

Community-Based Educational Approach to Reduce Health Disparity

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Health disparities refer to differences between groups of people. These differences can affect how frequently a disease affects a group, how many people get sick, or how often the disease cause death. Racial and ethnic disparities in health and health care recently have received considerable attention. Racial and ethnic minorities tend to receive poorer quality care compared with non-minorities. The Institute of Medicine (IOM) defines disparities as “racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention [1]. While the World Health Organization (WHO), have adopted a different view of what constitutes a disparity, major stakeholders agree that such disparities are unjust and need to be addressed [2]. In order to decrease this differential, it is critical to understand the particular barriers to health and health care that underserved minorities face. The barriers have been identified as: inadequate access to and availability of health care services, lack of knowledge of disease prevention and screening recommendations, low literacy, mistrust of the health care system, fear, fatalism regarding cure, genetic and environmental risk factors.

The proportion of the minority groups within the U.S. population is growing rapidly, increasing the need to respond to their health care needs. In 1985, in response to concerns about the health status of Blacks and other minority populations, the Report of the Secretary’s Task Force on Black and Minority Health (the Heckler Report) was released. It documented significant disparities in the burden of illness and mortality experienced by Blacks and other minority groups in the U.S. population. In 2000, Congress passed the Minority Health and Health Disparities Research and Education Act (Public Law 106-525) to address “the significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates.” The United States Census Bureau estimates that in 2013 there are nearly 42 million African Americans living in the United States, comprising 13% of the total population [3]. In 2010, nearly one out of every four African Americans resided in New York, Florida, or Texas [4]. Of the more than 3 million foreign-born African Americans, the majority were born in the Caribbean (53%) or Africa (35%) [5]. The causes of these inequalities are complex and are thought to reflect social and economic disparities more than biological differences associated with race. Socioeconomic disparities include inequalities in work, wealth, income, education, housing and overall standard of living, as well as barriers to high-quality cancer prevention, early detection, and treatment services. Much of the difference in survival is believed to be due to barriers that limit access to timely, high-quality medical care [1,6-11]. Furthermore, African Americans are more likely to be diagnosed at a later stage of disease, when treatment choices are more limited and less effective. These issues are recognized to largely reflect socioeconomic disparities associated with race.

Health literacy is defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions [12]. Since 1990s, federal government, health insurers, and other stakeholders have taken an increased interest in addressing health disparities among minority groups. For instance, the Healthy People 2010 initiative highlighted the elimination of racial and ethnic health disparities as a prominent public health goal for the next decade. In Healthy People 2020, the goal was

expanded even further to achieve health equity, eliminate disparities, and improve the health of all groups. Many minority groups are poorly represented in the health professions relative to their proportion in the overall U.S. population. Although minorities make up 25% of the U.S. population, they account for only 6% of physicians [13]. By 2050, it is projected that the racial or ethnic minority groups will account for almost half of the U.S. population. Even when a language barrier is not present between doctor and patient, many patients do not understand health-related recommendations conveyed by health care professionals. Increasing the diversity of the health care workforce is a key to increasing access to care and improving the quality of care for minorities. Minority providers are more likely to serve in a minority community. In 2013, the U.S. Department of Health and Human Services (HHS) released its 10th annual report which concluded: “health care quality and access are suboptimal, especially for minority and low-income groups [14,15]”.

This publication is intended for community-based educational approach which integrates education and social action to obtain improved life expectancy and overall health which have remained out of reach for many communities of color, particularly for low-income communities. Effective programs must incorporate community participation, innovative outreach, use of social networks and trusted social institutions. Programs that include these strategies are much more likely to be effective in reducing health disparities. Health education and promotion efforts are often not effectively targeted to minority populations. There are recommendations to disseminate community-based participatory research which fall in three categories: in student pipeline strategies, academic culture change strategies, and university/college-community partnership strategies. At Edward Waters College, through one of the biology elective/ general health education courses viz., BIO 290: African American Health and the One Florida Cancer Control Alliance’s “Minority Education Program”, we are determined to increase awareness of prevention, early detection and treatment tools by addressing the issue on fronts viz., increasing access to quality health care, patient care, provider issues, systems that deliver health care, societal concerns, and continued research which can help everyone in our community to lead healthier lives. Advancing these methods may reduce health disparities by increasing access to quality health care.

References

1. Smedley BD, Stith AY, Nelson AR (2002) Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care.

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2. Hebert PL, Sisk JE, Howell EA (2008) When does a difference become a disparity? Conceptualizing racial and ethnic disparities in health. *Health Aff (Millwood)* 27: 374-382.
3. US Census Bureau (2012) U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin: 2000-2050.
4. <https://www.census.gov/2010census/news/press-kits/summary-file-1.html>
5. US Census Bureau (2012) Table B05006: Place of Birth for the Foreign-Born Population in the United States; 2006-2010 American Community Survey Selected Population Tables.
6. Komenaka IK, Martinez ME, Pennington RE Jr, Hsu CH, Clare SE, et al. (2010) Race and ethnicity and breast cancer outcomes in an underinsured population. *J Natl Cancer Inst* 102: 1178-1187.
7. Carey LA, Perou CM, Livasy CA, Dressler LG, Cowan D, et al. (2006) Race, breast cancer subtypes, and survival in the Carolina Breast Cancer Study. *JAMA* 295: 2492-2502.
8. Li CI, Malone KE, Daling JR (2002) Differences in breast cancer hormone receptor status and histology by race and ethnicity among women 50 years of age and older. *Cancer Epidemiol Biomarkers Prev* 11: 601-607.
9. Chlebowski RT, Chen Z, Anderson GL, Rohan T, Aragaki A, et al. (2005) Ethnicity and breast cancer: factors influencing differences in incidence and outcome. *J Natl Cancer Inst* 97: 439-448.
10. Jemal A, Simard EP, Dorell C, Noone AM, Markowitz LE, et al. (2013) Annual Report to the Nation on the Status of Cancer, 1975-2009, Featuring the Burden and Trends in Human Papillomavirus (HPV)-Associated Cancers and HPV Vaccination Coverage Levels. *J Natl Cancer Inst*.
11. Wolin KY, Yan Y, Colditz GA (2011) Physical activity and risk of colon adenoma: a meta-analysis. *Br J Cancer* 104: 882-885.
12. U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion. Health Literacy-Fact Sheet: The Basics.
13. Association of American Medical Colleges (2000) Minority graduates of U.S. medical schools: trends, 1950-1998. Washington, D.C., USA.
14. Agency for Healthcare Research and Quality (AHRQ) (2012) National Healthcare Disparities Report. Rockville MD: U.S. Department of Health and Human Services (HHS).
15. Ulmer C, Bruno M and Burke S (2010) Future Directions for the National Healthcare Quality and Disparities Reports. National Academy Press, Washington, DC, USA.