Medical treatment in the lower socio economic status

An investigation into the disparity of health care and medical treatments amongst the homeless and indigent population

Tag Words: Medical treatment; health care; lower ses; homeless; indigent population

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Summary (MSE)

Throughout the modern world there exists a strong correlation between an individual’s socio economic status and poor health. Not surprisingly, exposure to risk factors tends to be greater in this population which increases the rates of morbidity and mortality of various acute and chronic illnesses. Limiting exposure to these risk factors reduces these rates but is usually a result of a dramatic change in the lifestyles of each individual, a problem that must be addressed by society on a much larger scale than we could focus our project on. Therefore, we would not be able to tackle the issue from an economic standpoint but we believe that we can make a difference by investigating the inherent disparity of health care and medical treatment amongst the homeless and indigent population in our community. We choose to research three specific illnesses; coronary heart disease, sexually transmitted diseases, and mental illnesses and their prevalence in lower socio economic communities. These illnesses are common across all economic statuses but we were interested in why rates tend to be higher in lower statuses and how to combat this disparity. What we found was that poor health is directly correlated with poor healthcare which in turn is a direct result of a lower socio economic status. We would not be able to affect an individual’s personal economic status at our level but we focused our attention on why individuals received poor health care and what we could do to address this issue. Further investigation into the health care and medical treatment available in our specific community revealed several health outreach programs that were accessible to the homeless and indigent population. Therefore, our project was focused on raising awareness of these programs and helping individuals receive quality health care and medical treatments when needed. In order to do so, we raised money to purchase a few basic health care items including hand sanitizer, shaving, and oral hygiene products. We then distributed them, with information detailing the programs available, to individuals at Elijah’s Soup Kitchen in downtown New Brunswick, NJ with the hopes that we could help individuals get the health care they needed. Our intentions were to help at least one person get the health care that they may need and if we were able to do so then we feel we made a positive impact on our community and the time and effort put into the project was well spent.

Video Link

http://www.youtube.com/watch?v=X7zHeDDn1qg
Diseases such as heart disease, STDs, and mental illness affect and kill millions of people each year. Through our study we have examined how these illnesses have a clear concentration on lower socio economic status citizens. This concentration may be attributed to access to health care treatments, environments, as well as simple awareness. We will look in depth at three of the most common said illnesses including HIV, Schizophrenia, and coronary heart disease. We then will delve into why their role in lower class societies appears inflated and means to which they might be avoided or deflated.

Sexually transmitted diseases (TC)
Sexually transmitted diseases infect people all over the world. HIV (Human Immunodeficiency Virus) is the most prevalent sexually transmitted disease carrying with it lethal implications. The disease has a predominant impact on all social classes; however, there seems to be a clear correlation with lower socio-economic communities. This correlation can be credited to an array of different issues which include awareness, environment, access to treatment, and inequality in the health and educational systems. If we can spread awareness and work to bring equality in these systems then maybe we can lessen the effect the disease has on these communities.

HIV is a global epidemic. The disease has infected millions since its inception almost four decades ago. HIV belongs to the family retrovirus and is further grouped under the genus lentivirus. A lentivirus is characterized by its slow development and latency after infection (4). A person can become infected with the virus and not show symptoms for long periods of time.

It is important to note that HIV is not what kills an infected person but the ending stage of the disease called AIDS (Acquired Immunodeficiency Syndrome). “HIV destroys CD4 positive (CD4+) T cells, which are white blood cells crucial to maintaining the function of the human immune system. People who have been diagnosed with AIDS have fewer than 50 CD4+ T cells in their entire body.” A healthy human has anywhere from 800-1200 CD4+ T cells per cubic millimeter of blood (5). With this negligible amount of white blood cells the body’s immune system is depleted and therefore cannot fight off infection. When the virus progresses to this aptitude the infected person is highly susceptible to other infection and can easily die from a simple bacterial infection such as the common cold.

There are two different strands of HIV defined as HIV-1 and HIV-2. Both of these strands are transmitted through sexual contact, exchange of blood or bodily fluids, from mother to child, and also ultimately lead to AIDS. Evidence has shown that, “HIV-2 is less easily transmitted, and the period between initial infection and illness is longer in the case of HIV-2 (3).” HIV-1 is much more common with HIV-2 being found only in certain regions of the world.

Thorough research has been able to identify the most likely origins of HIV-1. “The ancestry of HIV-1 has been traced to SIVepz (simian immunodeficiency virus) infecting chimpanzees (Pan troglodytes) in west central Africa (2).” There is no definitive answer to how HIV crossed species but there are some interesting theories. The most accepted theory among scientist is that hunters may have been exposed to the infected blood during a hunt.

UNAIDS estimates that there were approximately 33.3 million people living with HIV in 2009 (1). While the overall trend of new incidences has been declining there were still an estimated 2.6 million people who newly became infected with HIV in 2009(1). With all of the new high
quality antiretroviral treatments available, people with resources to obtain the drugs needed are living longer. AIDS related deaths worldwide have been decreasing an estimated 2.1 million deaths in 2004 to 1.8 million deaths in 2009 (1). According to the WHO guidelines 5 million people are currently receiving treatment for HIV; while this is a solid public health achievement this number represents only 35% of the people who need treatment now. (1) These numbers reflect a positive direction across the globe but the question is how many people living in lower socio-economic communities are receiving these necessary treatments?

We define our lower socio-economic status by ones income, education, and quality of life usually influenced by the environment in which they live. Most people living in lower socio-economic communities are much more susceptible to disease especially a disease such as HIV. This increased susceptibility possibly stems from communities not being cognizant of the disease or just being surrounded by people who are much more likely to have HIV. Furthermore, once contracting the disease those with fewer resources are less likely to identify that they are infected, left with limited treatment options and continue with their lives unknowingly passing on the disease to one another.

Another factor that must be taken into consideration is the way in which HIV is contracted. One can become infected with HIV through unprotected sexual contact, drug use (sharing needles), and from mother to child. People living in lower socio-economic communities are more likely to live stress filled lives. This unhealthy lifestyle may encourage the use of injectable drugs. “It is estimated that there are around 15.9 million injectable drug users (IDUs) worldwide, with around 80% living in developing and transitional countries. (3)” The other issue with injecting drugs is the act of sharing needles. IDU’s will share needles for one reason or another whether it is because they just don’t care or just don’t have access to clean needles. This sharing is a huge factor in the spread of HIV especially in lower SES.

Prostitution is also very common in lower socio-economic communities. Illicit sex work poses a huge threat to the spread of HIV. Many people who sell their bodies for sex are unaware they have HIV or turn a blind eye to it. What makes the issue even worse is the majority of prostitutes also abuse drugs and use the money they receive from sex to obtain the drugs. “The link between substance abuse and sex work is hard to pinpoint though there are a variety of factors that are common to both, including homelessness, unstable family lives, socio-economic deprivation, disrupted schooling, local authority care and confidence and esteem issues (3). This combination of drug use and prostitution puts these people at an extremely high risk for contraction and spread of HIV/AIDS.

Race and ethnicity may also help to explain why lower socio-economic communities are at a higher risk for HIV. “African-Americans males are 6.5 times and African-American females are 19 times more likely to contract HIV compared to their Caucasian counterparts. (1)” According to the US Census Bureau 24.7% of African Americans lived in poverty in 2008. Compare this statistic with the fact that in that same year 52% of all new HIV diagnoses were African Americans (3). These numbers are astronomical and can help us account for why lower socio-economic communities are at such a higher risk to be infected with HIV.

There is no definitive cure for HIV/AIDS. However, within the last decade science has been able to develop extremely effective treatments that prolong the latency between HIV and AIDS. The drugs are referred to as antiretrovirals (AVRs). “The aim of antiretroviral treatment is to keep the amount of HIV in the body at a low level. This stops any weakening of the immune
system and allows it to recover from any damage that HIV might have caused already. (3)” The only problem with these drugs is HIV quickly adapts and soon becomes resistant. For this reason people must consistently take different medication with slight variations to ensure effective treatment. Combination therapy is also a common method of treatment. This method involves taking multiple anti-HIV drugs in unison and therefore slowing the rate at which the virus becomes resistant.

Starting HIV treatment can be particularly demanding and the infected person will be required to take a multitude of drugs every day for their entire lives. These drugs carry huge potential benefits and can help extend people lives another 20-30 years than if they were to not undergo treatment. Treatment first consists of first-line drugs. Once HIV becomes resistant people must turn to second-line drugs. “Drugs used to combat resistance are called second-line drugs…10-15% of people taking antiretrovirals will develop resistance to the combination of drugs that they are taking within 4-5 years(3).” The issue with treatment is that medication is extremely expensive. Fortunately, over the past few years costs have seen a significant decrease. “Between 2004 and 2008, first-line antiretroviral regimens in lower- and middle-income countries declined by 30-68% (3).” The most common triple drug combination can now be made available for as low as 885$ per year. However, second-line treatment is still expensive. An infected person needing second-line drugs would be spending anywhere in the area of $853-3668 per year for medication (3).

These numbers pose a huge threat for those categorized in lower SES. Infected people living in these areas likely do not have the means necessary to purchase the array of medication they need to survive. If we look to an example of an infected person of higher status such as Magic Johnson we can easily see the disparities. He was diagnosed with HIV in 1991; however, the disease has lied dormant in his system. This is due to his access to resources and the highest quality of treatment. If there was a way to develop universal access to these treatments for all infected individuals regardless of their social status we would be taking a huge step forward in the fight against this global epidemic.

The final and most important piece to solving this puzzle is prevention. If we can prevent new HIV incidences then we can knock out all the rest of the subsequent problems. Unfortunately, the response to HIV is hindered by poverty and unequal resource pathways. This is why education must be at the forefront for prevention of HIV. People living in these lower socio-economic communities must be made knowledgeable of the dangers that await them if they do not proceed through their lives with caution. Preaching the use of a condom during any type of sexual contact is essential. If you are going to use needles to inject drugs do not by any means share needles. Finally, urging the need to get tested to identify if you are infected with HIV. This is an ongoing struggle especially for those in lower socio-economic communities. If you don’t know you have the disease you are that much more likely to pass it on to someone else. “One in every five people living with HIV has not even had their infection diagnosed, let alone reported. (3)”

In order to effectively educate these communities HIV prevention programs must be “scaled up to deflect the trajectory of the epidemic. (1)” National and local investments must be made in health care and social support systems, that work to eliminate violence against women, and to ending the stigma and discrimination against people living with HIV. Achieving in part a few of these aspects can help build stronger communities and help provide social environments that are effective against the spread of HIV. If we can focus our efforts on preventing the continual
spread of HIV through education and somehow develop a universal access program for those who need treatment then we would be making leaps and bounds in the direction to someday wiping out this global epidemic.

Schizophrenia (DC)
The word Schizophrenia was coined by Eugen Bleuler, Swiss psychiatrist, in 1911. However the disease itself was originally identified by a Dr. Emile Kraepelin, German physician, in 1887 as a mental illness. In early years many mental and physical deformities were thought to be caused by possession and were treated the same. Dr. Emile Kraepelin was one of the first to differentiate the mental disorders of the time. Dr. Kraepelin deemed the disease “dementia praecox” (early dementia), for which we now know as Schizophrenia. Dementia praecox was the term used by Dr. Kraepelin because he wanted to differentiate it from other dementia forms such as Alzheimer. Other forms of dementia occurred later in life, while Dr. Kraepelin’s studies focused on young adults with dementia.

Bleuler changed the name of the disease to Schizophrenia due to Dr. Kraepelin’s term “dementia praecox” (early dementia) being an incorrect description. Schizophrenia did not always lead to a mental deterioration, and thus was not truly dementia. In addition, Schizophrenia at times occurred later in life as well as early. Therefore the term schizophrenia, meaning split mind, was more appropriate.

Schizophrenia is often thought by the general public to be a split personality, but this is inaccurate. It is actually a debilitating brain disease of which an individual can be completely out of sync with reality. There are five different categories of schizophrenia based on symptoms observed during assessment. Symptoms of the illness are put into two descriptive groups, positive and negative. Positive symptoms are overtly psychotic, while negative symptoms are potentially less overtly psychotic. Positive symptoms include symptoms such as delusions, hallucinations, disorganized speech and behaviors, and catatonic behaviors. Negative symptoms on the other hand include restrained facial expressions, and lack of speech and motivation. The list and description of each category of Schizophrenia is provided by the schizophrenia article by Dr. Roxanne Dryden-Edwards via medicinenet:

- Paranoid schizophrenia: The individual is preoccupied with one or more delusions or many auditory hallucinations but does not have symptoms of disorganized schizophrenia.
- Disorganized schizophrenia: Prominent symptoms are disorganized speech and behavior, as well as flat or inappropriate affect. The person does not have enough symptoms to be characterized as catatonic schizophrenic.
- Catatonic schizophrenia: The person with this type of schizophrenia primarily has at least two of the following symptoms: difficulty moving, resistance to moving, excessive movement, abnormal movements, and/or repeating what others say or do.
- Undifferentiated schizophrenia: This is characterized by episodes of two or more of the following symptoms: delusions, hallucinations, disorganized speech or behavior, catatonic behavior or negative symptoms, but the individual does not qualify for a diagnosis of paranoid, disorganized, or catatonic type of schizophrenia.
- Residual schizophrenia: While the full-blown characteristic positive symptoms of schizophrenia (those that involve an excess of normal behavior, such as delusions, paranoia, or heightened sensitivity) are absent, the sufferer has less severe forms of the disorder or has only negative symptoms (symptoms characterized by a decrease in function, such as withdrawal, disinterest, and not speaking).

Schizophrenia is like many mental diseases, is not completely understood. No single cause can be ascribed for Schizophrenia. However, it has been proven that schizophrenia does run in genetic pools. That is to say that the disease runs in families and having a family member with the disease increases the chances of one developing the illness. The disease is a result of genetic, psychological, and environmental factors. According to the article by Dr. Roxanne Dryden-Edwards, “Environmentally, the risks of developing schizophrenia can even occur before birth. For example, the risk of schizophrenia is increased in individuals whose mother had one of certain infections during pregnancy. Difficult life circumstances during childhood, like the early loss of a parent, parental poverty, bullying, witnessing parental violence; emotional, sexual, or physical abuse; physical or emotional neglect; and insecure attachment have been associated with the development of this illness. Even factors like how well represented an ethnic group is in a neighborhood can be a risk or protective factor for developing schizophrenia. For example, some research indicates that ethnic minorities may be more at risk for developing this disorder if there are fewer members of the ethnic group to which the individual belongs in their neighborhood”.

Even though Schizophrenia is not fully understood, there are treatments and medications available that have shown to be effective in some cases. Many different antipsychotic drugs alongside antidepressants and anxiety medications have been produced to treat certain symptoms of schizophrenia. These drugs help to normalize biochemical imbalances that cause schizophrenia. While these medications are affective for the psychotic symptoms they often are not affective on the behavioral symptoms such as communication and motivation. In these symptoms psychosocial treatments have proven to be more affective. Psychosocial treatments include techniques such as rehabilitation, individual psychotherapy, and self help groups. The psychotherapy is a regularly scheduled session with a psychiatrist and aims to help them understand more about their problems and distinguish from reality and delusion. Self help group has patients acting as a group rather than individually. With both antipsychotic drugs and psychosocial treatments implemented together the patient has a great chance to be cured.

However many cannot acquire these treatments, either because they do not know where to receive help or because they can not afford such medications. Clozapine is one the more cost efficient antipsychotic drugs, yet is $4.00 per pill for 25mg and triple that amount for 100mg. For a medication that must be taken daily, one can see how these charges become very costly. Some can afford such medications or have people to help them get the help they need, while others are not as fortunate.

Presently about one percent of the population is affected by this disease, which is estimate to about 2 million people in the United States. Taking this information into account one can see that this mental disease affects many individuals. For those whom are fortunate enough to have families or people close to them it is more likely for them to find the help that they need. Also they would have a better chance to be able to afford to receive treatment and have the support to
stay on the medications. However one must wonder about those who are not so fortunate. According to the Congressional Research Service in the Library of Congress, it is estimated that the population of homeless in the United States ranges from 600,000 to 2.5 million. This is a huge population of individuals who do not have the everyday conveniences that others have. This means there is a great amount of people without a place to live or people close to them to notice the first signs of the disease or encourage them to seek help. In Marvin Ross’s book “Schizophrenia: Medicine’s Mystery – Society’s Shame” he pulls stats from E. Fuller Torrey’s “Out of the Shadows” about mental illness in the homeless population. He estimates “that about 35% of the homeless suffer from severe mental illness. If we add in those with alcoholism and addictions, then the percent jumps to about 75%”. That means that out of the estimated 600,000 estimated homeless in the United States 75% or 450,000 people suffer from mental illness. Therefore taking the lowest estimated amount of the homeless population in the United states and taking into consideration the estimated 2 million who suffer from schizophrenia, we can see that about 22.5% of the people who suffer from the disease are potentially homeless and do not have the care and medication they need.

With such a large part of our population without the care and help they need, we as a nation must show compassion. Such individuals need to be able to receive the help that they need. We need to establish national programs to help such individuals receive the medication and support that they need. In addition, these individuals need to be informed or have some way of finding out where such assistance can be received. To look at an example of what kind of services that need to be implemented we can look to the H.I.P.H.O.P. program of Robert Wood Johnson. This is the Homeless and Indigent Population Health Outreach Project, a program established in 1992. This program is a student-directed community service and learning program. The students provide community outreach, health promotion programs, preventive education and clinical services. Truly leading by example, many other programs such as this must be implemented across the nation to help those whom would otherwise not receive assistance. National Health care also needs to make these medications more readily available for such underserved populations. By creating more programs such as this and developing easier access universally to medication we could dramatically affect the numbers of individuals who suffer from this disease.

Coronary Heart Disease (MSE)
The number one killer in United States today is a disease that can often be prevented. According to the American Heart Association, heart disease is the nation's single leading cause of death for both men and women accounting for one out of every three deaths (18). Consequently, the epidemiology of coronary heart disease has been, and continues to be, a major area of focus for public health. Studies have shown that there is a strong correlation between incidence and prevalence rates of coronary heart disease and socio-economic status (13). Not surprisingly, lower socio-economic status has higher rates as compared to other statuses.

Coronary heart disease is usually caused by atherosclerosis, a condition of the heart in which fatty material and plaque builds up on the arterial walls causing them to narrow. As the coronary arteries narrow, blood flow to the heart can slow down or stop, causing chest pain (stable angina), shortness of breath, heart attack, and other symptoms (22). Specific risk factors including diabetes, high blood pressure, high LDL cholesterol, low HDL cholesterol, menopause, physical activity or exercise, obesity, and smoking have all been linked to higher incidence rates of coronary heart disease (18). Asymptomatic patients can be treated with either medicine or
angioplasty. Some medications that are commonly used to treat coronary heart disease include: ACE inhibitors to lower blood pressure, blood thinners (anti-platelet drugs) to reduce the risk of blood clots, beta-blockers to lower heart rate, blood pressure, and oxygen use by the heart, calcium channel blockers to relax arteries, lowering blood pressure and reducing strain on the heart, diuretics to lower blood pressure, nitrates (ie. nitroglycerin) to stop chest pain and improve blood supply to the heart, and statins to lower cholesterol (19). Often, doctors will perform percutaneous coronary interventions in order to treat and diagnose coronary heart disease in addition to prescribing medication. Percutaneous coronary interventions, or PCIs, are performed by interventional cardiologists and are typically less painful and require access only to patient’s vascular tissue through use of a needle rather than using an “open” approach that exposes inner organs and tissue. If necessary, other treatments including coronary atherectomy, coronary radiation implant or coronary brachytherapy and surgeries including coronary artery bypass surgery and minimally invasive heart surgery may be required (18).

Throughout history, heart disease has traditionally been associated with affluent lifestyles and the upper and middle social classes. However, as societies change and environments are modified, the style, living and types of activities available to members of various social classes also change. Consequently, in the United States there has been a dramatic change in the incidence of heart disease. In the past 30 years heart disease has declined for all Americans but, the decline has been greatest among the upper and middle classes (14). This decline has likely been caused but not limited to further education of risk factors and preventative measures. As a result, coronary heart disease is now more concentrated among the poor and rates of incidence and prevalence are higher as well. Statistics show that in 2006 the overall death rate due to coronary heart disease was 262.5 per 100,000 (20). Yet, there existed a dramatic disparity between the rates for various ethnic groups (15). For instance, the rates were 306.6 per 100,000 for white males, 422.8 per 100,000 for black males, 215.5 for white females per 100,000, and 298.2 for black females per 100,000 (20). Unfortunately, this disparity between ethnic groups can be associated with socio economic statuses.

Treatment of chronic diseases such as coronary heart disease can be very costly. Frequent checkups, numerous medications, and stays in the hospital are common as a result of the treatment plan of a chronic disease. For individuals with insurance the out of pocket cost may be more affordable. However, it has been estimated that 52 million Americans lived without health insurance coverage for sometime in 2010 (21). For those without insurance, treatment is generally unattainable because of the high costs. This creates a cycle of poor health caused by bad economic standing that continues to compound upon itself. Amongst the debate of health insurance, attention has been brought to the importance of reducing exposure to risk factors that produce ill health. Unfortunately, people living in poverty and reduced socioeconomic circumstances have the greatest exposure to risk factors that produce ill health. These risk factors include physical (poor sanitation, poor housing, overcrowding, extreme temperatures), chemical (environmental pollution), biological (bacteria, viruses), psychological (stress), economic (low income, lack of health insurance, unhealthy jobs), and lifestyle (poor diets, smoking, alcohol and drug abuse, lack of leisure-time exercise) in origin (13). Consequently, higher rates of obesity, smoking, and stress occur in the lower class, in addition to higher levels of blood pressure, less leisure-time exercise, and poorer diets. Exposure to these risks adversely affects lower class health and as a result, lower socioeconomic status is associated with lower life expectancy, higher overall mortality rates and higher rates of infant and perinatal mortality.
It has been known that there is an inverse relation between social class and most health outcomes almost everywhere in the industrialized world. This trend was most clearly illustrated by Michael Marmot and colleagues in 1967 London. The Whitehall studies, as they were commonly known, were the first to recognize a trend in incidence and prevalence of coronary heart disease. The subjects were 17,530 civil servants aged 40 to 64 at baseline in 1968. The age adjusted prevalence of chest pain (angina pectoris (23)) was 53% higher for men in the lowest employment grade than for those in the top administrative grade, and electrocardiogram abnormalities caused by reduced blood flow to the heart (ischemia) were 72% higher in the lower than in the top grades. At follow-up the 10-year coronary mortality rate was 3.6 times higher in the lowest than in the top grades (17).

Lifestyle and social/environmental conditions, along with preventative health measures, primarily determine health status, and maintaining a health status is integral to the prevention of chronic diseases such as coronary heart disease. A healthy lifestyle includes the use of good personal habits such as eating properly, getting enough rest, exercising, and avoiding practices such as smoking, abusing alcohol, and taking drugs. However, the type of lifestyle that promotes a health existence is more typical of the upper and middle classes who have the resource to support it. Therefore, an important step forward for the lower socio economic status to reduce rates of incidence and prevalence must be reduction of exposure to risk factors and preventative health measures. Visits and checkups at the doctor’s office need to be routine rather than a caused by an ailment that can no longer be dealt with. This needs to be achieved through education and advocacy for health outreach programs. In the greater New Brunswick community, there exist multiple community health outreach programs that have been developed specifically as a resource for the lower socio economic status. The Eric B. Chandler Health Center offers primary care services and accepts a variety of insurances and community welfare programs, in addition to having a sliding scale for individuals without insurance. Additionally, the Homeless and Indigent Population Health Outreach Program which is run by doctors and medical school students at Robert Wood Johnson Medical School offers free services to individuals at Elijah’s Soup Kitchen in downtown New Brunswick. However, the problem of equality with respect to health services is and remains a serious problem in American society. In a free market system lacking national health insurance, those persons who are economically disadvantaged are also medically disadvantaged when it comes to obtaining quality services.

Obtaining equal access to care is a major step in improving the health of the general population. Improved access to health services is only part of the solution for advancing an individual’s overall health status. By advocating for health outreach programs and raising awareness of their services the health status of the lower socio economic status can be improved. Yet, the fact remains that people at the bottom of society have the worst living condition that goes along with having the worst health. Preventive services need to be aggressively targeted at lower socioeconomic groups and areas in an effort to reduce disparities in not only cardiovascular risk but all risk factors that cause ill health between different socioeconomic groups.

The Service Project

Summary (MSE)
After completing our detailed investigation into the disparity of health care and medical treatments amongst the homeless and indigent population and the resulting rates of incidence and
prevalence of particular disease, we focused our project on spreading awareness of health outreach programs amongst this population in our community. We discovered that individuals in the lower socio-economic status have multiple options in the greater New Brunswick area for health care and medical treatments including the Eric B. Chandler Health Center, the Homeless and Indigent Population Health Outreach Program (H.I.P.H.O.P.), the Promise Clinic, the First Step Addiction Program, and the multiple hospitals in the vicinity. We were able to identify and contact members of the H.I.P.H.O.P. program and learned that they run their clinic out of Elijah’s soup kitchen Thursday evenings after dinner and provide their services free of charge to those who attend. Our project then became centered on raising awareness of this community health program. We raised money and were able to purchase a handful of general health items including hand sanitizer, razors, oral hygiene items, and condoms and distributed them along with information detailing the time and whereabouts of the program. We encouraged individuals to see a doctor whether or not they felt it necessary and advocated the importance of preventative measures such as reducing exposure to risk factors that cause ill health. In addition to our service project, we each wrote editorials to major news outlets advocating for health insurance reform and the importance of all Americans having the ability to receive the health care and medical treatments necessary.

Conclusion (TC)
Throughout our investigation we have uncovered the disparities of medical treatments and disease of lower socio-economic communities with a focus on the homeless population. The incidence of HIV, Schizophrenia, and coronary heart disease all show up in an unreasonable amount in these communities displaying a clear connection. If this problem is ever to be reduced efforts must be made to make access to health care more affordable along with promoting education in these communities as a mean to raise awareness. Through our service project we have donated supplies such as hand sanitizer, clean shaving utensils, floss, and condoms to the local soup kitchen at Elijah’s Promise. We have also included an informational packet directing the homeless to places where they can get the free medical attention they need and deserve. Everyone should have a right to be healthy it should not be a privilege. We feel that through our service project if we were able to help at least one person we have done our small part in improving this injustice.

References

(2) Bailes et al. (2003, 13th June) 'Hybrid Origin of SIV in Chimpanzees', Science 300(5626)
Health care is a prevalent issue in yesterday, today, and tomorrow’s world. It is an issue that will continue to affect the lives of every breathing soul on this planet. The methods we chose to treat people are skewed. In my opinion, health care should not merely be a privilege but a right. Every person from the moment they are born should be given the right to be healthy. It should not be an entity that one has to earn through social status. There are countless amounts of people that have zero access to health care. Whether it due to the environment they reside, their social status, or yearly income. It is an inhumane and cruel truth plaguing our world. Not only are sick people suffering but the common good of our society also takes a toll.

I recently returned from a medical brigade in Lima, Peru where I volunteered my services in providing health care to extremely poverty stricken areas. It was an experience I will keep with me forever. The condition the people live in day to day is difficult to put in to words. For
many of them it was their first time ever even seeing a doctor. We spent the week there and provided as much health services as we could to as many of these communities as possible. Our services ranged from enabling them access to a primary care physician, a gynecologist, a dentist, as well as simple medications to aid them in their suffering.

While we did a whole lot of good down there and helped a lot of people we merely brushed the surface. A single visit to the doctor is insufficient. Patients need follow ups and different medications that our resources did not allow us to offer. There are people living like this not only in Lima but all over the world including our own country. It is unacceptable. I recognize that money does not grow on trees and an extremely large amount of resources are necessary to be able to provide health care but at the same token are we just suppose to stand by and let this injustice proceed?

Reaching out and providing services to the 3rd world and the like seems unrealistic from where we stand today. But it is not unrealistic to imagine an America that provides health care to all of its citizens regardless of their social status. People are suffering everyday and you can help. Write your local congressman tell them how you feel. No matter how frustrating it may be you have to keep pursuing. Put yourself in their shoes. What if it was your child who needed some sort of health care in order to survive but was denied access because you didn’t make enough money? Everyone deserves a chance to be healthy, stand up and help make a change!

Dante Callahan (Submitted to Targum)

“We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.” These are truths that we hold intimately to our philosophy of life, right? If this is true then why is it that we sit back while so many are denied the ability to receive medical treatments, and in effect denied their life and pursuit of happiness. Many people in our country as well as other countries battle or die from treatable diseases. They do not receive the care they need mostly because of their income or lack thereof. According to the Census Bureau in 2010 more than 50 million people were uninsured. This is an approximate number due to the fact that many unaccountable figures potentially derive from those who are homeless. The homeless have up to six times more susceptibility to illness. With that being said, how many people can we let just die in our very own streets?

Yes this new health care law by President Obama is supposed to address this issue but to what extent? With this law in effect, President Obama estimates up to 32 million uninsured Americans to receive healthcare in the future. However, this shall not become effective until 2014. In addition, let’s acknowledge the fact that only up to 32 million will be insured yet the number of uninsured was 50 million last year and this number is constantly growing due to recession layoffs. For many, all they have to do is live their life for three more years without getting sick. Shouldn’t be hard right? Are we just going to assume that the others who will not be affected even after the healthcare reform will figure it out on their own? I implore everyone to put whatever personal agendas they have aside and make healthcare available for all. Being able to be healthy should be a right, for the only way one can pursue happiness is to live a healthy
life.

Mikel S. Ehntholt (Submitted to NJ Voices via NJ.com)

The problem of equity with respect to health services is and remains a serious problem in today’s society. As the national and state governments struggle to reform the current state of health insurance millions of American remain uninsured. It has been estimated by the Commonwealth Fund, a health care advocacy group that 52 million people living in the United States went without medical coverage for a period of time in 2010. Among those uninsured, the homeless and indigent population is grossly overrepresented. Not surprisingly, the homeless experience illness three to six times more frequently than those that are housed and complicating things further, homeless patients typically present multiple interrelated chronic health conditions, including high rates of mental illnesses, substance abuse disorders, and infectious diseases. What ensues is a viscous cycle of illness, lack of treatment, and overall declining health. Kudos to those who offer free medical services to populations that can’t afford it otherwise. Unfortunately the acts of a noble few will not solve the problem of the masses. The issue will continue to spiral out of control, so the question is: Where does it stop?

To President Obama, Governor Christie, and the likes of the 49 other states: It is time to put an end to the cycle. It is time to treat those who need to be treated. It is time to address and fix the shortfalls of the American health care system. We hold pride in the fact that we are the greatest nation in the world, yet we can’t figure out a way to treat our own. I challenge you to put aside your political agendas and insure the uninsured. I challenge you to make health care more affordable, accessible and accountable, for the better of society today and tomorrow.