640.)

The required 12-month waiting for families previously insured was amended to six months. Virginia also, implemented a cost-sharing requirement for families whose incomes are above 150%, which is up to 5% of the family's gross income. Families whose incomes are at or below 150% will have a shared cost of up to 2.5%. The cost sharing requirements are defined as co-payments for medical care. To ensure delivery of the benefits and services there is no pre assignment process or fee-for service program at initial application. Families have several

choices of plan, which may include a HMO, PPO, Indemnity or other types of health insurance plans. Most FAMIS children receive care through an MCO. An MCO is health service organization that provides its members with all health services through a network of primary care providers (PCPs), specialist, and hospitals. Depending on the geographical location of the applicant, they may select from the following list of healthcare providers, Anthem Heatlhkeepers Plus, CareNet, Sentara, Unicare, and Virginia Premier. (FAMIS)An added feature is the employer sponsored health insurance plan. Families have the choice to explore the cost effectiveness of premium assistance if their employer offers a health plan (Virginia Department of Medical Assistance Services).

The current state of the Virginia FAMIS program shows a decline in enrollment as of March 2003 from 32,626 to 32,359. Although, the overall enrollment has declined in the past month, there is a steady increase in enrollment in Richmond City, Petersburg, Chesterfield, Petersburg, Hanover, and Henrico. Virginia is continuing its efforts to promote and enroll uninsured children.

The Holl, Szilagy article published in the Archives of Pediatrics and Adolescent Medicare, adds a interesting point concerning marketing. "Marketing health insurance for uninsured children at healthcare sites is unlikely to be an effective mean to reach most uninsured children".(Holl, Szilagy 1995). OMB projects that 900,000 children will lose SCHIP coverage from 2003 – 2006. (FamiliesUSA 2002). State will begin receiving lower funding allotment in the upcoming fiscal year. If that is the case this program will not cover every uninsured child regardless of eligibility for FAMIS (SCHIP).

SECTION III:

STATSITICAL ANALYSIS

In the continued analysis of our examination of equity within healthcare, it has been found that most major determinants in the status of a community are associated with factors that are strongly contingent on choices in personal lifestyle, personal responsibility, risk behaviors, and regard for the environment. The first step in the movement toward positive health change in any community is to inform residents about health risks and health status issues that need improvement. Informed residents are in a better position to create and maintain positive change. Greater awareness of the urgency to improve lifestyle practices, reduce risk behaviors, and protect the environment contributes to an improved health status of the community. Also, keeping our public, private, nonprofit, and voluntary agencies abreast of issues that affect the health status of the community equips these agencies to more effectively establish programs that are in step with the community's needs. Increased attention to opportunities to improve health through concerted action at the community level includes development of methods to amass local health data, choose local priorities, and monitor health and health improvement activities. (1)

In regards to the sample population, it was important to draw from a local cross sample in insuring continuity in developing measurable "peer" comparison techniques for identifying areas of possible concern. Statewide to national values for health indicators are valuable comparisons, but may not compare to the existing similarities within our local populations. Thus, the five targeted areas of study – the counties of Chesterfield, Hanover and Henrico as well as the cities

of Petersburg and Richmond – all provide 'demographic uniqueness' while remaining somewhat congruent to each other in regards to relevancy of the indicators selected.

As such, there were three indicators chosen as a priority of study for this project. These indicators are *race, transportation availability of health care resources and socioeconomic status* (with regard to the affordability of basic well-infant care). While they (indicators) certainly do not represent an exhaustive list of 'tell-tale signs', they are relevant and significant community indicators which provide a "snapshot" of well being within the five targeted localities and create awareness of the need for continued improvement of the public health in the Commonwealth.

RACE

In regards to the observation of racial/ethnicity specific data, the presence of sub-indicators - perinatal/natal (28 weeks and more) and infant mortality rates (per each 1000 births) and percent low birth weight infants – aid in further quantifying the data for observational analysis. Examination of these results showed significant variations in the availability and convenience of available healthcare in the targeted areas.

In analysis of regional statistics, African-Americans exhibited a rate of perinatal mortality double of whites (12.9 to 5.6) while also contributing 42% of the 58.5% rate of births by single teenage mothers (<18 years of age) (based on 2001 statistics). In addition, between 1993 and 2000, African-Americans had the highest rate of mortality – 9.9 – compared to 5.4% of whites. Disparities were also recognized in the infant morality rate where African-Americans ratios were at 2.5 times (14.5 to 5.5) the rate of whites. Hispanics experienced fluctuations in their infant morality rate, which fell to 5.1% after four years of steady increase. Asians, when compared, had the lowest rate of infant mortality (1.4%) in the targeted areas while also having the lowest number of actual deaths (2).

Regional Composite Statistics

Further analysis of regional data identified additional racial incongruence as African-Americans demonstrated lower rates than whites (12.7 to 6.5) of children of equal birth weights (although both groups experienced increases). Hispanics – under the same unit of measurement – showed parallel to whites (at 6.4%) whereas Asians demonstrated a higher percentage of low birth weights (7.4%) than in previous years. It should be noted that there was still a unilateral increase in all proportions - although all minority groups still had lower proportions of birth weights than African-Americans – in regard to this criterion. Detailed examination of the specific areas of study also shed similar light.(2)

Counties of Henrico, Hanover and Chesterfield

In Henrico County, a suburban residential/commercial area of 262,300 residents - with approximately 30% of minority heritage - there were 283 reported low birth weight infants and 8 infant deaths (per 1000 births – 2001). Similar statistics exist within Hanover County, a suburban residential area of 86,320 residents - 12% of minority heritage. In 2001, there were 79 low birth weight infants and only 9 reported infant deaths (per 1000 births) within the county (2, 3). Within Chesterfield County, a suburban residential/commercial area of 259,903 residents – 20% of minority heritage – data statistics revealed that there were 233 low birth weight infants and 6 reported infant deaths (per each 1000 births).

Cities of Richmond and Petersburg

Surprisingly, the City of Richmond, an urban/commercial area of 197,780 residents – 60% of minority heritage – revealed no statistical anomalies in its findings (2, 3). Additionally, there were 398 low birth weight infants and 25 reported infant deaths (2001); numbers which

remain parallel to the observational data of the surrounding region(s) with regards to population (size) and demographics (markup) (2, 3).

Similarities in the urban population exist within the analysis of data from the City of Petersburg, an urban/industrial area of 33,740 residents – 81% of minority heritage. Petersburg City, the smallest of the targeted areas of study, had 64 low birth weight infants and 15 infant deaths (per each 1000 births - 2001); exhibiting parallels in its numerical data per capita to the sample's overall size (2, 3).

The use of birth weight and mortality as sub indicators are done in order to provide a stable unit of measurement. Per the Virginia Center for Health Statistics, the leading cause of death of Virginia infants from 1996 to 2002 was from disorders resulting from short gestation periods and lower birth weights giving way to underdeveloped bodily functions. Since such tragedy occurred statewide among all races, colors and creeds, it (weights/mortality) can be used an unbiased, quantifiable and reliable tool of study within the targeted areas of study without succumbing to any changes in its interpretation. Although the overall percentages of low birth weight and infant mortality seem to prove the inverse, closer examination of the areas of study seem to show that (again with regard to population) there are some definite commonalties and not enough 'observed' disparity in the 'reported' numbers of infant cases profiled. As such, what can be concluded from this data analysis is that, although the populations that make up the specific areas of study are somewhat diverse in their demographics, race – solely - is not an accurate predictor of the equitable distribution of infant healthcare based on the data observed (4).

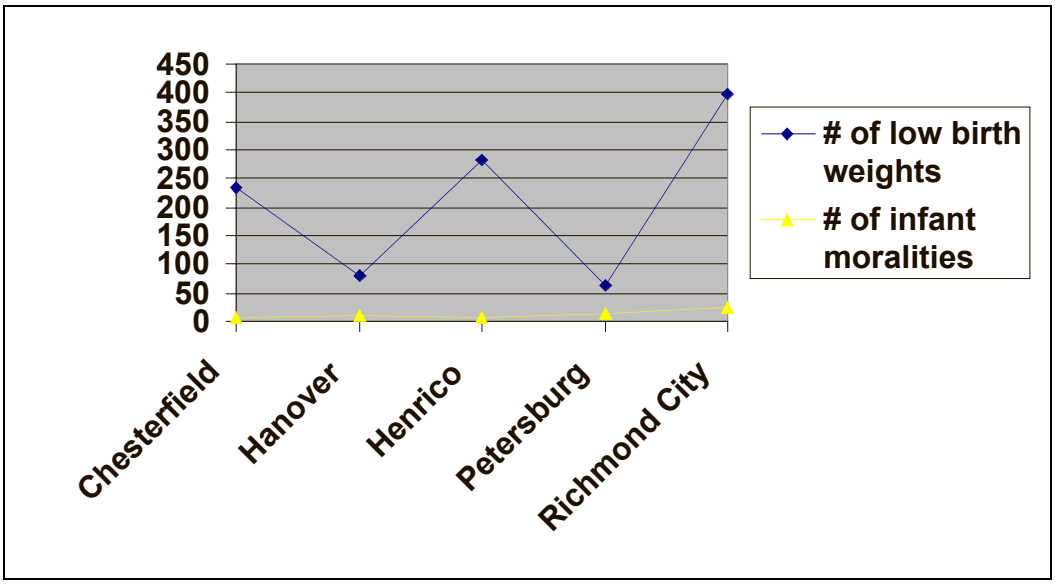

Figure 1: Disparities between low birth weights and infant morality within the studied localities

TRANSPORTATION AVAILABILITY TO HEALTHCARE RESOURCES

Within all five areas of the targeted study, there has been constant activity in forming partnerships and coalitions with other agencies and organizations in providing reasonable healthcare available to all citizens regardless of geographic location. In the City of Richmond, for instance, there are number linkages in place. Organizations such as Children's Health Involving Parents (CHIP) have established a van escort service to take parents and infants enrolled in the program to their physician visits and return them after the appointment. Other programs have established that work in the opposite fashion by bringing the provider to the community. Under the auspice of the Virginia Department of Health, a contract with MCV Hospitals has been forged wherein the internal medicine, family medicine, and OB/GYN departments are providing primary care south of the James River. In the building within the South Side Shopping Center – a facility that is bus line accessible for all residents housed in one

central location for services. Additionally, partnerships were formed with Richmond Community Hospital and Bon Secours in 1995, which permitted the Virginia Department of Health to use the third floor to deliver services to the East End residents in the categories of maternity, pediatric, family planning, and WIC. Furthermore, the Virginia Department of Health participates in the car seat distribution program for mothers of newborn and infants to sustain reasonable assistance in providing safe passage for children while riding in a car. These are just some of the established collaborative linkages developed by the Virginia Department of Health and City of Richmond made available to Richmond City residents and those in surrounding counties who apply and meet the eligibility criteria. In addition, there are a number of privately owned physician offices, hospitals, clinics and alternative medicine providers that offer a range of services for infants from well-baby care to problem diagnosis - exacerbated even more by the fact that only 68% of Richmond City residents have access to private healthcare benefits. Although that there is little data available in regards to measuring the amount of 'geographical' accessibility within the five localities of study, there is enough credible evidence present to justify that based on geography – there is an equitable distribution of healthcare providers within the city limits that can provide infant care if utilized (5).

HANOVER

Within Hanover County, healthcare accessibility (governmental) is divided between the four offices that comprise the Hanover Health District, the entity charged with providing reasonable access and care to Hanover, Charles City, Goochland and New Kent County citizens who may or may not have private health insurance. As offices of Virginia Department of Health, each clinic has the ability to perform the well baby and infant care functions for those in need and have access to that particular area facility as needed. However, given the lack of public

transportation in those areas, many citizens are heavily dependant on cars to transport them to and from their pediatric appointments. As such, many in Hanover County (in particular in the areas of Mechanicsville and Ashland) have privatized insurance carriers, and patronize a number of private healthcare dealers (Patient First, Sheltering Arms Hospital) that are more accessible to the average county resident as a 'satellite' clinic rather than an attempted trip to a full-fledged hospital. By virtue of this 'additional' availability in medical care, coupled with the fact that 88% of county residents have access to some type of privatized health care benefits at their disposal, it can be established that so long as county residents have reliable transportation to transport them to and from appointments as needed, geographically providers of basic health do exist in this locality. Thus providing reasonable infant care to those populations in need (6).

CHESTERFIELD

The three locations comprising the Chesterfield Health District (the City of Colonial Heights and counties of Chesterfield and Powhatan) also offer (as with the Hanover Health District) comprehensive baby and infant care services in tune with standards established by the Virginia Department of Health for customers who have no accessible private health coverage. As districts operating in 'pseudo-rural atmospheres', the Chesterfield Health District satellite offices are not easily accessible due to lack of public transportation in those areas. However, if the customer has access to a vehicle, it is possible for someone to reach these offices within a given amount of time – inasmuch as that they are located on the main thoroughfares in the respected areas. In terms of services, the Chesterfield Health District offices provide managed care services while adhering to the same practices exhibited within the other districts of study (car seat and child safety, lead screenings, well-baby exams, and metabolic testing for possible chemical abnormalities in infants and newborns). Like other discussed localities, residents of the

county who have private health insurance cannot participate; hence the development of hospitals and clinics (Chippenham Johnston-Willis, Stony Point Medical Center) that offer a comprehensive array of services all available through private insurance carrier. Additionally, like in Hanover County, the existence of 'satellite' clinics such as Patient First also provide greater accessibility for parents to location of care for there newborns assuming that they possess the necessary health coverage. Chesterfield County, with the largest number of residents with access to medical healthcare at 89% in our study has private hospitals, clinics and public usages of state supported clinics that basic health care provisions. Therefore providing geographical accessibility to infant care. However, these services are most accessible to customers possessing a vehicle or some reliable way to access these facilities due to the lack of a standard county-wide transportation system (7).

HENRICO

With two locations of service on the polar opposite ends of the county, Henrico County has the least availability of public health facilities studied. Broken into two locations, Dixon Powers Drive and East Nine Mile Road county residents who desire services from for their infants must be able to transport themselves to either one of these locations to participate in any service delivery. Differentiating from the other localities, however, is the fact that the City Richmond through the Greater Richmond Transit Consortium, has provided city buses that have routes reasonably close to either one of those locations for people heading out of the city into those areas. Unfortunately, there is an absence of intra-county service; meaning public transportation is only limited to those only traveling in and out of the city exclusively. Due to this fact it is still a great necessity to have access to a vehicle in regards to transport infants to their health appointments. Additionally, inasmuch as there are a limited number of locations

sponsored by the Virginia Department of Health, there are a greater number of privatized healthcare providers than there is public transportation accessible. Henrico Doctors Hospital, Bon Secours St. Mary's Hospital and a number of Patient First locations all dot the landscape of Henrico County, where over 85% of county residents has access to private health care benefits. The combination of privatized care and state (albeit limited) provided care provides enough geographical accessibility to infant care in Henrico County – as long as reliable transportation is in existence (8).

PETERSBURG

Petersburg City, the last area of study, is headquarters to one of the largest government-managed health care district in the state. The seven offices that comprise the Crater Health District are predominately rural in nature but serve as some of the few bastions of available infant care services in their respected areas. As typified by the counties of Dinwiddie, Greensville, Surry, Sussex and Prince George and the cities of Hopewell, Emporia and Petersburg, a multitude of services must be offered in response to the needs of such a diverse population equally. With all providing similarities in services to each other and their counterparts in other counties, the Petersburg area locations (as well as the others under its umbrella) provide comprehensive resources for infants in hope of maintaining well-baby care and ensuring for steady growth and development as byproduct of such. An additional dynamic to Petersburg City location and healthcare accessibility is the presence of Fort Lee, one of the few 'open' bases remaining in existence where civilians have access to military hospital facilities. As such, Petersburg (and surrounding areas) do not have a many of 'commercial' privatized dealers; however, the local area hospitals (John Randolph Regional Medical (Hopewell), Southside Regional Medical and Fort Lee Military Hospital (Petersburg) provide a

'web of care' for individuals living in those particular areas. The health departments' satellite locations, however, work in tandem with Petersburg area residents to alleviate their infants concerns more closely. Although the city only has 62% of its residents with available and accessible privatized health care - it can be concluded that the presence of the VDH offices attempt to provide reasonable standards of care to mothers in search of proper managed care for their children. The city of Petersburg, although transportation is not necessarily an issue due to the city's small size and population, does provide access to centers of care as desired by customers in need of services (9).

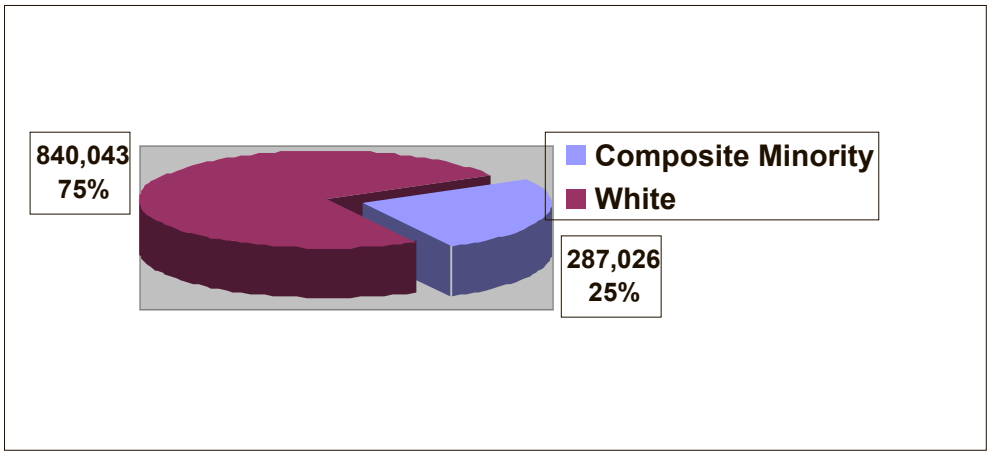

Figure 2: Demographic composite of the all targeted study regions

SOCIOECONOMICS

Socioeconomics has long stood as one of the cornerstones forming the wall between what is 'equitable' and what is 'substandard' in many opinions. There are characteristics that have shown to affect the health status of infants and children: income, education, and employment, and the proportion of the population represented by various levels of these variables. As such, information obtained on three separate but highly correlated sub-indicators of socioeconomic status, the average per capita income of the area, percentage of local unemployment, and the percentage of children receiving TANF or any other public assistance benefits. These measures are used as 'across the board' indicators, and provide reliable measures of economic prosperity. The higher the increase in the average per capita income of the area, new demographics will inversely effect the number of (a) unemployed within that area, (b) residents participating in TANF and/or TANF-related programs, (c) the rate of unemployment and (d) demographic information with regard to the major base(s) of population within the locality.

In analysis of the observable data, there are some recognized disparities within our targeted area of study. Petersburg City, although representing the smallest population, it had the highest unemployment rate (5.2%) in addition to having the lowest average income per capita ($23,931) of the targeted study. Further indicators of the areas socioeconomic health can be drawn from the amount of children currently receiving Temporary Assistance for Needy Families (TANF) assistance through the Virginia Department of Social Services (VDSS). Additionally, 1,159 (or 154.9 per each 1000 eligible children). Petersburg City children received benefits in regards to the provision of proper infant and well-baby healthcare for city residents. In terms of the demographics, the majority population of Petersburg City is aged between 18-44

years of age (38%) - the stereotypical 'working age' for those who have the capability to embark on some type of employment if such is attainable (10).

Hanover

Hanover County, by comparison, exhibited the lowest rate of unemployment (1.5%) of any surveyed areas in addition to the having the lowest number of children receiving TANF benefits – 159 (or 8.2 per each 1000 eligible children). Additionally, Hanover County residents (in terms of the average income per capita) placed the county squarely in the middle of the reviewed income statistics within the data sample ($27,007). Demographically, the major bases of population within he area can be found within three groups: 18-44 ('working age' population – 39%), 45-64 ('baby boomers' – 25%) and those residents who are 65 and over (14%) in which many are retired from employment and living on fixed income bases (10).

Henrico

Analysis of Henrico County displayed regional similarities in their data statistics. Possessing the largest average income per capita of the studied communities ($30,761), Henrico County also possessed the second lowest rate of unemployment (1.9%) within the surveyed populations. Further data analysis also showed that 1,672 received TANF benefits, a ratio of 30.5 per each 1000 eligible child. Analysis of the county demographics shows a breakdown across many age groups. It can be eluded that the largest, 18-44 (43%), make up the majority of the county's working population along with the second largest, 45-64 (21%). Henrico County also possesses a significant population of residents aged 65 and over (15%), as well as a number of child residents (aged 5-11: 9%). It is also possible that these are the children of the larger demographic groups residing within the count (10).

Chesterfield

Chesterfield had the second largest average income per capita in the study ($30,288) as well as the second lowest ratio of children receiving TANF benefits based on population (1,133 or 16.1 per each 1000 eligible children). The county also had a seemingly constant rate of unemployment (2%). Chesterfield County demonstrated similarities to the other mentioned targeted areas of study. In regards to demographics, the population of Chesterfield County divides more evenly then in any other studied locality. Although the major base of population is 18-44 (45%); 45-64 (21%), 5-11 (11%) and 65 and over (6%) all have significance within Chesterfield County, which spread the bases of population along many criteria as opposed than consolidated to a selected few (10).

Richmond City

Richmond City, as the most populated urban area, displayed the largest amount of data variance in comparison to the four regions of study with regard to analyzed units of measurements. While the average income per capita remained at a level constant with the other localities of study ($29,439), noteworthy exceptions were made in the ratio of children receiving TANF benefits, where 7,790 (or 217 per each 1000 eligible children). Richmond City children have enrolled and are receiving services. In addition, the level of unemployment within Richmond City, 3.4% is the second highest in the region. As so, Richmond City demographics represent the largest shift toward a more 'working age' population within its regional boards; where citizens between the ages 18-44 made up the residential majority at 42% while those aged 45-64 (20%) contributed to the population as well. Most noteworthy in this data analysis, however, was the observation that Richmond City has the largest base of 65 and over residents within the studied area (20%).

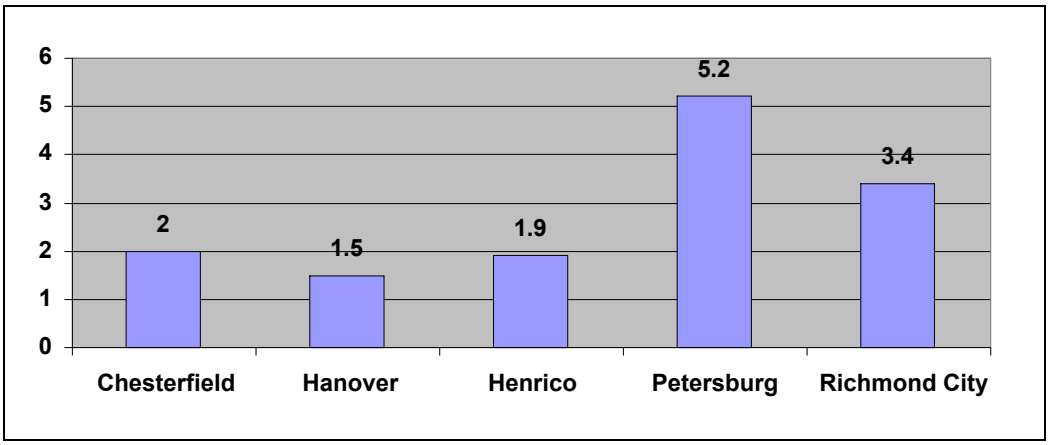

Figure 3: Percentage Rate of Unemployment per locality

What was the main regional indicator of inequity within infant health care and why?

The observed data displayed for all localities of study seem to show noteworthy parallels with regard to establishing socioeconomics as an indicator of inequitable regional infant healthcare. Due to a seemingly non-ignorable factor: the regional unemployment rate (joblessness) and its detrimental effect on the availability of citizens to obtain privatized (employment-based) healthcare coverage - which if left unattainable - results in the further dependence on public-mandated healthcare. Statistics can be used to illustrate. Hanover County and Chesterfield County – the localities with the lowest ratio per 1000 children of citizens receiving TANF benefits within the study (8.2 and 16.1) - also had the lowest and third lowest levels of unemployment (1.5 and 2.0%) within the regional study as well as the two highest percentages of individuals insured with privatized coverage in the region (88 and 89%, respectively). In opposition, the two urban localities of study, Richmond City and Petersburg City had not only the highest levels of unemployment (3.4 and 5.2%) but also the highest level of local residents receiving state-supported assistance (217 and 154.9) per 1000 eligible children and lowest percentage receiving employment –supported coverage (62 and 68%, respectively).

This, additionally, is not to say that public care is 'substandard' than privatized care, however - especially in more rural regions with limited availability to public providers (office hours only, no weekends) - immediate/emergency care provisions might be difficult to attain. As shown, it becomes evident that the adverse changes in the socioeconomic landscape within a given area can and will affect the level of infant health care in regards to ensuring equitability within levels of care and service delivery.

SECTION IV:

RECOMMENDED STRATEGIES FOR IMPROVEMENT/OBSTACLES:

There are two main strategies for improvement of infant healthcare. The first is increased utilization of marketing efforts to include greater outreach efforts. To address the social inequity of infant health care within Richmond and the surrounding area, we must look carefully at the Family Access to Medical Insurance Security Plan (FAMIS) program. As mentioned earlier, this plan is a federally funded program that provides low cost health insurance for infants and children in families that do not have private health insurance and do not qualify for Medicaid benefits. As the number of uninsured families continues to grow in the Richmond metropolitan area, the utilization of this program helps to fill the gap between the insured and uninsured. The difficulties within the FAMIS program have included intensive underutilization resulting in the return of millions of dollars to the federal government. In order to address the unequal distribution of infant health care in the Richmond metropolitan area, we need to take a closer look at the FAMIS program and consider a possible strategy to increase its utilization through the expansion of its marketing and outreach efforts.

From its onset, the FAMIS program has generated negative publicity and the numerous articles in the local news media have served to enhance this negative view. In addition, the

stigma attached to the program further alienated those families who may lack the knowledge of the many benefits available to their children. Statistics have shown that this poor utilization found throughout the state and is equally distributed across ethnic lines. If the purpose of FAMIS is to provide health care coverage for those who meet the criteria, then insufficient allocation of resources amount to continued inequity in infant health care coverage in the Richmond metropolitan area. At the onset, this program was under marketed and benefit information was shared as an addendum to material mailed to families who happened to be receiving other services from their local social services agencies. A marketing campaign utilizing both print and broadcast media that is informative, positive and easily understood is critical to increasing participation.

Although a website has been developed (www.famis.org) that provides information regarding eligibility, health plan information and a calendar of events, this information only proves helpful to those citizens who either have a computer or have access to a computer. This group is not generally found in the population that is eligible for FAMIS benefits and thus a website is not inclusive enough for its identified population. A mass mailing that consists of easily readable information being sent to eligible families that addresses the many benefits of the FAMIS program is needed. In addition, a follow up contact, by either telephone or in person should be explored to assist families in filling out the application, answer questions, or clarify service delivery options.

Finally, the need to recruit, hire, and train a sufficient number of social workers to follow up on all inquiries, meet with families within their own homes or neighborhood and assist in application completion is also suggested. In addition, the development of a network provider list and greater utilization of current non-profit agencies to assist in providing 'hands on' assistance

in getting into the program should also be strengthened within the program. Although the web site shows a calendar of informational settings around the state, this only consists of three actual days in March and April amounting to a paltry 15 hours of available informational time with prospective clients. As these sites restrict access due to transportation restrictions for the identified population, utilizing designated staff on the provider list to assist in this will be helpful. Expanding the current available sites for such informational programs through the utilization of this network provider list and other designated non-profit locations may assist in informational sharing. In addition, regular, monthly meetings at multiple sites throughout the state (specifically the Richmond metropolitan area) staffed with workers would go far in increasing awareness of the program.

The implementation of the above strategies will require strengthening of the current administrative oversight of the program. The obstacles to implementation include the length of time it may take to 'brighten' the negative publicity of the past, the actual cost of marketing and print material and inability to recruit and train staff for the network provider list.

EDUCATION

Another strategy that can temper the potential inequity of infant healthcare is increasing overall education. In this context education refers to both the education of the healthcare provider and the recipient(s), (mother and infant). Through monitoring research on client preferences the health care provider can determine the best way of disseminating information to the patient. Several studies relay the utility of healthcare providers' role in promoting education and how it can positively affect mother and infant health. One study (Gaffney & Altieri, 2001) recorded mother's preferences for intervention strategies used to promote infant health. The researchers found the most preferred clinical intervention strategy was nurse home visitation,

followed by group sessions with mothers, and led by a nurse. The least preferred methods were brochures and videotapes. These studies are important to educate healthcare providers as to what means of intervention are effective, as well as policymakers. There are certain methods that have been proven ineffective in promoting infant health and utilization of these methods waste scarce healthcare dollars (Gaffney & Altieri, 2001). Furthermore, "preconception obstetric risk assessment, along with health promotion, education, and therapeutic intervention, can reduce risks and improve outcomes" (Swan & Apgar, 2002). This study recognized education and health promotion as a way of decreasing infant morbidity and mortality.

Finally, the mothers and the infants themselves benefit from increased exposure to health education and education in general. Lack of access to care and lack of information on which to base individual and community health decisions have contributed to the high maternal and infant mortality rates that continue to exist in may areas of the world…Education is a successful intervention in changing health behaviors" (Gennaro, S., Dugyi, E., Doud, J., & Kershbaumer, R. (1998). Patient education is at the forefront of a majority of prevention strategies. When suggesting ideas to combat the complications of preterm birth, Lefevre (1992), states that educating patients about the signs and symptoms of preterm birth is a reduced risk, low cost intervention that could have a beneficial effect. Furthermore, as cited in Nevzer (1998); a considerable number of studies in the United States suggest that the number of completed year's of formal schooling is the most important predictor of good health (Auster, Leveson, & Sarachek 1969; Grossman 1972; Silver 1972; Grossman & Benham 1974), [in addition] evidence shows much progress has been made in raising schooling levels and reducing infant mortality.

Not only does education have the potential to reduce effect mortality rates and raise consciousness about certain complications, it has the potential to benefit the individual as a whole. Mal-informed individuals make mal-informed decisions.

> The consequences of poor health decisions reach tragic proportions…the nation has yet to put into place the interlocked networks of health promotion, health education, and health care that are necessary to achieve the kind of health goals needed for familial, community, and economic vigor and social justice (Elias, 1990).

One obstacle with the selection of an increase in overall education as a solution to inequitable infant healthcare is compensation. The educators (both health, and academic) additional time spent in classrooms and clinics would require taxpayers or interested individuals to increase their salaries. However, additional educational time could also be as simple as effectively utilizing all the allocated time for (health) education. This could include reemphasizing the benefits of good health and responsible decisions during down periods in classroom instruction. Another low cost education addition would be for physicians and healthcare providers to implement preconceptual risk assessment and health promotion (Swan & Apgar, 2002).

Although increased education is not the sole solution to more equitable health and infant health care problems, research seems to indicate that education and healthcare are closely related. Furthermore, if increased education is combined with more effective and efficient marketing, perhaps a solution to healthcare inequity is closer than imagined.

CONCLUSION:

The intent of this paper was to introduce the reader to the concept of social equity and its presence in the Richmond Metropolitan Area specifically regarding infant health. Denhardt (2000), paraphrasing the Minnowbrook Conference Papers, describe social equity as "the reduction of economic, social, psychic suffering and the enhancement of life opportunities for those inside and outside an organization". This paper finds there is a need for improved equity between Richmond Metropolitan Areas regarding infant healthcare, as evidenced the analysis of the studied localities socioeconomic make-up. In the Richmond Metropolitan areas, race and geographic access are not indicators of inequitable healthcare. In the Richmond Metropolitan areas, infant healthcare inequity stems from socioeconomic foundations. Section IV discussed two feasible options to ameliorate some problems plaguing the distribution or access to equal infant healthcare. This paper determined the most effective alternatives for improvement lay in being broader and more inclusive marketing of infant healthcare programs as well as overall education.

"Public policy can save more lives more cheaply than many of the fancy technologies that fill U.S. hospitals. The nation needs a larger vision of the concept of health care" (Lamm, R. & Bluemke, D., 1990, p.29). The first step starts with improving the social equitability of healthcare programs. As noted in this paper, improvement of public health care policy does not always have to come with monumental costs. Some improvements especially regarding broader marketing and exposure of as well as increased education can be incorporated into current systems with minimal disruptions. However, the obstacles to implementing these strategies must be noted and rigorous studies conducted on the subject. Once again, it is important to remain

conscious that the interpretations of these findings are only applicable to Richmond Metropolitan areas (Chesterfield, Hanover, Henrico, Petersburg, and Richmond City). The study of other regions infant healthcare systems and options are encouraged, as they would only enhance the public's understanding of potential disparities in infant healthcare.

Overall the value of the concept of social equity and how it affects healthcare still need to be explored. Infant healthcare is only one of the many sub-policy areas that factor into healthcare policy. As a citizen's "right" to healthcare continues to be debated (Cypher, 1997), quality healthcare will remain on the public agenda indefinitely.

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