P U B L I C H E A R I N G

before

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

SENATE BILL NO. 2063
(Establishes and Office on Minority Health)

February 13, 1990
Room B-721
UMDNJ-Dental School
Newark, New Jersey

COMMITTEE MEMBERS PRESENT:

Senator Richard J. Codey, Chairman
Senator Gabriel M. Ambrosio, Vice Chairman

ALSO PRESENT:

Senator Ronald L. Rice
District 28
Senator Wynona M. Lipman
District 29

Eleanor Seel
Office of Legislative Services
Aide, Senate Institutions, Health and Welfare Committee

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New Jersey State Legislature
SENATE INSTITUTIONS, HEALTH
AND WELFARE COMMITTEE
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January 30, 1990

NOTICE OF PUBLIC HEARING

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE
ANNOUNCES A PUBLIC HEARING ON SENATE BILL NO. 2063
ESTABLISHING AN OFFICE ON MINORITY HEALTH

Tuesday, February 13, 1990
Beginning at 10:00 A.M.
Room B-721
UMDNJ-New Jersey Dental School
110 Bergen Street
Newark, New Jersey

The Senate Institutions, Health and Welfare will hold a public hearing on Tuesday, February 13, 1990 beginning at 10:00 A.M. in Room B-721 at the UMDNJ-New Jersey Dental School, 110 Bergen Street, Newark, New Jersey. The purpose of the public hearing is to discuss Senate Bill No. 2063, sponsored by Senator Codey, which establishes an Office on Minority Health in the State Department of Health.

Address any questions or requests to testify to Eleanor Seel, Committee Aide (609-292-1646), State House Annex, Trenton, New Jersey 08625. Those wishing to testify are asked to submit 9 typed copies of their testimony on the day of the hearing. The chairmen may find it necessary to limit the number of witnesses and the time available to each witness at the hearing.

SENATE, No. 2063

STATE OF NEW JERSEY

Introduced Pending Technical Review by Legislative Counsel

PRE-FILED FOR INTRODUCTION IN THE 1990 SESSION

By Senator CODEY

AN ACT establishing an Office on Minority Health and making an appropriation therefor.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. The Legislature finds and declares that there are dramatic differences in death, disease and injury rates between White and minority populations in the State. For example, the non-White infant mortality rate in 1987 was 18.7 per 1,000 live births, whereas the rate for White infants was 7.1; esophageal cancer death rates among Black males are three times greater than among White males; of the cumulative total of AIDS cases reported in 1988 in the State, 34% were White, 52% Black and 13% Hispanic; Black and Hispanic women represent 77% of all female AIDS cases in the State; and chemical poisonings among the employed Black population are almost three times greater than that of the employed White population, as measured by the frequency of hospitalization.

The Legislature further finds and declares that presently there is no coordinated State effort to address the wide disparity in death, disease and injury rates and, therefore, there is a need to establish a State Office on Minority Health to identify and develop innovative programs which will close the gap between the health status of White and minority populations in this State, and to coordinate current State programs which seek to address minority health concerns.

2. There is established an Office on Minority Health in the Department of Health for the purpose of promoting health and the prevention of disease among members of minority groups.

The administrator and head of the office shall be a director who shall be a person qualified by training and experience to perform the duties of his office. The director shall be appointed by the Commissioner of Health, and shall serve at the pleasure of the commissioner during the commissioner's term of office and until the appointment and qualification of the director's successor. The director shall receive a salary which shall be provided by law.

3. The office shall:

a. Review the findings and recommendations of the Department of Health's Minority Health Task Force and other research conducted by nonprofit organizations and institutions of

higher education in the State that concerns minority health issues.

b. Use the findings and recommendations of the Task Force and other research as a basis to provide grants to community-based health groups which will assist in the development of innovative, culturally sensitive education materials and services for targeted, at-risk minority populations.

c. Review the programs of the Departments of Health, Human Services and Community Affairs that concern minority health and make recommendations to the departments that will enable them to better coordinate their efforts in order to ensure that effective solutions to the problems of minority health are achieved.

4. The Commissioner of Health shall report annually, by September 1 of each year, to the Legislature and the Governor on the activities of the office, including the programs and services funded by the office and the health care problems that the grant funds are intended to ameliorate. The commissioner may include in the report any recommendations for administrative or legislative action that he deems appropriate.

5. The office is entitled to call to its assistance, and avail itself of, the services of employees of any State, county or municipal department, board, bureau, commission or agency as it may require and as may be available to it for its purposes. All departments, agencies and divisions are authorized and directed, to the extent not inconsistent with law, to cooperate with the Office on Minority Health.

6. The Commissioner of Health shall adopt rules and regulations necessary to carry out the functions and responsibilities of the Office on Minority Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

7. There is appropriated to the Department of Health $500,000 from the General Fund to carry out the provisions of this act.

8. This act shall take effect on the 60th day after enactment.

STATEMENT

This bill establishes an Office on Minority Health in the Department of Health. The purpose of the office is to promote health and the prevention of disease among members of minority groups in the State.

Specifically, the office is directed to:

a. Review the findings and recommendations of the Department of Health's Minority Health Task Force and other research conducted by nonprofit organizations and institutions of higher education in the State that concerns minority health issues.

b. Use the findings and recommendations of the Task Force and

other research as a basis to provide grants to community-based health groups which will assist in the development of innovative, culturally sensitive education materials and services for targeted, at-risk minority populations.

c. Review the programs of the Departments of Health, Human Services and Community Affairs that concern minority health and make recommendations to the departments that will enable them to better coordinate their efforts in order to ensure that effective solutions to the problems of minority health are achieved.

The bill appropriates $500,000 to the office to carry out its responsibilities under the bill and requires the Commissioner of Health to report annually, by September 1 of each year, to the Legislature and the Governor on the activities of the office.

The Department of Health's Minority Health Task Force found, in its preliminary report Health Profile: Black and Minority Populations in New Jersey, that there are wide differences in the death, disease and injury rates between White and minority populations in the State. Other studies by nonprofit organizations in the State also confirm these findings and recommend that a State agency be established to coordinate the efforts of various State departments regarding programs for minority populations in the State, so that effective solutions to the health problems of minority populations can be achieved.

HEALTH

Establishes Office on Minority Health and appropriates $500,000.

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SENATOR RICHARD J. CODEY (Chairman): Good morning. We'd like to start our public hearing today. The subject matter today is Senate Bill No. 2063, establishing an Office on Minority Health. The reason for that, as we probably in this room all know, is the major gaps that exist today in the State of New Jersey, and in our country, between the health status of white Americans and minority Americans.

Just a few brief statistics that really brings this picture into clear focus: Black infants in New Jersey are dying at a rate of two-and-a-half times more than that of white infants. AIDS deaths among black infants are 14 times greater than white infants. Homicide death rates among black adults are four times greater than white adults. Chemical poisonings, which are measured by the frequency of hospitalization, among the employed black population are almost three times greater than that of the white population.

The purpose in establishing an Office on Minority Health in the Commissioner's office would be, obviously, to focus on the problem, and to start doing something about it so that all Americans and all New Jerseyans have the same life expectancy.

Our first witness this morning will be Dr. John Alexander, a member of the UMDNJ Minority Institute, and as well, the Director of the Division of Ambulatory Pediatrics here at UMDNJ. Dr. Alexander.

D R. J O H N A L E X A N D E R, M.D.: Good morning, Senator Codey.

SENATOR CODEY: Good to see you, Doctor.

DR. ALEXANDER: Good morning, panelists.

SENATOR CODEY: By the way, I'm joined here by our colleagues Senator Ambrosio, Senator Lipman, and Senator Rice. Doctor, the one on your left. (referring to microphone)

DR. ALEXANDER: There's an ominous trend in America today to a greater inequality between whites and blacks.

Economic statistics have shown that whites are getting a bigger piece of the economic pie and live longer, healthier lives. Blacks today are growing poorer, have higher morbidity and mortality. Life expectancy for whites has increased, while life expectancy for blacks declined from 69.5 years to 69.4 years, declining for the second year in a row. The report "Health United States 1988" by the Public Health Service showed the glaring discrepancy between the health of the white and black population.

An Office on Minority Health is sorely needed in New Jersey in order to collect data, while it will focus attention on the causes for the increased morbidity and mortality in the minority population when compared to the white population. For example, the non-white infant mortality rate in New Jersey in 1984 was 18.5 per 1000 live births, whereas the rate for white infants was 7.1.

In Newark the Public Affairs Committee of Healthy Mothers/Healthy Babies Coalition of Essex County showed in their study "Where and Why Babies Die in Newark" that the communities of Vailsburg, Upper Clinton Hill, and Weequahic comprised on 29% of the total population of Newark, but contributed 43% of the infant deaths. One half of the infants who died in Newark lived in the same 14 of Newark's 95 census tracts. Therefore, the infant mortality rate in those 14 census tracts exceeds 30 per 1000 births; far worse than any impoverished third world country.

The problem of infant mortality among black infants, who die at twice the rate of white infants, has remained virtually unchanged for the past 20 years. We know that the preponderance of infant deaths that occur in Newark are attributed to prematurity and its complications. The racial gap could be narrowed if all women received high quality prenatal care, including smoking cessation counseling, alcohol and other substance abuse counseling, and comprehensive

prenatal care, with particular attention to nutrition supplementation. To further narrow this gap, we must prevent unintended pregnancies by making effective contraceptives and contraceptive education universally available.

The report of the Secretary's Task Force on Black and Minority Health to Secretary Margaret Heckler, Department of Health and Human Services in 1985, listed infant mortality as one of the six causes of death that account for more than 80% of the mortality observed among blacks and other minority groups, in excess of that in the white population. The other five major contributors are cancer, cardiovascular disease and stroke, chemical dependency, diabetes, homicide and unintentional injury, and now AIDS must be added.

One of the responsibilities of the Office on Minority Health, for the purpose of promoting health and the prevention of disease among the minority population, would be to gather data so that an accurate assessment can be made of the risk factors leading to the disparity between the health of whites and blacks. The second responsibility of the Office on Minority Health would be to define public health, to reduce the gap between the health of whites and blacks. Third, the Office on Minority Health would use its surveillance data to influence the allocation of scarce resources. The office would be responsible for developing, implementing, and evaluating community based programs to close the gap between the health status of white and minority populations in New Jersey, and to coordinate current State programs which seeked to address minority health concerns.

Although America devotes a larger proportion of its resources to health care than any other nation, the disparity between blacks and whites not only persists, but in some instances has increased. We spend less than 5% of the health care dollar on prevention. We know that the major risk factors leading to the disparity in health status between blacks,

whites are preventable. Poor nutrition, tobacco use, alcohol and other substance use and abuse, unintended pregnancy, unintentional injury and violence, are not only preventable but are responsible for 80% of the unnecessary deaths. The disproportionate poverty of the black populations means that the health problems of blacks are a low priority for the attention of the expensive United States health care system, which provides excellent care for those who can afford it.

The Secretary's Task Force on Black and Minority Health states, "Because many of the identified behavioral and environmental risk factors associated with the causes of excess deaths among minorities can be controlled, more work is needed to educate minority populations about the risk factors." Health education has been effective in teaching how individuals and communities can enhance personal health.

Health education leading to behavior change will promote health, and prevent disease and disability. Many studies have shown that by spending more to educate people about the risk factors responsible for the disparity in health status will not only save money by reducing health care costs, but will also save lives.

To make preventive programs effective for blacks and other minorities, we need to target our efforts precisely to members to those groups who are at greatest risk. Health education initiatives must be culturally sensitive. As Associate Medical Director of Children's Hospital, I am responsible for preventive and community pediatrics. In my experience with Child Health Month and the Safe Kids Program, both of which are statewide programs aimed toward prevention, we need more programs that involve local community groups in behavior changing activities leading to illness and injury prevention. We need an Office on Minority Health that will have the responsibility to close the gap between white and black health status in New Jersey.

I want to thank you for giving me this opportunity to make this presentation to you this morning. I've been practicing medicine since 1943, and things, after all these years of my life, are not looking better, but looking worse. And I certainly hope that you will be influential in bringing to the State of New Jersey an Office on Minority Health so we can get accomplished some of the things that I haven't been able to do in my lifetime. Thank you.

SENATOR CODEY: Doctor, if you'd just hold it a second. Any questions, Senator Rice or Senator Lipman?

SENATOR LIPMAN: Doctor, we have been told by the last Commissioner of Health that it is very difficult to reach those teenagers, for example -- I'm using right now -- who get unintentionally pregnant, or those that get intentionally pregnant. It doesn't matter. Special programs had to be set up where social workers went out into the community and tried to find these teenagers because one of the reasons for the low birth weight was that they did not get proper attention. In your estimation, how could an Office on Minority Health improve this type of situation?

DR. ALEXANDER: Well, thank you, Senator Lipman. The reason that we haven't been able to reach our young people is because the health care system in the United States puts up so many roadblocks, and is not sensitive to the needs of many of our young people. We have to have community based programs. We have to have programs that will be able to reach children in their own neighborhoods.

I was, for many years, part of the program here at UMDNJ where we tried to get young women who were pregnant to come in and get their prenatal care. At that time, either you got prenatal care and failed in school or you got no prenatal care. We put up these obstacles. And now, UMDNJ has a program in a school where young women can go to school and get educated and get their prenatal care at the same time. There is no

doubt that we are going to prove that that kind of a program will reduce the infant mortality rate. So, we've got to base the programs where the people are.

SENATOR LIPMAN: Thank you, Doctor.

SENATOR CODEY: Doctor, just two questions or thoughts, really -- I think they kind of dovetail -- and that is: How do we get more doctors into minority areas? And how do we change the life-style of a good number of minorities who go to emergency rooms as opposed to having a physician?

DR. ALEXANDER: Okay. You've hit on a major problem that exists: One, how do you get more minority providers into minority communities where you can provide care? Well, in Newark it's difficult for a physician to open an office after he's come out of medical school with a debt of $75,000 to $100,000, and to be able to pay off that debt. If you come into Newark and your practice is 100% Medicaid or 95% Medicaid, like mine has been over a long time, and you get $9 a visit, you can't pay the people that work for you. You can't put bread on your own table.

So, there's no way in the world that you're going to recruit minority students to come into Newark and open an office, unless you make other kinds of programs available that will help them to wipe out their debt, for example. If I've got $100,000 I've got to pay off, and you told me that here's a program that will help you wipe out your debt over five or ten years if you stay in an underserved area, then I would be willing to come because I could then work and my indebtedness would be paid off. But I couldn't pay off my indebtedness, coming and having to pay that off and meet my current overhead in Newark.

So, one of the problems is, if you want, not just minorities, but any physician to come into an underserved area, there have got to be programs that are organized to help offset some of this tremendous debt he's going to bring with him.

The other thing that you asked me about was how do you reach young people; how do you get them to come to services? I've been trying over the last three or four years to introduce into our local churches what are called "health ministries." We've got a real resource in every minority community, the church. We've got many, many young people t
How many of these young people are told that tobacco will damage your infant? How many of these young people are told about the risk factors that cause this discrepancy between white and minority population?

I'd been practicing medicine almost 15 years before anybody even told me, as a physician, that tobacco smoke was harmful. And we still see, as recently as last month, where some of the tobacco companies are marketing their products in minority communities. You go look at anything that is harmful. We've got more of it being advertised in the black community than you do in the suburban communities. So we've got to have somebody else that tells the true story. And you've got to do it over and over again. It's got to be in the schools, but it's got to be in the communities.

And so you've got to have prevention programs that are based in the community. That's the only way you're going to reach our young community, or any young people.

SENATOR CODEY: Okay.

SENATOR RICE: Mr. Chairman?

SENATOR CODEY: Go ahead, Senator.

SENATOR RICE: I don't disagree, Doctor, that we must do more to educate. But when it comes to those of us who are minority, we always send the message as though there are things happening in other communities that don't necessarily happen in our community. In many cases that's true, but it's interesting a tobacco company would, like you said, target their advertisement to a minority community. I haven't done any research, but I've got a feeling that they're doing

that because non-minorities are probably smoking whatever they're advertising in greater numbers, and they're trying to boost up the minority market.

And if in fact that's true, the other community, "non-minority community," from what I can tell -- and I visit those schools, too, and I don't see a lot of things posted -- are getting no more information about tobacco and things being harmful than anyone else. Yet, there's a disparity as related to the effects.

I guess what I'm trying to say is that there is something else taking place besides education in the minority community--

DR. ALEXANDER: Well, Senator Rice--

SENATOR RICE: --and those are things that, I think, we really need to be paying attention to. I don't know if they are all just what we consume. I don't know if it's how dollars are flowing to institutions in our community, and what happens to those dollars by those who oversee them and manage and direct them. I'm not so sure-- I know at this particular institution here at one time, people said they had to wait on the one floor while non-minorities go to another floor and get priority treatment.

So, I don't know if those things are true, but my point is that there appears, to me, to be a broader picture than what we depict as professionals as we do the comparison. And I'm telling you that I see as many non-minorities, when I move through this country, this State, smoking and puffing cigarettes. And I see advertisements there, too; maybe not as much.

So it seems to me that we're not-- The advertisement companies are not trying to maintain their patrons in the minority community. They're trying to apparently increase that to make it comparable to something else they're doing. That's the way I see it. It's the same with alcohol.

So, I'd just like to know, what are those other variables that we need to be looking at, because I don't want to get caught up, and we start to move in one direction. The Chairman is going to move this in such a way that it is a broad-based objective piece. But the professionals need to tell us, when we talk about objectivity, what we really should be looking at.

DR. ALEXANDER: Well, as far as statistics on use of tobacco is concerned: The number of young people in the white community that are beginning to smoke is decreasing. The number of young people in the black community beginning to smoke is increasing.

The number of women who have lung cancer has just passed the number of men who are dying of lung cancer. These statistics indicate that there is a decreasing market in the white community for tobacco products, and it's necessary then to increase the advertising in the minority population because this looks to be where the ground is most fertile.

And there is no doubt that the statistics show that the glamorous black young woman with a handsome black man with a great big limousine, puffing on a cigarette, is glamorous to young people as you are growing up: How else are you going to get to be glamorous like that unless you're puffing on a cigarette? The message is that this is what you want to be. And there's nobody else telling them, "Yeah, but that's going to kill you."

And what I'm trying to say is, that we have to organize the other message; that the companies that are going to sell alcohol and tobacco and are going to push these things that are harmful in our community. They're making money so they're going to advertise. We have to organize so that we can tell our young people there's a different message, and the facts of the matter are that this stuff kills you.

Now, I don't know whether that answers your question, but I've tried, and my concerns now are how we can introduce into our community preventive efforts, because it's too late when you've got AIDS; you're going to die. It's too late when you've got lung cancer; you're going to die. We've got to start when our young people are one year of age and two years of age, and right on up through school. We've got to have programs in our school that encourage children to be able to say, "No." It's all right for the President to say, "Just say no," but when you've got five kids around you calling you chicken, you ain't going to say, "No."

You've got to have a way of helping kids to meet the demands on them as they're growing up. And I think we have to do that in our families, in our churches, in our communities.

SENATOR CODEY: Thank you, Doctor. Our next witness will be Dr. Diana Lake-Lewin, Director of the Oncology Program at Saint Michael's Medical Center. Doctor.

D R. D I A N A L A K E - L E W I N, M. D.: Good morning. I am here to speak in favor of Senate Bill No. 2063 on behalf of Sister Margaret J. Straney, President and Chief Executive Officer of Cathedral Health Care System, and myself, the Director of the Oncology Program at Saint Michael's Medical Center in Newark and a member of the Minority Task Force of the National Institutes for Health.

We would first like to commend Dr. -- excuse me -- commend Senator Codey for his insight--

SENATOR CODEY: I've got enough problems being a Senator. (laughter)

DR. LAKE-LEWIN: --for this insight into the pressing health issue and his willingness to offer a creative solution.

The disparity in the health status of the white and non-white populations have been well documented. Blacks have a death rate of 2.5 times higher than whites. A study by the Centers for Disease Control stated that 31% of the difference

cannot be explained by preventable factors or by socio-economic factors. A recent United States Department of Health and Human Services Task Force Report on Black and Minority Health identified six major causes of death for which mortality among minority populations is in excess of the white population. These are: cancer, cardiovascular disease and stroke, chemical dependency, diabetes, homicide and accidents, and infant mortality.

Clearly there is a need to focus attention on this pressing issue, to channel funds, to prioritize areas of study, and to facilitate access of minority patients to the health care resources. The proposed Office on Minority Health could serve such a role.

At Saint Michael's Medical Center we have been analyzing the data concerning minority health care in cancer for the last four years. Part of this analysis is supported by two grants, one from the National Institutes of Health and the other from the New Jersey Commission on Cancer Research. The latter grant was to study the immune parameters and tumor biology in minority cancer patients. During this time we have identified several problems, most notably poverty. In our cancer patient population, which is most familiar to me, we have identified other major issues which interfere with administration of adequate health care, and these are: lack of trust, impoverished home situation, lack of support systems, and poor understanding of the treatment plan. Therefore, a specifically trained staff are needed for this patient group.

In our breast cancer studies, we have studied the tumors of newly diagnosed patients, stratifying for race. We note that black patients have more of the known poorer prognostic features than their white counterparts. This is indicative of a difference in the biology of the tumor. The question still remains: Why is this so? These studies could

lead to findings that would have an important impact on the health status of minority population, and they should be encouraged and funded.

Another pressing issue which the Office on Minority Health could focus on is the access of minority patients to the health care system. How do we ensure that minority patients have equal access to state-of-the-art therapy through clinical trials? The Federal government has recently launched a project to provide funding for social workers, nurses, record keepers and other personnel to place patients -- minority patients in specific -- on these clinical trials, and similar efforts in this direction should certainly be encouraged at the State level.

We also need to look at the economics of health care delivery. A high percentage of minority patients do not have adequate health insurance coverage, and this undoubtedly hinders their access to quality health care.

I would hope that the proposed Office on Minority Health would address these areas: First, it should identify the major problems related to minority health, such as infant mortality, cancer, heart disease, etc., and prioritize these issues.

Second, it should act as a channel for funds. We cannot begin to make a difference unless adequate and ongoing funding is provided. It's imperative that the Office on Minority Health Care provide funding not only for research, but for trained, designated staff in the urban hospitals to administer concrete and supportive services to the patients. In performing this function, the office would collect data and thereby form a data bank which is badly needed.

Third, the office should maintain close contact with the urban, inner city hospitals that know firsthand the health problems of our minority populations. Representatives from these urban hospitals should serve as an advisory body to the

Office on Minority Health. These and other health care providers should be involved early on in the planning process.

Fourth, the office must play a coordinating role with other key areas that impact on minority health including housing, food, transportation, insurance, and medication. It should also serve as a liaison with other national and local groups that are looking at the same issues.

Last, the office must continuously monitor and evaluate its activities to ensure productivity.

We firmly believe that the creation of an Office on Minority Health would be an important step in both understanding the health status of our minority populations, and in beginning to improve that status. I strongly urge support of this important legislative initiative. Thank you.

SENATOR CODEY: Thank you, Doctor. Any questions? (no response) Doctor, in part of your testimony you mentioned about equal access to the state-of-the-art therapy through clinical trials. To your knowledge, have minorities been excluded from those trials?

DR. LAKE-LEWIN: They have been excluded for several reasons. I know that specifically in Newark many patients are not aware that clinical trials exist. Also, by having a lack of access into the mainstream of health care which traditionally has been in the private sector, private hospitals, the patients do not have access to the clinical trials.

If the Federal government realizes now -- and I am speaking specifically in the area of cancer -- that a very small percentage of patients in the United States, in general, are placed on clinical trials, and a fraction of the small percentage of patients are minority-- And now there is a thrust, and as a matter of fact, there is a call for grant applications in the fall for accessing minority patients onto the clinical cancer trials. And the purpose of this is, as was discussed earlier by a previous speaker, to encourage: One, physicians to treat more patients -- minority patients.

We realize that it's a problem because of the various areas that I mentioned: the lack of trust, the lack of education, not understanding the purpose of a clinical trial, thinking that one is experimenting. I think you need a team approach to work with these patients; that is, a designated staff to include social workers, nurses, and physicians. So, if we put all of this together, because it has not been in place in an organized fashion, clearly the minority patients do not represent a significant percentage of patients on clinical trials, and have, in a way, been excluded.

SENATOR CODEY: Thank you very much, Doctor.

DR. LAKE-LEWIN: Thank you.

SENATOR CODEY: Our next witness will be Mr. George Hampton, Vice President of Urban and Community Affairs at UMDNJ. Mr. Hampton, good morning.

G E O R G E H A M P T O N: Good morning. Senator, first I'd like to welcome you to the University. Unfortunately, yesterday State government was closed and we were unable to indicate the time of your arrival. I'd like to welcome you, if you have not been. I'm glad you chose to come to our University, and at any point we can, we'd love to show you our University.

My comments today, of course, will be regarding the legislation, but in the office. In addition to that, I thought it appropriate that you get some understanding of the roles that the University is playing in this regard, and indeed what is called the Minority Health Institute, Minority Health Task Force. My comments will then further be used to introduce, whenever it's appropriate, Mr. Doug Morgan who is our Executive Director, who is scheduled for your program later on.

Again, good morning to all of you. My name is George Hampton, Vice President of Urban and Community Affairs at UMDNJ. I am also the Chairman of the UMDNJ-Minority Health Task Force. This group is composed of senior faculty and

administrators from all of the three of the UMDNJ campuses in Newark, Piscataway/New Brunswick and Camden/Stratford. The Task Force, which was developed in the spring of 1988, remains concerned with the growing disparity in health status between whites and all minorities in New Jersey. The primary focus of the Task Force has been the development of the UMDNJ-Minority Health Institute, an entity that would bring together the resources of the State's Academic Health Science Center and other educational institutions within the State, to investigate the causes of the health status disparity, and to identify effective programs that will remove the disparity.

Black Americans have a life expectancy that is five years less than whites, and infant mortality rates that are twice that of whites, despite a steady decrease in overall infant deaths during the last few decades. Indeed, I'm sure Dr. Behrle will give you more detail on that later on.

The tremendous gains made in medical science and technology which have enhanced the health of the average American, have not equally benefited the African-American and Hispanic populations. The desperate shortage of primary care physicians in the inner cities, the lack of health insurance among poor populations, and the absence of health education opportunities have prevented minorities from seeking medical services in a timely manner that would result in lowering disease occurrences and death rates. Excess illness and death among minorities can be partly attributed to fewer resources to access health care, a condition that is intensified by the scarcity of black and Hispanic physicians and other health care professionals.

Nationwide, not enough minority students are receiving the preparation, encouragement, and resources needed to enter the medical professions. Indeed, greater proportions of minority high school graduates are not going to college. Critical shortages of black and Hispanic physicians and

dentists, and the lack of health care in the minority communities will not be solved until more progress is made to prepare minority students to appreciate science and mathematics, which will lead them toward college and medical careers. These are roles that the University can play.

The University of Medicine and Dentistry is pleased to be at the forefront of some of these efforts. Today, for example, nearly 200 junior and senior high school students from Newark and Camden participate in UMDNJ pre-college programs. Again, this is at the seventh, eighth, ninth grade level we're referring to. At the undergraduate level, pre-med minority students participate in UMDNJ summer enrichment programs and other UMDNJ outreach efforts which seek to interest minority college students to pursue health science careers.

In many ways, urban and community health and minority health are synonymous. The problems of-- In some cases, we argue that it's culturally specific. In other cases it's a question of genetics. But clearly it's also a question of living in urban America. In Newark for example, in the two decades since UMDNJ came to Newark, it has viewed its community responsibilities broadly and has taken major steps to address Newark's health issues.

These efforts have paid dividends in some instances. The University's Newark campus has made a major contribution to the City's health, serving 180,000 patients a year. The UMDNJ-New Jersey Medical School has recruited and graduated hundreds of minority doctors. Today, 70 New Jersey Medical School minority graduates practice in the Newark area. Despite this progress, the health needs of the City are still great and dictate that our commitment remain large.

Poverty is touching more Newark families and, the depth of their poverty is growing. The accompanying economic problems placed on many Newark families, mothers, and children often mean poor attention to health needs, nutritional

problems, family violence, education failure, and alienation that cuts short many thousands of Newark lives each year.

Bill Moyers' TV documentary, "Crisis in America: The Vanishing Black Family," gave us memorable portraits of the faces of the inner city desperate: Black and Hispanic mothers and babies needlessly dying from poor health care; children hungry, abused, and without hope; and our youth, jobless and homeless facing the daily specter of drugs and alcohol. The problems, as indicated by the following figures, almost seem to defy the most resolute efforts.

Every year in the City of Newark 100 babies die before their first birthday; another 80 babies are stillborn, a rate 40% higher that the statewide average; 6500 children are abused or neglected; 650 babies are prematurely born with low birth weights, a rate nearly double the State's; 100 persons die by suicide or homicide. Newark residents are four times more likely to contract tuberculosis, and stand a 30% to 50% greater chance of dying accidentally than other residents of New Jersey.

Only slightly more than one-half of Newark residents live to age 65, and the biggest killers remain heart disease, cancer, cerebrovascular diseases, death by accident, diabetes, and homicide. In addition, an increasing amount of IV drug abuse has contributed to the AIDS epidemic, which as of January 1, 1988 -- these are old figures here; they're much worse now -- 600 cases were numbered. This number, which reflects AIDS cases among Newark residents only, does not include persons diagnosed with AIDS Related Complex or those who have tested positive for the HIV virus, conditions that frequently develop into full-blown AIDS. In Newark, one of every 22 babies born at University Hospital is testing positive for AIDS antibodies.

Recent data from the State Department of Health indicates that minorities are experiencing higher rates of infant mortality, deaths due to injury, homicide, and some of

the things I mentioned before. Indeed, demographers project that the minority population will increase at a much faster rate than that of the white population in the next decade. If we fail to take steps to address these health problems the disparity will worsen.

What should the Task Force be involved in? The UMDNJ-Minority Health Task Force is in support of the development of an Office on Minority Health. We believe that such an office can be effective in three major areas. First, the office can begin to better focus on a number of the Department of Health's existing programs to insure that minority health concerns are better addressed throughout the State.

Second, an Office on Minority Health can provide leadership within State government in the development of health policies that will insure the availability of, and access to, health services that are appropriate to the health care needs of New Jersey's minority residents.

Finally, the proposed office can stress the need for prevention activities, starting with school-aged children to improve the health of minorities in New Jersey. It is here that the office can have a major impact in the development of new and innovative approaches that have demonstrated their effectiveness in addressing specific health problems.

The University of Medicine and Dentistry will work with this new office in addressing the health needs of minorities in New Jersey, and pledges to make available our resources. You will hear later from the Director of the Minority Health Institute, Doug Morgan, who has specific recommendations regarding the proposed legislation. Mr. Chairman and members of the Committee, I have included with my statement materials that will be submitted to you that describes the Institute's activities and membership of the Task Force.

Thank you for the opportunity to talk to you today and I will be happy to answer any of your questions.

SENATOR CODEY: Senators?

SENATOR LIPMAN: Yes, me.

SENATOR CODEY: Go ahead.

SENATOR LIPMAN: All right. Mr. Hampton, there are other task forces, as for example, my notes say Ohio and Michigan, as well as the Federal government. Have they been established too late? I want to just put it like that. Not really too late, but early enough for your Task Force in New Jersey to have any kind of statistics?

They were established in 1987, 1988, the Federal government in 1985. Do you have statistics from the success of these other offices?

MR. HAMPTON: We have talked to the other offices. If you recall, we all have been involved in a conference that was held last year at the Ramada Inn, the State conference, which was indeed funded by the Department of Health. Each of those offices have a variety of ways that they function. In terms of these statistics and the success of their programs, at this point it is too soon to tell, I think, in this sense.

But let's face it now. Let's be for real here. We all should recognize that the creation of a statewide office in New Jersey in 1990 does not mean that by 1991 or 1992 all of the problems of minorities, particularly as it relates to health, will have been eliminated. In fact, if they do their job, as I would argue, one should always find -- be at the forefront of new health care problems. I mean, the reality is, we are humans, and therefore we have health problems and will always have that.

The question becomes, how do you monitor that? How do you be in the front of that. So, what I've seen with the other offices in Ohio and other places is that they are interested;

they're doing a lot; they'd like to do more. But if we're looking for a success rate, at this point, I think it's too soon to tell.

They are beginning to aggregate their statistics. And there are a lot of statistics that I purposely left out of my discussion because my assumption was in the course of the day you will hear that from some of the others, as it relates to New Jersey.

SENATOR RICE: Mr. Chairman?

SENATOR CODEY: Senator Rice.

SENATOR RICE: Yes, first of all, if you maybe could provide us with a copy of your message, that would be appreciated. Let me just ask a quick question, and that is, how do we ensure that the data collected is being reported as accurately as possible? And let me tell you why I'm raising that. I raise it because the data can be played with, and depending on how it's analyzed and how it's reported it is going to determine what we should be doing in terms of any future direction; in particular, how we should be funding.

The former Mayor of the City of Newark has always politic, in writing and verbally, that one of his major accomplishments was reducing the infant mortality rate in the City of Newark. I disputed those numbers. I disputed him in the State Senate when Molly Coye came before us and there was testimony from this institution that we're doing a great job, and everyone said I was crazy. But no one verified the statistics.

And I found it interesting when I stopped talking about it, that about two or three months later the Federal government, on the front page of The Star-Ledger, said that Newark is fourth in the nation for infant mortality, which became obvious to me that I was more right, and the data was being analyzed improperly, or not properly reported, which means that over the years we wasted a lot of dollars or didn't

spend enough dollars in resolving our problems. And my feelings are that that may be indicative of most of our areas in New Jersey where you have high minority populations.

So how do we ensure accurate reporting, and how do we ensure that we're going to tell the truth about that as best as we can; not to embarrass ourselves, but to admit that we need to be doing more, and we're not satisfied?

MR. HAMPTON: Absolutely. First, about statistics: I used to teach a course at Rutgers, and one of the books-- I used to use a little book called "How To Lie With Statistics," just to tell the problem side of the argument. I believe-- I don't know if Dr. Behrle is here just yet, but there are others that are more expert exactly on the infant mortality rate. I believe, in general, however, across the country, and including Newark, overall the infant mortality rate went down. I believe the problem was when you compared infant mortality here with other places, we're still at the worst. So, there's some kind of comparison between the two, but there are others who can speak better to that than I can.

Let me get back to your question: How do you ensure there are better statistics? First off, we're also on the-- When Commissioner Coye was in office she created an advisory panel, and one of the things that that advisory panel did was collected all the data that they happened to have on minority health within their various departments and programs. And clearly, while it was very good to have that information -- there was no question about it -- it was good for at least the first time, to get in one place a compilation of minority health data for the State. That was very good.

The downside of it, however, was that it was obvious that the data was not consistent. It was not consistently collected, much less reported. But it wasn't consistently collected. There were spots in the data that would show-- It

would say "black New Jerseyans" and then other places it would say "non-white New Jerseyans." Now there's a lot of difference between non-white and black. Okay, so obviously, one of the first things that has to happen, and I believe -- I am so glad you asked the question -- is we have to make sure that data is appropriately collected in the first place. And I believe that's one of the functions that, indeed, this office could be doing, particularly if we, in various ways, monitor that.

I have my own special-- And again, I'm stepping out of my role as either Chairman or the University because it's really just my own thought on this. But, I think one of the things that should happen when we begin to collect data, we certainly look for a consistent source. Right now, bad as that source might be, or good as that source might be, the census is the only place where there is an attempt at trying to get thorough data, in terms demography, on our populations. I would argue, therefore, that when the State office is created, that they begin to collect and then aggregate all health data as it relates to the New Jersey census, using the same categories. It also means I'd have the same inherent problem, but at the same time it's a first step at getting us in that direction.

SENATOR CODEY: Thank you very much, George.

MR. HAMPTON: Okay.

SENATOR CODEY: And thank you for your help in setting up today's meeting.

MR. HAMPTON: Thank you.

SENATOR CODEY: Our next witness will be Dr. Stanley Bergen, President of UMDNJ. Dr. Bergen.

D R. S T A N L E Y S. B E R G E N, J R.: Good morning Senator Codey and members of the Committee, and welcome to UMDNJ's Newark campus. I am Dr. Stanley S. Bergen, Jr. I'm the President of the University of Medicine and Dentistry of New Jersey, and I am here this morning to address you on Senate

Bill No. 2063. I wish to express the wholehearted support of the University for this legislation which will establish an Office on Minority Health in the Department of Health, State of New Jersey. In addition, and for the record, we similarly support the companion legislation introduced by Assemblyman Charles and in support of this action.

As you've already heard from Mr. Hampton, and will hear from Mr. Morgan, and others, we at UMDNJ have long recognized this special set of health problems in a minority populations in New Jersey and have given leadership within the University on a University-wide basis to try and address some of the potential solutions.

For many years it has been recognized that there are unique problems of health among minority populations within the United States. Many studies have been conducted that identify these unique minority health care problems in various regions and states of the Union. New Jersey is no different. There are specific problems of health and patterns of disease, unique disease processes and health care delivery access issues that affect minority populations in a different manner, different scope, and quantity from those affecting the majority population of our State.

Some of these unique health problems are limited to black citizens, others manifest themselves in Hispanic groups, while still others are evident in migrant farm workers and recent new immigrant populations from Asian countries and elsewhere. Sickle cell anemia, other forms of anemia and blood disorders, hypertension, unusual forms of heart disease, the incidence of diabetes mellitus and many other diseases have significant impact and intensity of manifestation in minority populations.

In the February 9, 1990 issue of "The Journal of American Medical Association," a study by a group from the Centers for Chronic Disease Prevention and Health Promotion at

the Centers for Disease Control in Atlanta, Georgia reported that "the effect of known risk factors on the excess mortality of black adults in the United States" was not merely explained by risk factors alone, but at least 31% of the incidence of disease among minority blacks was left unexplained. The authors urged that broader social and health system changes and research be targeted at the cause of this mortality gap, coupled with increased efforts aimed at modification of risk factors, so that all segments of our populations would receive equal access and health care through our public system.

Lastly, let me note the well-established risk factors among minorities include smoking, other use of tobacco, high systolic blood pressure, high blood cholesterol levels, increased body mass, excess alcohol intake, and diabetes mellitus. All these diseases and parameters of health maintenance should receive special consideration. Therefore, the establishment on an Office on Minority Health within the Department of Health, State of New Jersey, would seem critical and essential for the well-being of our minority populations and the long-term health and economic stability of our State.

I thank you for the opportunity to appear before your Committee and state the position of the University and my personal beliefs in this matter, and I would be happy to attempt to answer any questions that you might have.

SENATOR CODEY: Thank you, Dr. Bergen. Any questions of Dr. Bergen? (no response) Doctor, I had asked Dr. Alexander before: How do we get more doctors in urban areas?

DR. BERGEN: That's an excellent question. Up until now, most of the efforts that have been made, even by the Federal government -- subsidizing physicians to go into minority communities and inner city communities -- have failed miserably. Those who have gone into the National Health Service Corps have, at best, completed their obligations to pay

back their loans to serve for the two or three years required, and then most of them leave immediately after that period of time.

I wish I knew the answer to that. I think that the only way that I have noted that that can be increased and improved is by using the structure of the existing hospitals, developing family health centers, and trying to increase the delivery of care through these family health centers, and hope that some of the physicians working in the family health centers will decide to go into private practice in those communities. If they do not, at least they have the structure and the functioning health center unit at which they can work and have a salaried position in those health centers. But all other efforts that I'm aware of, both in the very rural and dispersed communities, but even more importantly in the urban inner city areas, have been total failures.

OEO tried it. It didn't work. National Health Service Corps tried it. They have programs, essentially, out of existence now. And there's been no lever found, no area of enticement that would get physicians to do that.

SENATOR RICE: Mr. Chairman?

SENATOR CODEY: Go ahead, Senator Rice.

SENATOR RICE: I'm not so certain if there aren't ways that need to be looked at. And maybe that's what this commission should do, particularly when Dr. Bergen uses the term "enticement." I'm not sure if we cannot entice.

As a City Council person here in the City of Newark, I've had several minority physicians who wanted very much to get the administration to work with them to identify property someplace near the University here, so they could set up a practice. In fact, a couple of those individuals were looking for a location where they could actually live on the premise and have facilities downstairs.

The question, I guess, then becomes one, or the issue becomes one that was raised by Dr. Bergen and others as to the payoff of loans, etc. I guess, what they're actually saying is they need help if they're going to be in this area. So, I think that there are ways to "entice" if you will, but I think it's going to take a partnership between local government and State government to maybe help provide some of those facilities near the institution. And I'm not even talking about a medical facility, I'm talking about a private physician who wants to come into the City of Newark and be there.

In fact, one physician is trying to set up a whole house call scenario, and I think it's something that maybe this commission should look at also.

DR. BERGEN: If there are any physicians like that, Senator, that either Senator Rice knows of, or any others, we would certainly be willing and happy to work with them, either here or in Camden, or any other of the major urban areas of our State. It's interesting, due to the work of Chancellor Hollander and his predecessor, Chancellor Dungan, there was a loan -- a Medical/Dental Student Loan Forgiveness Bill passed years ago -- 15 years ago. In the entire history of that loan program only two of our graduates took advantage of it; both were dentists. No physicians took advantage of the bill, and you could get up to 80% of your tuition forgiven over a period of about four years, if, in fact, you practiced in a area that was without adequate medical services, as deemed by the Commissioner of Health and the Chancellor of Higher Education.

They only had two applications; both from dentists, both were granted. Both worked out their four years and that was it. We essentially let the program lapse. I think it's still on the books, but we let the funding of it lapse about five or six years ago because there just were no takers. And it was silly to put money in the appropriations bill every year for that and it never be used.

If Senator Rice feels there's a new awakening of interest, it might be important for the Committee's staff to take a look and see if that statute is still on the books, and we might try to reactivate it and see if we get any interest out.

SENATOR CODEY: Senator Lipman?

SENATOR LIPMAN: I was going to ask a question along the same lines: Were the terms of that old statute which existed before, enticing enough for young physicians or interns to take advantage of it? What kind of financial help did this program allow?

DR. BERGEN: You may have hit upon a very important point. Of course, when we put it together we thought it was very generous and very adequate, because if you spent four years, you got 80% of your tuition cost. Maybe that is not enough. And what I mean there is that, there are much more heavy costs than just the tuition. There's the cost of maintenance, housing and food, and if they have families during that period of time. Maybe we have to make it more attractive in helping them pay off their total debt.

Maybe if we can have some way of having to verify what their real debt is, and then make the provisions of legislation or the statute allow 80% forgiveness of their total debt, not just their tuition, which actually becomes a small part of the total debt. So maybe, we have to liberalize it a little, make it more attractive, and maybe we, in return, could lengthen the period of service that's required.

You get people putting down roots for five, six, seven years, then it's going to be more difficult for them to give those roots up. Also, they'll become accustomed and comfortable in practicing in those areas.

Now, we do have a few-- And you're going to hear from Dr. Tom Ortiz-- I mean, we have a few graduates who have gone in and worked in urban areas and are very happy, and have been

able to do it and do it successfully. So there must be some formula there that we could hit on. But I think maybe you put your finger on it, Senator Lipman, maybe we haven't been liberal enough in the enticements for them to come in the urban areas.

SENATOR LIPMAN: Okay, thank you.

SENATOR CODEY: Senator Ambrosio.

SENATOR AMBROSIO: Doctor, you know, your statement is way in line with what we've heard so far, and I guess that the tenor of this hearing is going to be all day; that we all are going to know what the problem is, and we're going to be able to define it very distinctly. But the question is, are we as a State going to set the priority that's needed to deal with this problem? And really, no one has talked about the money, but isn't that where the real problem is; are we going to dedicate the resources that are necessary to deal with this problem? And while many people say throwing money at problems is not the answer, isn't this one of the areas where we know what the problems are? The question is, are we going to set the priorities and dedicate the resources to solve it?

DR. BERGEN: I think that's a very important question and philosophy, not only to come out of these hearings, but for our State as a whole. I personally believe we should do it. Even if we've got a limited amount of resources, we should take a bigger percentage of those resources and dedicate them to this problem of minority health just within itself.

Secondly, I'm not sure we do know all the answers yet. We do know the risk factors. This study from CDC was almost like they wrote and published this study for today's hearing. I mean, it just came out on February 9. There's still 31% that's unexplained. They can explain 31% on these six risk factors which we've already identified and know full well. There's another 38% they feel is due to financial status and social factors. There's still 31% that's not yet

explained. So, I think we do need further study of why minority populations, and particularly in this study, adult blacks-- Why do they have more disease? Why do they die prematurely? We don't always know. There's not always an explanation for that.

I think the only way we're going to find that out is to specifically dedicate resources to this area of investigation and support of the medical treatments needed for the people that fall into these categories. And as I say, I think we've-- You know, the economic well-being of this State, in the long term -- not next year or the next three years -- is going to depend on our minority population's being available to the work force; being able to go to college and come out as educated citizens of our State. They can't do that if they're carrying the extra burden of health and disease processes that the rest of us don't have. So, we got to have a healthy minority population in order for the State to survive into the year 2000 and beyond.

SENATOR AMBROSIO: Thank you.

SENATOR CODEY: Thanks very much, Dr. Bergen, and thank you for your hospitality.

SENATOR RICE: And get elected, right?

DR. BERGEN: What?

SENATOR RICE: I said, and also get elected. You left that out--

SENATOR CODEY: Our next witness will be Dr. Franklin Behrle, the Executive Director of the Statewide Perinatal Services and Research Center here at UMDNJ. Dr. Behrle.

D R. F R A N K L I N B E H R L E: I'm also on the Executive Committee of the Healthy Mothers/Healthy Babies Coalition of Essex County. We did an interesting study of babies born in Newark in 1985. We looked at the death rate, infant mortality; that is, babies dying in the first year of life, and we separated those as is conventionally done, into

babies dying within the first 28 days of life, which has a whole distinct list of specific causes usually related to the birth process, and then those babies dying after the 28th day of life.

And the novel approach, I think, that we took was to look at the census tracks in Newark. Newark's a pretty big city. In 1985 it had a population of 325,000. And we looked at the census tracts to see if we could find pockets in which there was an exceptionally large contribution to the infant mortality rate. And that's exactly what we found. We found that of the 98, I believe, census tracks in the City of Newark, over 50% of the neonatal deaths -- that is, in the first 28 days of life -- happened in births from only 14 of the census tracks. And these 14 census tracks, I think, had only 27% of the population, and yet they contributed to over 50% of the newborn mortality.

When we looked at the post neonatal mortality -- that is from 28 days to a year of life -- we found that over half of those deaths -- there were some 31 deaths in that group -- 16 of them occurred in only five census tracks out of the total 97 tracks.

When we looked at the geographic distribution in the City of Newark, it's quite clear that in the south and primarily in the districts populated by blacks, we found this unusual contribution of infant mortality. The eastern section and the northern section of Newark had very, very low infant mortality rates.

The other thing that has been impressive in terms of our Healthy Mothers/Healthy Babies activity, we've developed outreach teams called our Perinatal Teams. University Hospital here has a team, Beth Israel has a team, and Saint Michael's has a team. And we send these teams out and attempt to enroll pregnant women into the system and get them into early prenatal care.

We're finding a number of problems that have to be addressed. The problem of adequate medical care for pregnant women and for early child care, is not a lack of facilities. We have some of the best hospitals in the State of New Jersey right here in Newark, and the best medical care available. So it's not availability. The availability is not a problem. It's getting access to the system that's a real problem. And we've identified a number of factors.

First of all is the homelessness. A number of pregnant women, particularly those in the adolescent age group, have difficulty keeping a home over their heads. Another problem is in transportation; getting individuals who presumably would get into the system, and perhaps would like to get into the system, getting them child care, for example, if they have other children, and transporting them into the facilities that can offer the comprehensive prenatal care.

The drug situation definitely is having a serious impact, particularly on premature births. There is, to my knowledge, right now, no program for pregnant women who are abusing drugs. They're not getting any kind of assistance from that standpoint. So there are a number of factors: the bureaucracy; getting into the system is not the easiest thing in the world, even though they're eligible; establishing their eligibility frequently is rather complicated and discouraging to them. So that, when one puts all these things together, I think you find a number of barriers to enter into a system that actually is available here, is working for those who get into the system.

Getting access to that system is a very serious problem, and we need more outreach activity. We need to develop some kind of transportation system. We need to sure up the child caring system while they make their clinic appointments, and the problem of homelessness -- getting a roof over their heads -- is also a serious one.

SENATOR CODEY: Any questions? Senator Ambrosio.

SENATOR AMBROSIO: Doctor, did any of your studies indicate what percentage of the people that you serve are covered by medical insurance?

DR. BEHRLE: No, we didn't study that aspect, but I can tell you from my own experience, here in our nurseries at University Hospital, that at least 80% of all of the deliveries that we have here are Medicaid eligible. And in this high risk group that I talked about in the census tracks, I would think that close to 100% of those would be Medicaid eligible.

SENATOR AMBROSIO: Okay.

SENATOR CODEY: Thank you very much, Doctor.

SENATOR RICE: Mr. Chairman.

SENATOR CODEY: Oh, I'm sorry. Senator Rice.

SENATOR RICE: I received in the mail some data relating to that study. And once again, who did the particular census track study? Was it the institution here or was that--

DR. BEHRLE: We did, yes. I did, Mr. John Esplanshade who is the Administrator for the Statewide Perinatal Center, and Dr. Netravali who is a pediatrician in the Newark Health Department.

SENATOR RICE: Well, I'm not a statistical expert, but I have some basic knowledge. I was reading about it -- it was sent to me-- And it was basically a summary. And I followed the various areas of our City, and I found something interesting, but I could not properly analyze what it meant. I just wondered just how far the study went.

For example, as indicated, it appeared that "Where and Why Babies Die in Newark," we came out with the Vailsburg community which happened to be one segment of the ward I represent. The Upper Clinton Hills section and Weequahic comprised only 29% of the total population of Newark, but contributed 43% of the infant deaths. Now the reason I said I

would like to see that data, the total package or see just how far it went, is because if you know anything about the City of Newark, the Vailsburg community of the west ward is probably -- with the exception of the transition taking place now -- is my better housing stock. I probably have the greatest number, percentage-wise or ratio-wise, of working class, middle income individuals. And if you look at the Weequahic section you're really saying the same thing. The Upper Clinton Hill falls in-between, etc.

And it tells me that traditionally our stereotype, or our perception is that, our major problems imbedded in "the central ward" that had the most problem. We're trying to bring it back.

Looking at this data, I get the impression that either the central ward is housing a lot more senior citizens than we think they are, or through the community based organization, and all the activities that are taking place there, there are some things happening; via education, via services to the individual, or something.

But I'd like to see that data, and maybe take it a little further, because I think that's an interesting phenomenon, because you would think the opposite. You would think "where folks have access to medical treatment, dollars to get things done," education if you will, you would think that the numbers would be different in terms of geographics. And so maybe we need to take another look at the data, take another look at those areas of the City that are "more decayed" that appear to have a different economic level, and find out what the good things are that's happening there; at least try to identify the unknown; why, you know there, if you follow what I'm saying. Maybe I confuse folks.

DR. BEHRLE: Yes, and I would agree with you. I think this was just a scratching of the surface in terms of the

demography. I think that a further analysis would definitely be in order, particularly to try to pinpoint specific characteristics of those census tracks in which there was an inordinate contribution to infant mortality.

SENATOR RICE: I mean, if we can-- And I'll make this brief. If we can actually identify, once again, a central ratio that there are more young mothers, there are more infants in the central ward, the east ward areas, like Dayton Street, etc., some of those areas. But yet, we're doing better at birth and going further with it than we are in other areas that are "supposed to be in a little better shape" economically. We need to measure that to find out, because there may be some indicators there as to what we should be doing more of, or funding. I don't know if it's education, community based organizations, funding, health care facilities available-- I'm not sure what it is.

But it's like the numbers we look at when we talk about who are actually having babies now. Across this country I think the latest statistic shows that minorities -- and it certainly makes me feel good -- aged 13 and those younger groups -- are having less babies now than non-minorities in that same age group. But the problem among minorities seems to lie now, that we still have substantial numbers at 17 and 18. Well, that makes me feel good in a way. It makes me feel bad. At least I know I'm close to adulthood, and if I can push that up a little further, we'd be doing okay.

But it tells me across the country, something is taking place in the minority community for those numbers to come down. I don't know if it's education. I don't know if it's a combination of dollars. I don't know if we're getting the message, because the non-minority community, at those younger ages, the birth rate is going up.

And so, I think we need to look at all that data from the nation, as well as the states and the cities, and try to

make those comparisons. Do you think it's something that this commission should be doing, or is something that needs to be done in conjunction with other--

DR. BEHRLE: No, I think it's exceedingly important that we take a look at the demography and what are the risk factors involved in each specific geographic location. I think that probably would play a more important role in terms of what happens in the future, than beefing up the medical system. I think the medical system is all right. I think it's these other factors that are interfering with entrance into the medical system that really need to be looked at. And it's very complicated.

SENATOR CODEY: Okay. Thank you very much, Doctor. Our next witness will be Ms. Alice Stevens, the Coordinator for Healthy Mother/Healthy Babies Coalition of Essex County.

A L I C E K E L L Y - S T E V E N S: Good morning. I'm Alice Kelly-Stevens, and I'm a public health nurse for the City of Orange Health Department. As one of the sites for the Healthy Mothers/Healthy Babies Coalition of Essex County, our team serves the high risk childbearing women or Orange. I have been with the program for about a year. Our team consists of myself and two half-time outreach workers. They are both Orange residents and one is bilingual, to service our Spanish speaking clients.

Each month we add about 15 to 20 new clients to our caseload. This last quarter of 1989, we added 52 new clients. Their ethnic breakdown was similar to months past: 52% are Afro-Americans, of which half of teenagers; 21% Caribbean, from either Haiti or the former British colonies; 23% are Hispanics, mostly recent immigrants from Central and South America; with 4% being European or Asian.

The history, background, and problems of each of these cultural groups is unique and requires different strategies and solutions to help them have successful pregnancies and healthy babies.

About half of our referrals are from the clinic at Hospital Center at Orange, with the rest from other community agencies, such as Orange High School, the YWCA, and the Orange Health Department.

Through our program we strive to do a number of things: To identify the woman as early as possible in her pregnancy; to see that she is registered for prenatal care early and she keeps her appointments; to evaluate her particular situation by a visit to her home; to refer her to the appropriate supplemental services such as WIC, N.J. CARE, welfare, food stamps; to be her advocate when barriers occur at various agencies; to assist her at home after the baby is born with a reevaluation and new referrals; to assist her in making appointments for both family planning and baby's immunizations; and finally, to follow the baby for one year to check immunizations and to identify any developmental delays.

Our caseload has been growing for three years, but for the last six months it has remained fairly stable. We currently have 109 maternity clients and 127 pediatric clients, for a total of 236. Our pediatric clients are increasing and are in need of more of our time than our staff really can handle.

If a woman enters care early, or we receive her referral early in her pregnancy, we can make the necessary connections for her, and we find that the outcome is better for both her and the baby. Our team made 44 initial prenatal visits this quarter. In addition, there were 20 follow-up visits. These 64 visits were necessary because many of the women we see have a vast array of economic and social problems in addition to their pregnancies and perhaps other children; problems of inadequate housing, limited food and clothing, and lack of day-care.

Our team visited 35 women for the first time after their babies were born. These were women who came to the

hospital without prenatal care or women who did not start their care until they were eight months pregnant. There were 26 follow-up visits to postpartum women as well. This total of 61 visits reflects the great need for health teaching and social and emotional support that our clients express. They are poorly informed about parenthood. They need to learn how to care for the babies and themselves. Some don't know how to mix formula, some don't know how to hold the bottle, or how to care for the babies umbilicus, or how to hold the baby. Overfeeding is as much a problem as underfeeding. We've seen babies fed rice water because the mother ran out of formula and had no money, and others fed solid food at two weeks and a month because the baby was crying too much and they didn't know what to do.

This quarter we saw four of our babies die before they were three months old, and one was a stillborn. Though we get discouraged by this, we don't see it as a failure, but rather the fact that we've targeted a very needy group.

Our clients gave birth to 66 babies in this last quarter. Fifteen of them, or 22% were low birth weight, under 2500 grams. And we know they are in danger.

These 15 babies were born to mothers who were teens, or who had started prenatal care late, or were substance abusing women. Those that we saw earlier had a much better outcome.

We need to be able to make contact with the expectant woman earlier, and we need to have the available services, barrier free. Multiple registrations, applications, certifications, and eligibilities make the job of getting the necessary care a full-time occupation for even the most motivated woman. The complexities often deter the young, the immigrants, and those least able to handle the stress of bureaucratic red tape.

The one stillborn and two of the low birth weight babies were to women who used drugs. Two of these women asked for help with their drug problem because they were aware that the drug use was harming their babies. There was no place that I could send them for appropriate services. We followed them and were supportive, but we couldn't send them anyplace for more services. The third woman also tested HIV positive. There was no place for her to go to get appropriate treatment either. These women entered prenatal care because they wanted help with their problems and we could offer them very little.

The number of women coming to the hospital with no prenatal care is increasing. Many know they should have gotten care but were unable to overcome the many barriers that stood in their way. And even after they have their babies, there are very few services that can handle them.

We need broad based community and governmental support to address these problems. In Orange, the Mayor's wife and the League of Women Voters have offered to help, but it's just a beginning. We must provide every woman with the care she needs for a successful pregnancy. We need easy access to prenatal care. We need prenatal care that is culturally relevant and addresses the social, emotional, and physical aspects of these economically disadvantaged pregnant women.

One of my mothers is a 15-year-old high school student. She hasn't been in school this year. She stays home to care for her son. He was born one pound 13 ounces and was in special nurseries for months. Discharged last August to her care, he requires suctioning, six to seven medications a day, and is developmentally delayed at nine months. She is only one of the 25 teenage women I have gotten to know this year. They need school, but there is little day-care available for their children.

Another mother, a young woman from Mexico, weighs 93 pounds. Her baby is three months old. Her husband was laid

off just before Christmas. She is pregnant again even though she started birth control pills. There was a misunderstanding and poor communication across the language barrier. There was no translator available. She's had no time to develop friends. She spends her days in her bed crying.

Each of these women have different needs that are again different from the substance abusing women, but we need to meet these different needs of these pregnant women. We can provide all of their babies with the one thing that they need; a healthy start in life. Thank you. If you have any questions--

SENATOR CODEY: Okay, thank you. Questions? (no response) This program is about a year old?

MS. KELLY-STEVENS: The program is about three years old.

SENATOR CODEY: Three years old.

MS. KELLY-STEVENS: I've only been with the program about a year.

SENATOR CODEY: Oh, okay. And how is it funded?

MS. KELLY-STEVENS: It's funded through the Healthy Mothers/Healthy Babies Coalition of Essex County, which I think is State money.

SENATOR CODEY: State money, oh, okay. Any other questions? (no response) Thank you for your excellent testimony. Our next witness will be Dr. Munoz from UMDNJ. Dr. Munoz. How are you, Doctor? Good to see you.

D R. E R I C M U N O Z: Thank you. Mr. Marc Lory, the CEO of University Hospital has asked me to give testimony. I would speak in strong support as Medical Director of University Hospital of this program.

I think that we have the opportunity before us to look at data from the State level. And although you've heard testimony about the problems in the inner city, you well know that as New Jersey is the most densely populated State in the

Union and has rapidly growing black and Hispanic populations, that that places us in an unusual category. The handout I've given you is recent data on the one million New Jerseyans that are hospitalized, and to look at their costs and outcome, by race. And we at the University Hospital and the Minority Health Institute here at UMDNJ have that capability.

We analyzed one million New Jerseyans that were hospitalized and looked at them by black/Hispanic versus the white population relative to the number of days in the hospital, their costs, and their mortality and emergency admission rate in 1987, which was two years ago. And we found, for example, that the 181,000 black adults versus the 800,000 white adults had 50% emergency admission rate compared to a 36% for whites. So that was much higher. They had length of stay in the hospital which was a full day longer. They had a hospital cost that was $4500 for blacks versus $3800 for whites. And they had a mortality rate that was 3.7% for blacks versus 2.8% for whites.

These differences go on when you look at the pediatric population. And we analyzed black, Hispanic, and white pediatric patients -- and these are all hospitalizations in the State -- and we found the same differences; that black youngsters had a hospitalization cost of $4000, versus $3500 for Hispanics, versus $3000 for whites. And the mortality for minority youngsters was 1.2% for blacks, versus .5%, versus .36% for whites. So black had three times the mortality -- these are for recent hospitalizations -- and Hispanics had a 50% higher mortality than the white population.

Now obviously, you ask, "What do we do with this data?" This type of data, and the various clinical epidemiology that we have available at the State level, could begin to look at the diseases, and the various populations at risk. And if you look at the Federal model, what they've attempted to do there is to look at differences in outcomes,

differences in cost, and where to target the scarce resources. Also the question comes up of how to interface the other social institutions, education, transportation, employment opportunities that might affect health outcomes for blacks and Hispanics.

In conclusion, I can say that the State of New Jersey, looking at their recent hospital experience, mirrors some of the work done at the Federal level and demonstrates that blacks and Hispanics have higher costs and poorer outcomes compared to other New Jerseyans. And I think that these issues give compelling reasons for the establishment of a minority division and also the types of policy questions we'll then get into about approving delivery for those populations at risk. Thank you.

SENATOR CODEY: Senator Ambrosio.

SENATOR AMBROSIO: Doctor, the numbers dealing with emergency admissions-- By the way, this is for University Hospital only?

DR. MUNOZ: No, no, this is for the great State of New Jersey. This is all hospitalizations in the State of New Jersey. And there are about one million New Jerseyans hospitalized a year in the 90 hospitals.

SENATOR AMBROSIO: I think it's been already testified to, but the emergency admissions for blacks as opposed to whites probably relates to the fact that they're being used for primary care rather than emergency care. Is there anything being done at University Hospital to divert primary care patients from the emergency room setting?

DR. MUNOZ: We have several programs that are attempting to download acute care deliveries, as they call it, health policy. One is a community based clinic we've attempted to establish. Obviously, our clinic structure provides a lot of primary care. One of the difficulties, as you've heard in previous testimony, is how to locate primary care centers in

very urban environments that have payment disincentives, that also have other delivery disincentives. So we are doing things at University Hospital, which you have to ask yourself is-- If you could go all over the State of New Jersey, in say, Freehold, New Jersey, which I know -- I mean, that city, that small city is likely to have these same delivery kinds of issues -- and what are they doing in that city, and all the other urban areas. I think that if you look at the trend over the next 10 years in terms of New Jersey's population, we will be an immensely urban area. It's complex problem, but it needs a lot of attention.

This greater emergency admission rate-- I mean, I think the key thing that we need to educate the American and the New Jersey public is, not only with people with gunshot wounds, which is the classic -- or automobile accidents come in, but if you have breast cancer, and you happen to be a black or Hispanic female, you are more likely to show up in our emergency room, or Atlantic City, or in Freehold, than you are to be admitted through a doctor's office, etc. That has, obviously, a higher cost and a poorer outcome. That's a very serious issue for us.

SENATOR AMBROSIO: Thank you.

SENATOR CODEY: Thank you very much, Doctor,

SENATOR RICE: Mr. Chairman, just one quick question. This is all well and good, but we talk about-- My mind keeps working back to all the other speakers. Don't you think when you take a look at the DRG rates, and just how we're really addressing those-- For example, you take the City of Newark, and the majority of our welfare recipients and those who are destitute are going to wind up in long lines at this institution, primarily because we don't really have the State authority or legal authority to direct where we're going to send the folks. We should be able to send folks where we get the best DRG rate. And comparison and stuff, I've analyzed,

not too long ago, shows that this is not the cheapest place in the world for us to be directing our citizens. I mean, I should be able to direct them Beth Israel, Saint Michael's -- where I want. That should be some discretion given to our Health Commissioner or Director.

So, when we start to talk about cost, and we start to talk about education, and we start to talk about treatment-- You know, some folks have all the education in the world. They're just not going to come for treatment in an institution where they may be not comfortable with. They're not talked to properly. There are long lines, a lot of paperwork. So, do you feel that we need to pay attention, particularly in our community, as to just our professional treatment and attitude towards people who need services?

DR. MUNOZ: Actually, Senator, you've touched on something that I'm quite sensitive to, and that's the financial issues. But if you look at our data, the New Jersey system, which brought in the Federal reimbursement system, was an average system. And the data you look at is corrected and gives you the average amount. But what we're showing here in terms of the finances, is that for any black or Hispanic patient, a hospital is likely to lose under the DRG because the hospitalization is more costly for the breast cancer patient, let's say. So that's a financial equity issue.

The other issue you raise about having institutions that are sensitive to the needs of their patients -- and, you know, culturally sensitive, I think, is very important. And I think that for both black and Hispanic patients it's something that we need to take serious looks at, not just in this City, but around the State. As previous testimony mentioned, if you cannot speak the language, it's hard to get the point across. And I think that over the next number of years we need to pay some serious attention to that, also.

SENATOR RICE: Well, even if you can speak the language and get your point across, folks don't want to be bothered with you; people that we pay. It's like local government, you know, you answer the phone, "Yeah, sit over there. Wait your turn." After a while, people walk out. I've watched a lot of people walk out of these institutions. I gave a guy $10 that I grew up with. He walked out of the hospital. He said he couldn't stand it here. I told him to take the $10 and go back. He's going to die out there on the streets.

So, I just wanted to be sure that, on the record, we try to draw these things out of the hearing and to see if, in fact, it goes beyond just my perception or my colleagues' perception; these things are, in fact, really happening because that's going to be a factor that's going to determine outcome again. I mean to have a commission spend a lot of dollars directed to the things that we should be doing, and not deal with that other aspect of it, to me, is not going to give us what we're looking for. Thank you, Mr. Chairman.

SENATOR CODEY: Doctor, I don't know if you're the correct person to ask this, but are you aware of a bed shortage problem here in Essex County?

DR. MUNOZ: Well, there are several factors, and I think that both the New York and New Jersey press has had a lot over the last year or two, about hospitalizing people and emergency room delays.

If you look at the reality, I take it University Hospital is a 500-bed hospital. We have-- The beeper you heard before was the incoming helicopter. We have various numbers of programs that put tertiary care right up against the primary care delivery which we must do because we take care of anyone that presents themselves to the hospital. And I would say that we have-- With the AIDS epidemic, we have a growing problem of acute care beds, number one, and our ability, number two, to download the acute system, which means, if I have a

patient that I want to try to discharge but can't go home, or doesn't have a place to be cared for, that's another serious issue for you. And I would say that over the next five years-- We have a problem already, and the problem is likely to get much worse. If you look at the way diseases are growing, not just in Essex County, but likely throughout the State-- Because we have some rapidly growing diseases, that are diffusing, for a very small state. And 100 miles in New Jersey in not 100 miles in Texas, so that we can literally traverse the State almost in a very short distance.

SENATOR CODEY: Okay, thank you very much, Doctor. Next we have Lydia Valencia -- Valencia, (corrects pronunciation) the Executive Director of the Puerto Rican Congress of New Jersey. She's not here? (no response) Okay. Our next witness then will be Mr. Douglas Morgan, Executive Director of the Minority Health Institute at UMDNJ.

D O U G L A S H. M O R G A N: Good morning, Senator Codey, and members of the Committee. My name is Douglas Morgan and I'm Executive Director of the Minority Health Institute here at UMDNJ.

In 1985, the then Secretary of the Department of Health and Human Services, Margaret Heckler issued the first comprehensive report detailing the health status of minority populations in the United States. The report identified major disparities in health status between minority populations and whites in this country.

The report of the Secretary's Task Force on Black and Minority Health, as it was called, identified six major causes responsible for the disparity: heart disease and stroke, cancer, homicide and accidents, infant morality, cirrhosis, and diabetes.

Today, almost five years later, not only does the situation remain the same, but we can now add a new illness to the list that was indicated earlier: Acquired Immune

Deficiency Syndrome, or AIDS. While New Jersey has benefited from a booming economy in recent years with low unemployment, the health status of New Jersey's minority populations, like the United States', evidences growing disparities with that of whites in this State.

For example, the infant mortality rate for non-whites in New Jersey is over twice that of white infants. The rate of very low birth weight is two-and-a-half times higher for black infants than white infants.

Hispanic and black females evidence higher rates of cervical and breast cancer than that of their white counterparts in New Jersey, as well.

While recognition of the problem is the first step in any process of correction, the next step is the development of mechanisms for problem solution. The development of a State Office on Minority Health is a vital next step.

An Office on Minority Health can begin to focus attention within State government on minority health problems, and coordinate the important programs that currently address many of the preventable illnesses which trouble minorities. The Office on Minority Health can work within the State Department of Health, the State's Public Health Agency, and with other State departments like Human Services, Environmental Protection, and Community Affairs to ensure that the many programs and activities that these departments operate or manage do not work at cross purposes in addressing minority health problems.

The Office on Minority Health can also be a strong advocate for the development of a comprehensive and culturally sensitive State health care policy; a policy that stresses the importance of preventive services, as well as the need for greater access to primary care services.

Finally the Office on Minority Health can evaluate the effectiveness of the programs that are currently funded by

State and Federal dollars to determine their progress in meeting the health problems of minorities.

In order to meet the challenge before it, the Office on Minority Health must have a clear mandate to carry out the functions I have just outlined. While your bill, Senator Codey, provides a good general structure, I would like to recommend that the bill be strengthened by adding language as follows:

1) Add language to Section 2 of the bill establishing the office at the level of Assistant Commissioner in the Department of Health, with the Assistant Commissioner reporting directly to the Commissioner of Health.

2) Add language to Section 3(c) that stipulates that the Office on Minority Health shall have the authority to not just review but to evaluate continuously, programs in the Department of Health, Human Services, Community Affairs, and Environmental Protection to determine their effectiveness in addressing minority health problems.

3) Add language to Section 3(b) that requires the Office on Minority Health to evaluate all activities that are funded under its own authority.

4) Add language to Section 5 that allows the Office on Minority Health to contract with other State agencies, institutions of higher education, or appropriate public bodies to conduct studies or research as directed by the office.

I would also suggest that perhaps new language be added to the bill, and that part of the new language formally recognize the Commissioner's Minority Health Advisory Committee as the advisory group for the office. That language might

include -- of that group -- to include the Commissioners of Health, Human Services, Environmental Protection, and Community Affairs as members of that body.

And second, that the Office on Minority Health be required to submit recommendations for the uniform categorization of racial or ethnic groups identified in health status information data that is currently collected by all Health Department units. The Office on Minority Health should make the same recommendation as well to the Departments of Human Services, Community Affairs, and Environmental Protection.

Finally, I want to say that the Minority Health Institute here at UMDNJ does not view the development of an office as duplicative of our activities. Rather, we see the roles or agendas of the two agencies as complimentary.

We believe that a close working relationship between the two agencies will ensure success in addressing the health problems of minority populations in New Jersey.

I'd like to thank you for the opportunity to talk with you today, and I'd be happy to answer any questions you might have.

SENATOR CODEY: Senator Rice, any questions?

SENATOR RICE: Yeah, I heard three pitches today. Are we pitching to send our money to UMDNJ?

MR. MORGAN: No, sir. I suggest that you establish the office first. (laughter)

SENATOR RICE: You know, there are other organizations and institutions that need to participate. It's got to be a real partnership. If not, we're going to get backed up and trapped again. And we need to pay attention.

I do think that your recommendations in terms of amendments, make good sense. It's something we need to discuss. And I also feel that if we don't discuss them, Senator Codey, Senator Lipman is going to have a bill in. Thank you.

SENATOR CODEY: Doug, one of my questions, I think, you really answered in your testimony with: How do we bring these various groups together? And I think your recommendation really was that the Commissioners' group be the focal point of these organizations that have been working independently, but obviously on the same issue, trying to bring this issue to the forefront. And I thank you for the suggestion and also for the help that you've given the Committee in regards to this issue and this particular bill, and setting up our hearing today.

MR. MORGAN: Thank you very much, Mr. Chairman, members of the Committee.

SENATOR CODEY: Thank you. Our next witness will be Ceil Zalkind of the Association of Children of New Jersey.

C E C I L I A Z A L K I N D: Thank you Senator Codey and other members of the Committee. My name is Ceil Zalkind and I'm representing the Association for Children of New Jersey to express our strong support for S-2063 to establish an Office on Minority Health in the Department of Health.

Our Association is a statewide child advocacy organization which advocates on behalf of the children of our State, particularly those who are vulnerable and dependent on State services for their well-being.

ACNJ strongly supports this bill because we feel this office is an important step to address the health needs of minority children. As you've already heard this morning, there are great disparities in health care services to the children of our State. The infant mortality rate for minority infants is more than double that of white infants. Minority infants are more than twice as likely as white infants to be low birth weight babies. Three-quarters of the pediatric AIDS cases in the State are minority children. Births to non-white adolescents are two to three times greater than births to white adolescents. And non-white mothers are four times less likely to receive adequate prenatal care than are white mothers.

And this is just-- You've heard many statistics this morning. This is just a small sense of what we've looked at in terms of the children of our State.

We feel strongly that many of these problems are linked to poverty. Minority children are four times more likely to live in poverty than white children. They account for a disproportionate percentage of the still, over 200,000 in our State who do not have any health coverage. For them, prenatal care is inadequate or nonexistent and routing medical care must be postponed until health problems become an emergency.

Other needs related to good health such as adequate nutrition are also linked to poverty, leaving minority children at greater risk. Poor families must spend a great deal of their income on fixed costs such as housing, leaving too little money for food. Government programs such as the WIC Program and the school nutrition programs are inadequately funded on the Federal and State level, leaving many eligible children unserved.

For these reasons and others, we believe that an Office of Minority Health would be a critical unit within the Department of Health. We feel strongly that children must be a priority for this office. Strengthened approaches to prevention, early intervention, and access to adequate health care are critical to improving the health of minority children and their families. And we believe an office like this can fulfill that role.

We do, however, have two very specific concerns with language in the bill about the coordination issues and the authority of this office within the Department of Health, and also interdepartmentally, with other State departments.

Although the bill describes some functions and responsibilities of the office, we feel that greater specificity is needed. We're very concerned about the section

of the bill which addresses coordination of services among the various operating units of the Department of Health. The bill, for example, directs the Office on Minority Health to make recommendations to the Department on minority health issues. It does not, however, describe the relationship of the office to other line operations within the Department. Language is needed either in the bill, or in subsequent regulations to specify what these other entities must do once a recommendation is made by the Office on Minority Health. We believe that some language is needed to specify the responsibility of the other units within the Department as well.

We're also concerned about how this office will coordinate its activities, especially the grant funding role, with other entities in the Department. This is critical since most of the Department's direct services functions are done through local grants. In the past we've been highly critical of "turf" problems that we've seen among the various divisions in the Department, and feel that some language must be included here to talk about coordination within the Department.

We're also concerned about coordination with other State departments in two ways: 1) that we believe that minority children served by other systems also have serious health problems, and 2) that some of these other systems can be an excellent resource for prevention and health care. Other State departments that we've taken a look at see an overrepresentation of minority children in their at risk population. Minority children represent the largest percentage of the 27,000 children in out-of-home placement in our State, particularly in the foster care and juvenile justice systems. Health issues are a serious concern for these children. Not only is access to health care a problem, but often the service plans or the treatment plans for these children and families completely ignore health issues.

Secondly, we feel that many health issues surface in school. Schools can serve a vital role in identifying and treating particular health needs, or at least providing access to health care. Immunizations, for example, are a serious problem for the urban areas. In Newark alone, the rate of full immunization among preschool children is only 23%. With appropriate direction and support, the schools could be a successful place to identify without immunizations and to provide some referral and follow-up on necessary inoculations.

So, we believe that coordination among the various State departments is necessary to identify health needs and to provide a way to address such needs. And although the bill does direct the Office on Minority Health to review the programs of other departments and make recommendations, again, it doesn't really address coordination among the various State departments.

How these recommendations are made and more importantly, how they're acted upon, must be spelled out more fully in the bill. Further, we feel strongly that the Department of Education should be included, along with Human Services and Community Affairs, in the list of departments with which this new office must interact.

In conclusion, aside from our recommendations that we feel would strengthen the bill, I do wish to express our strong support for this bill. The health concerns of minority children and families have been a priority of our organization for some time and we're pleased to see this bill, and urge that you fully support it.

SENATOR CODEY: Thank you very much, Ms. Zalkind. Any questions? (no response)

SENATOR AMBROSIO: Thank you, Ceil.

SENATOR CODEY: Thanks again. Our next witness will be Dr. Lawrence Frenkel of the New Jersey Maternal and Child Health Advocacy Coalition. Dr. Frenkel.

D R. L A W R E N C E D. F R E N K E L, M. D.: Thank you. Senator Codey and members of the Committee, good morning. I am Dr. Lawrence Dean Frenkel, Professor in the Departments of Pediatrics and Microbiology at the UMDNJ-Robert Wood Johnson Medical School. I am speaking today on behalf of the New Jersey Maternal and Child Health Advocacy Coalition. The Coalition represents organizations interested in the welfare of pregnant women, infants and children, and includes: The Association for Children of New Jersey; New Jersey Section of the American College of Obstetrics and Gynecology; Perinatal Association of New Jersey; March of Dimes; New Jersey Academy of Pediatrics; New Jersey Primary Care Association; New Jersey Section Nurses Association of the American College of Obstetrics and Gynocology; New Jersey Healthy Mothers/Healthy Babies Coalitions; New Jersey Hospital Association; New Jersey Human Genetics Association; New Jersey Planned Parenthood Association; and New Jersey Business and Industry Association.

Without strong leadership now, the quality of life as most of us know it in New Jersey, may soon disappear. Each year 100,000 babies are born in New Jersey. Of these, 10,000 are born critically ill or with birth defects, and 1000 die within a month after birth. Infants in 18 other countries and 19 other states, have a better chance of living to celebrate their first birthday, than a baby born in New Jersey.

A disproportionate number of these unfortunate beings, who start out life at a disadvantage, are minorities. The cost of these tragedies is high both in terms of direct economics, and in lost human potential. Infant mortality for white infants in New Jersey this past year, was 7.9 per thousand; for non-white infants it's more than double that, at 18 per thousand. Here in Essex County, for non-whites, this infant mortality is 21.4 per thousand; at the other end of our State, in Camden County, it is 21.0 per thousand.

During the past decade, it has become apparent that low birth weight is a significant cause of infant death. A low birth weight infant is 40 times more likely to die during the first month of life than a normal birth weight infant. Lack of prenatal care is clearly associated with low birth weight, as are teenage pregnancy, poor maternal nutrition, drug and alcohol abuse, and smoking. Early prenatal care can identify 80% of women at risk for having a low birth weight baby. In New Jersey nearly 30% of non-white mothers receive no prenatal care in their first trimester. This again, is double the incidence of their white counterparts.

Low birth weight infants on the average, cost society $25,000 in their first year of life. However, these extra costs can approach hundreds of thousands of dollars. We don't have this money to throw away.

Low birth weight infants also contribute to the roles of children who require special and expensive long-term care. The State of New Jersey pays 100% of early intervention programs for children zero to three years of age. This equates to $12 million to $13 million per year. We don't have this money to throw away.

Early intervention programs for children, three to five years of age, are paid for by local school districts and represent one of the factors that adds to the municipal tax burdens in our State.

The single major barrier to prenatal care, is lack of financial access for non-insured or underinsured pregnant, and often non-white women. One-fourth of women of reproductive age have no insurance to cover maternity care. Two-thirds of this group have no insurance at all. Uninsured women are likely to obtain prenatal care late in their pregnancy, and four times more likely to get no prenatal care at all. Stress, fear, and disillusionment with our health care system act as barriers for these pregnant women in accessing the appropriate care that

could often prevent tragic outcomes of pregnancy -- tragic and expensive outcomes of pregnancy.

The bureaucratic barriers that pregnant women in New Jersey must endure before they are informed that they qualify for prenatal care is distressing, at best. These include limited financial eligibility, assets tests, complicated long forms, unpleasant environment, etc. Some of these have been observed by Senator Rice in his comments today.

Once they qualify for prenatal care, they often have to wait weeks for an appointment to be seen at our overburdened prenatal clinics. We may have the facilities, but we don't always have the hands to give these women appropriate care. These clinics are overburdened largely because we have not kept our promise to increase reimbursement for health care providers to anywhere close to realistic levels. This single item may provide the answer that you have been looking for in terms of getting people to provide care for underinsured patients.

There are areas in New Jersey where optimal obstetric care for women without private insurance is almost unavailable. Other barriers to access to care include lack of transportation, lack of child care, waiting time, homelessness, drug abuse, illiteracy, and fear of deportation. Some of these have already been mentioned to you.

A crucial element in our efforts to provide better access to prenatal infant and child care is a realistic increase in Medicaid reimbursement to health care providers in New Jersey. Prenatal care is cost-effective. Every dollar spent on prenatal care saves in excess of $3.00 on the cost of caring for low birth weight infants. The efforts of citizens of New Jersey to address some of these issues of low birth weight have clearly demonstrated that appropriately funded and managed programs can make a difference.

In the 10 target areas within New Jersey, with partially State supported Healthy Mothers/Healthy Babies Coalitions, the rates of low birth weight and infant mortality have been dramatically reduced among the non-white population in 1987 and 1988 statistics. Medicaid is the main source of public financing for many health services to uninsured, low income, women and children. It is estimated that 24,000 women in New Jersey are eligible for Medicaid at 100% of the poverty level. An additional 16,000 women, who delivered in New Jersey this past year, were documented by our 69 hospitals to be "self-pay." That means: no Medicaid; no stated insurance. Approximately 10,000 of these, had incomes between 100% and 250% of the poverty level.

Currently, pregnant women whose incomes fall between these levels are eligible for Health Start services on a sliding scale and for the recently established New Jersey "Moms" Program. The cost of the New Jersey "Moms" Program are paid entirely through the Uncompensated Trust Fund, which unfortunately, increases the hospital cost of all New Jersey residents. This Program funds care provided only through the already overburdened hospital based clinics. It does not cover any cost of care to infants and children, and cannot take advantage of matching Federal funds. The Health Start and New Jersey "MOMS" Programs are both good programs, but they have limitations that should be addressed.

As of April 1, Federal regulations will mandate Medicaid eligibility to 133% of the poverty level. The expansion of Medicaid eligibility in New Jersey to 185% of the poverty level would provide prenatal, postnatal, and infant care to over 7000 additional women and infants each, with 50% of the cost paid by Federal funds. These matching Federal funds would result in a direct savings of over $34 million from the Uncompensated Trust Fund. There would be potential savings of additional millions of dollars through prevention of low birth weight.

In conclusion, we strongly feel that the overall social and economic viability of our State requires improvement in prenatal care for minorities and others. A realistic and economically sound way to achieve this goal includes the following: Expansion of Medicaid eligibility for pregnant women and children to 185% of the poverty level; increased provider reimbursement; expansion of funding for the Healthy Mothers/Healthy Babies Coalitions; and an effort to streamline the welfare procedures for determination of eligibility and facilitation of access to care.

We hope that the office and programs potentially provided by your bill will address some of these issues. Thank you.

SENATOR CODEY: Thank you, Doctor. Any questions? (no response) I just have one question, Doctor. A baby born with low weight-- How long does it take him or her, if treated properly, to get to a normal weight?

DR. FRENKEL: It depends on how much of a deficit that baby starts with. A premature, low birth weight infant can attain normal or average weight within a matter of months and almost all of them, if they are going to, within a matter of a couple of years.

SENATOR CODEY: Okay. Thank you very much, Doctor.

DR. FRENKEL: Thank you all for letting me appear before you.

SENATOR CODEY: Our next witness is Mrs. Alice Barnett from the Committee on the State of Black Health. Mrs. Barnett?

A L I C E B A R N E T T: Good morning. I already gave copies of my testimony to the aide.

My name is Alice Barnett. I am secretary to the Committee on the State of Black Health, and Executive Director of the Regional Health Planning Council. I'm here today in my role as Secretary to the Committee on the State of Black Health, but would like to state for the record, that the Board

of Trustees of the Regional Health Planning Council has endorsed the establishment of an Office on Minority Health.

First of all, we wish to applaud the intent of S-2063, and note that its sponsors are supporting a significant urban policy public policy platform; that is, equal health status for all New Jerseyans.

The elimination of health status differentials that exist between the minority and non-minority New Jerseyans requires strong legislation: Legislation that is proactive. Legislation that advocates; legislation that funds innovative solutions to the problem; legislation that sets adequate funding levels; in short, legislation that will achieve results.

Senate Bill No. 2063, while commendable, is not strong legislation. Senate Bill No. 2063 does not sufficiently advocate and promote the right of all New Jerseyans to enjoy equal health.

There is obviously a need to establish an Office of Minority Health within the New Jersey Department of Health. As noted in the proposed legislation, no coordinated, targeted State effort exists to address the differences in death, disease, and injury rates between white and minority populations. The proposed legislation would establish an office, but does not do so within parameters that insure that the office would be effective.

The Office of Minority Health delineated in this bill performs primarily a review and comment function. It is directed to review previously prepared studies, although these studies indicate the critical tasks and activities that must be completed. It is directed to review and comment on the programmatic efforts of other State departments. The office is not directed to present the findings or recommendations of its review and comment function to the Legislature or the Governor, or a review panel empowered to respond to the findings, or

correct dysfunctional, inefficient, or improperly targeted programs. Instead, the proposed legislation would have the Commissioner of Health report to the Governor and the Legislature on the activities of the office. Clearly, if the legislation is to be effective, the Office of Minority Health would be mandated to report to the Legislature the steps taken by the State of New Jersey to eliminate the gap.

The Office of Minority Health is mandated to dispense grants to community based agencies. This charge is the only significant proactive function of the office. Unfortunately, this function is funded at a level that precludes the staffing of an effective grants award component. Bilingual technical assistance for program development efforts must be available within the Office of Minority Health. Statisticians and research analysts should be available to measure the efficiency and effectiveness of community based agency efforts and State initiated projects. Without readily available bilingual technical assistance support staff, the only agencies who will be capable of receiving and implementing programs will be the traditional standard health and social service agencies.

The task force reports that the Office of Minority Health is directed to review, have already decreed that a non-traditional approach to the grant award process is required. An innovative, non-traditional approach encompassing different innovative methods for the dissemination of health promotion information, the development of culturally sensitive materials, and actual risk reduction activities is critical to ensure that the gap is eliminated. Adequate funding is a critical issue.

Senate Bill No. 2063, as delineated, creates just another State agency, not an Office of Minority Health, committed to eliminating the gap in health status differentials. Thank you.

SENATOR CODEY: Any questions?

SENATOR RICE: Ms. Barnett, you're saying as the bill is structured now, that we need an oversight provision, more or less, from the legislative body. Is that what you are actually saying?

MS. BARNETT: Well, what I'm saying is the office, if it is to be effective, has to be such that it has a charge and has a responsibility for reporting how it has succeeded in achieving its charge. That responsibility should be to an entity. A most likely or reasonable or rational entity, in my opinion, and that of my colleagues, is the Legislature.

SENATOR RICE: Okay. Do you agree with -- I'm not sure if you were here -- Mr. Morgan's comments--

MS. BARNETT: Yes, I was here.

SENATOR RICE: --in terms of the amendments he indicated we should be looking at?

MS. BARNETT: Yes, I do. I agree with most of Mr. Morgan's amendments. I'm not an advocate of giving all of the money to the University Hospital, UMDJ, but I do agree him, as much as I like Dr. Bergen.

SENATOR CODEY: He didn't say that in the amendments, though.

SENATOR RICE: Okay, let me make sure that I'm clear, because I'm reading-- Part of the bill was that a Commissioner of Health shall report annually, by September 1 of each year, to the Legislature and the Governor, on the activities of the office including the program services. I guess what I'm hearing you say is that it should be more than just that; that the legislators -- the Legislature -- should take--

MS. BARNETT: It's the language that I'm taking exception to. I think that as stated in the legislation-- It says, "report to the Legislature on the review and comment actions" of the office as opposed to on the activities of the Office itself. The office is not given real functions. It's given a review and comment. Then what the legislation says is

that the Commissioner reports to the Governor and the Legislature on these review and comment functions. But it doesn't charge the office with doing anything and reporting to the Legislature that this office has made a difference in health status of New Jerseyans -- the differential.

SENATOR CODEY: In other words, it's mandated in the bill. She just would like different language as to how it's mandated in terms-- If its reporting requirement -- what it reports on in terms of its activities.

SENATOR RICE: Okay.

SENATOR CODEY: Thank you very much, Alice. Our next witness is Dr. Francis Blackman, President of the Local Chapter and Chairman of the Regional Group of the National Medical Association. Is he here? No? (negative response) Okay, is Gwendolyn Long here? Gwendolyn, President of the New Jersey Public Policy Research Institute.

G W E N D O L Y N I. L O N G: Hello, I'm Gwendolyn Long, President of the New Jersey Public Policy Research Institute. New Jersey Public Policy Research Institute is a volunteer, not-for-profit, concerned with the identification analysis and public debate of issues affecting the African-American community in New Jersey.

Over the years, NJPPRI facilitated roundtable discussions, workshops, and presented working papers on contemporary issues. NJPPRI is probably best known for its annual publication. Mount Laurel, urban education, and blacks in South Jersey are among the topics of past publications. Our most recent publication, "Health Concerns of New Jersey's African-American Community," found that the health care system in New Jersey has been deficient in effectively meeting the needs of the African-American community in New Jersey, partly due to institutionalized philosophies and practices of the medical community, but also due to the socio-economic conditions of many African-Americans, and the impact of a racist society. The resulting indicators are sobering:

In 1987, the non-white infant mortality rate was 18.7 per 1000 live births, in comparison with 7.1 per 1000 rate for whites.

Black males experienced a steady increase of lung and prostrate cancer incidents from 1979 to 1985.

Black and Hispanic women represent 77% of all female AIDS cases in New Jersey.

Based upon a three-year average, 1985 to 1987, a percentage of firearms used for homicides is higher for non-whites, when compared to whites.

It is because of the declining health status of African-Americans in New Jersey, that NJPPRI endorses the concept of establishing a governmental office charged with ensuring a coordinated effort to address the health care needs of African-Americans and other non-whites in New Jersey. This office should have adequate resources to effectively coordinate and monitor health care delivery through research and data collection, analysis of the effective program models, training, as well as participation in policy development, to ensure replication of successful interventions.

I would contend, nevertheless, that this office should be in, but not of, the Department of Health. This office must be positioned and authorized to transcend departmental boundaries to do its work. Otherwise, it will be stymied by the same constraints which currently exist.

For example, in our most recent publications article, "Adolescence Pregnancy," it is affirmed that the primary objectives -- the two primary objectives -- in working with this population are: 1) to keep the young mother in school; and 2) to ensure that adequate prenatal care is given. The successful program model described in the article involves both the education sector and the health sector.

Another article indicates that accessibility of health care, including preventive health care, is significantly

determined by health care financing. The Department of Human Services, through Medicaid, plays a critical role vis-a-vis this issue.

Congressman Donald Payne's article speaks to the impact of crime, violence, and homicide, as a major cause of death and injury in the African-American community. He speaks to the youth, of an intervention strategy which teaches youngsters alternative means of conflict resolution. Community based organizations currently contracted with, by the Department of Human Services and the Department of Community Affairs may be best suited to implement such an intervention strategy. It is not my intent to be exhaustive with these examples, but rather to help portray the need for coordination beyond just the Department of Health in order to be effective.

In conclusion, let's be cognizant of the fact that if an earnest all-out effort is not made to turn around the declining health status of African-Americans in New Jersey, the costs for that oversight will cripple us, not only in direct health care costs, but also in work force productivity, and the general quality of life. Thank you.

SENATOR CODEY: Thank you, Ms. Long.

SENATOR AMBROSIO: Thank you.

SENATOR CODEY: Questions? (no response) Thank you again. Thank you for the report that we've looked at.

MS. LONG: Thank you.

SENATOR CODEY: Thank you, Ms. Long.

Our next witness is Dr. Thomas Ortiz. Is he here? No?

UNIDENTIFIED MEMBER OF AUDIENCE: He's not here yet.

SENATOR CODEY: Do you have his written testimony?

UNIDENTIFIED MEMBER OF AUDIENCE: No.

SENATOR CODEY: Okay, he can submit it to us later.

UNIDENTIFIED MEMBER OF AUDIENCE: He's on his way. We didn't expect him to come on until about 1:00.

SENATOR CODEY: Oh, okay. Maybe we could get a copy of his remarks and keep it as part of the record.

UNIDENTIFIED MEMBER OF AUDIENCE: Let me check.

SENATOR CODEY: Yes, okay. Thank you very much. We stand adjourned.

(HEARING CONCLUDED)

APPENDIX

TESTIMONY IN FAVOR OF S-2063

TUESDAY, FEBRUARY 13, 1990

MARGARET J. STRANEY, R.S.M.,

PRESIDENT AND CHIEF EXECUTIVE OFFICER, CATHEDRAL HEALTHCARE SYSTEM

DIANA LAKE-LEWIN, M.D.,

DIRECTOR, ONCOLOGY PROGRAM, SAINT MICHAEL'S MEDICAL CENTER

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GOOD MORNING. MY NAME IS DR. DIANA LAKE-LEWIN. I AM HERE TO SPEAK IN FAVOR OF SENATE BILL NO. 2063 ON BEHALF OF SISTER MARGARET J. STRANEY, PRESIDENT AND CHIEF EXECUTIVE OFFICER OF CATHEDRAL HEALTHCARE SYSTEM, AND MYSELF. I AM DIRECTOR OF THE ONCOLOGY PROGRAM AT SAINT MICHAEL'S MEDICAL CENTER IN NEWARK AND A MEMBER OF THE MINORITY TASK FORCE OF THE NATIONAL INSTITUTES FOR HEALTH.

WE WOULD FIRST LIKE TO COMMEND SENATOR CODEY FOR HIS INSIGHT INTO THIS PRESSING HEALTH ISSUE AND HIS WILLINGNESS TO OFFER A CREATIVE SOLUTION.

THE DISPARITY IN THE HEALTH STATUS OF THE WHITE AND NON-WHITE POPULATIONS HAS BEEN WELL DOCUMENTED. BLACKS HAVE A DEATH RATE 2.5 TIMES HIGHER THAN WHITES. A STUDY BY THE CENTERS FOR DISEASE CONTROL SAID THAT 31 PERCENT OF THE DIFFERENCE CANNOT BE EXPLAINED BY PREVENTABLE FACTORS OR BY SOCIO-ECONOMIC FACTORS. A RECENT UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES TASK FORCE REPORT ON BLACK AND MINORITY HEALTH IDENTIFIED SIX MAJOR CAUSES OF DEATH FOR WHICH MORTALITY AMONG MINORITY POPULATIONS IS IN EXCESS OF THE WHITE POPULATION. THESE ARE: CANCER, CARDIOVASCULAR DISEASE AND STROKE, CHEMICAL DEPENDENCY, DIABETES, HOMICIDE AND ACCIDENTS, AND INFANT MORTALITY.

CLEARLY THERE IS A NEED TO FOCUS ATTENTION ON THIS PRESSING ISSUE, TO CHANNEL FUNDS, TO PRIORITIZE AREAS OF STUDY AND TO FACILITATE ACCESS OF MINORITY PATIENTS TO HEALTH CARE RESOURCES. THE PROPOSED OFFICE OF MINORITY HEALTH COULD SERVE SUCH A ROLE.

AT SAINT MICHAEL'S MEDICAL CENTER WE HAVE BEEN ANALYZING THE

DATA CONCERNING MINORITY HEALTH CARE IN CANCER FOR THE LAST FOUR YEARS. PART OF THIS ANALYSIS IS SUPPORTED BY TWO GRANTS, ONE FROM THE NATIONAL INSTITUTES OF HEALTH AND THE OTHER FROM THE NEW JERSEY COMMISSION ON CANCER RESEARCH. THE LATTER GRANT WAS TO STUDY THE IMMUNE PARAMETERS AND TUMOR BIOLOGY IN MINORITY CANCER PATIENTS. DURING THIS TIME WE HAVE IDENTIFIED SEVERAL PROBLEMS, MOST NOTABLY POVERTY. IN OUR CANCER PATIENT POPULATION, WHICH IS MOST FAMILIAR TO ME, WE HAVE IDENTIFIED OTHER MAJOR ISSUES: LACK OF TRUST, IMPOVERISHED HOME SITUATION, LACK OF SUPPORT SYSTEMS AND POOR UNDERSTANDING OF THE TREATMENT PLAN. THEREFORE, A SPECIALLY TRAINED STAFF ARE NEEDED FOR THIS PATIENT GROUP.

IN OUR BREAST CANCER STUDIES WE HAVE STUDIED PATIENT TUMORS OF THOSE NEWLY DIAGNOSED WITH BREAST CANCER. STRATIFYING FOR RACE, WE NOTE THAT BLACK PATIENTS HAVE MORE OF THE KNOWN POORER PROGNOSTIC FEATURES THAN THEIR WHITE COUNTERPARTS. THIS IS INDICATIVE OF A DIFFERENCE IN THE BIOLOGY OF THE TUMOR. THE QUESTION REMAINS: WHY IS THIS SO? THESE STUDIES COULD LEAD TO FINDINGS THAT WOULD HAVE AN IMPORTANT IMPACT ON THE HEALTH STATUS OF THE MINORITY POPULATION, AND THEY SHOULD BE ENCOURAGED AND FUNDED.

ANOTHER PRESSING ISSUE WHICH THE OFFICE OF MINORITY HEALTH COULD FOCUS ON IS THE ACCESS OF MINORITY PATIENTS TO THE HEALTH CARE SYSTEM. HOW DO WE ENSURE THAT MINORITY PATIENTS HAVE EQUAL ACCESS TO STATE OF THE ART THERAPY THROUGH CLINICAL TRIALS? THE FEDERAL GOVERNMENT HAS RECENTLY LAUNCHED A PROJECT TO PROVIDE FUNDING FOR SOCIAL WORKERS, NURSES, RECORD KEEPERS AND OTHER PERSONNEL TO PLACE MINORITY PATIENTS ON EXPERIMENTAL PROTOCOLS, AND

SIMILAR EFFORTS IN THIS DIRECTION SHOULD BE ENCOURAGED.

WE ALSO NEED TO LOOK AT THE ECONOMICS OF HEALTH CARE DELIVERY. A HIGH PERCENTAGE OF MINORITY PATIENTS DO NOT HAVE ADEQUATE HEALTH INSURANCE COVERAGE, AND THIS UNDOUBTEDLY HINDERS THEIR ACCESS TO QUALITY HEALTH CARE.

I WOULD HOPE THAT THE PROPOSED OFFICE ON MINORITY HEALTH WOULD ADDRESS THESE AREAS:

FIRST, IT SHOULD IDENTIFY THE MAJOR PROBLEMS RELATED TO MINORITY HEALTH, SUCH AS INFANT MORTALITY, CANCER, HEART DISEASE, ETC., AND THEN PRIORITIZE THESE ISSUES.

SECOND, IT SHOULD ACT AS A CHANNEL FOR FUNDS. WE CANNOT BEGIN TO MAKE A DIFFERENCE UNLESS ADEQUATE AND ONGOING FUNDING IS PROVIDED. IT IS IMPERATIVE THAT THE OFFICE OF MINORITY HEALTH CARE PROVIDE FUNDING NOT ONLY FOR RESEARCH, BUT FOR TRAINED, DESIGNATED STAFF IN THE URBAN HOSPITALS TO ADMINISTER CONCRETE AND SUPPORTIVE SERVICES. IN PERFORMING THIS FUNCTION, THE OFFICE WOULD COLLECT DATA AND THEREBY FORM A DATA BANK WHICH IS BADLY NEEDED.

THIRD, THE OFFICE SHOULD MAINTAIN CLOSE CONTACT WITH THE URBAN, INNER CITY HOSPITALS THAT KNOW FIRST HAND THE HEALTH PROBLEMS OF OUR MINORITY POPULATIONS. REPRESENTATIVES FROM THESE URBAN HOSPITALS SHOULD SERVE AS AN ADVISORY BODY TO THE OFFICE OF MINORITY HEALTH. THESE AND OTHER HEALTH CARE PROVIDERS SHOULD BE INVOLVED EARLY ON IN THE PLANNING PROCESS.

FOURTH, THE OFFICE MUST PLAY A COORDINATING ROLE WITH OTHER KEY AREAS THAT IMPACT MINORITY HEALTH, INCLUDING HOUSING, FOOD, TRANSPORTATION, INSURANCE, AND MEDICATION. IT SHOULD ALSO SERVE AS A LIAISON WITH OTHER NATIONAL AND LOCAL GROUPS THAT ARE LOOKING AT

THE SAME ISSUES.

LAST, THE OFFICE MUST CONTINUOUSLY MONITOR AND EVALUATE ITS ACTIVITIES TO ENSURE PRODUCTIVITY.

WE FIRMLY BELIEVE THAT THE CREATION OF AN OFFICE OF MINORITY HEALTH WOULD BE AN IMPORTANT STEP IN BOTH UNDERSTANDING THE HEALTH STATUS OF OUR MINORITY POPULATIONS, AND IN BEGINNING TO IMPROVE THAT STATUS. I STRONGLY URGE YOU TO SUPPORT THIS IMPORTANT LEGISLATIVE INITIATIVE.

THANK YOU.

TESTIMONY TO THE
STATE INSTITUTION, HEALTH
AND WELFARE COMMITTEE

TUESDAY, FEBRUARY 13, 1990

PRESENTED BY:

GEORGE HAMPTON
VICE PRESIDENT
URBAN AND COMMUNITY AFFAIRS
UMDNJ

Good morning Chairman Codey and Members of the Committee. My name is George Hampton, Vice President for Urban and Community Affairs at UMDNJ, I am also Chairman of the UMDNJ-Minority Health Task Force. This group is composed of senior faculty and administrators from all three of the UMDNJ campuses in Newark, Piscataway/New Brunswick and Camden/Stratford. The Task Force, which was developed in the Spring of 1988, remains concerned with the growing disparity in health status between whites and all minorities in New Jersey. The primary focus of the Task Force has been the development of the UMDNJ-Minority Health Institute, an entity that would bring together the resources of the State's Academic Health Science Center and other educational institutions within the State to investigate the causes of the health status disparity and to identify effective programs that will remove the disparity.

Black Americans have a life expectancy that is five years less than whites, and infant mortality rates that are twice that of whites despite a steady decrease in overall infant deaths during the last few decades. The tremendous gains made in medical science and technology, which have enhanced the health of the average American, have not equally benefitted the African-American and Hispanic populations. The desperate shortage of primary care physicians in the inner cities, the lack of health insurance among poor populations, and the absence of health education opportunities have prevented minorities from seeking medical services in a timely manner that would result in lowering disease occurrence and death rates. Excess illness and death among minorities can be partly attributed to fewer

resources to access health care---a condition that is intensified by the scarcity of black and hispanic physicians and other health care professionals. Nationwide, not enough minority students are receiving the preparation, encouragement, and resources needed to enter the medical professions. Indeed, greater proportions of minority high school graduates are not going to college. Critical shortages of black and hispanic physicians and dentists, and the lack of health care in minority communities will not be solved until more progress is made to prepare minority students to appreciate science and mathematics which will lead them toward college and medical careers.

The University of Medicine and Dentistry of New Jersey is pleased to be at the forefront of these efforts. Today, nearly 200 junior and senior high school students from Newark and Camden participate in UMDNJ pre-college programs. At the undergraduate level, pre-med minority students participate in UMDNJ summer enrichment programs, and other UMDNJ outreach efforts seek to interest minority college students to pursue health science careers.

In many ways, urban and community health and minority health are synonymous. In Newark for example, in the two decades since the UMDNJ came to Newark, it has viewed its community responsibilities broadly and has taken major steps to address Newark health issues.

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These efforts have paid dividends. The University's Newark campus has made a major contribution to the City's health, serving 180,000 patients a year. The UMDNJ-New Jersey Medical School (NJMS) has recruited and graduated hundreds of minority doctors. Today, 70 NJMS minority graduates parctice in the Newark area. Despite this progress, the health needs of the City are still great and dictate that our commitment remain large.

Poverty is touching more Newark families and the depth of their poverty is growing. The accompanying economic problems placed on many Newark families, mothers, and children often mean poor attention to health needs, nutritional problems, family violence, education failure, and alienation that cuts short many thousands of Newark lives each year.

Bill Moyers' TV documentary, "Crisis in America: The Vanishing Black Family," gave us memorable portraits of the faces of the inner city desperate: Black and Hispanic mothers and babies needlessly dying from poor health care; children hungry, abused, and without hope; and our youth, jobless and homeless facing the daily specter of drugs and alcohol. The problems, as indicated by the following figures almost seem to defy the most resolute efforts.

Every year in the City of Newark:

- o 100 babies die before their first birthday;
- o Another 80 babies are still born, a rate 40% higher than the statewide average;

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- o 6500 children are abused or neglected;
- o 650 babies are prematurely born with low birth weights, a rate nearly double the State's;
- o 100 persons die by suicide or homicide;

Newark residents are four times more likely to contract tuberculosis, and stand a 30% to 50% greater chance of dying accidently than other residents of New Jersey.

Only slightly more than one-half of Newark resident live to age 65, and the biggest killers remain heart disease, cancer, cerebrovascular diseases, death by accident, diabetes and homicide. In addition, an increasing amount of IV drug abuse has contributed to an AIDS epidemic, which as of January 1, 1988 numbered 600 cases. This number, which reflects AIDS cases among Newark residents only, does not include persons diagnosed with AIDS Related Complex (ARC) or those who have tested positive for the HIV virus, conditions that frequently develop into full-blown AIDS.

In Newark, one of every 22 babies born at University Hospital is testing positive for the AIDS antibodies.

Recent data from the State Department of Health indicates that minorities are experiencing higher rates of infant mortality, deaths due to injury and homicide, higher incidence rates of cancer and incidence of AIDS than New Jersey's White population. Indeed, demographers project that the

minority population will increase at a much faster rate than that of the White population in the next decade. If we fail to take steps to address these health problems the disparity will worsen.

The UMDNJ-Minority Health Task Force is in support of the development of an office of Minority Health. We believe that such an Office can be effective in three major areas. First, the Office can begin to better focus a number of the Department of Health's existing programs to insure that Minority Health concerns are better addressed.

Second, an Office of Minority Health can provide leadership within State Government in the development of health policies that will insure the availability of and access to health services that are appropriate to the health care needs of New Jersey's minority Residents.

Finally, the proposed Office can stress the need for prevention activities, starting with school aged children to improve the health of minorities in New Jersey. It is here that the Office can have a major impact in the development of new and innovative approaches that have demonstrated their effectiveness in addressing specific health problems.

The University of Medicine and Dentistry of New Jersey will work with the Office in addressing the health needs of minorities in New Jersey and Pledges the make available our resources. You will hear later from the Director of the Minority Health Institute, Douglas H. Morgan, who has

specific recommendations regarding the proposed legislation. Mr. Chairman and Members of the Committee, I have included with my statement materials that describe the Institute's activities and membership of the Task Force.

Thank you for the opportunity to talk with you today and I will be happy to answer any questions you may have.

STATUS REPORT ON THE ACTIVITIES OF THE UMDNJ MINORITY HEALTH TASK FORCE AND MINORITY HEALTH INSTITUTE

January 12,1990

EXECUTIVE DIRECTOR'S OVERVIEW

My function as Executive Director has been to develop the Minority Health Institute into a functioning entity. Although the Institute has not been funded as yet. I have spent a great deal of time during the last few months talking with faculty and staff within the University as well as with others outside of UMDNJ. These discussions have been very rewarding because they have yielded information about many of the good projects or activities within UMDNJ that impact upon the health of minorities but which are not readily apparent to many of us. The discussions have also revealed some of the deficiencies that continue to remain within the University, which the Institute will have to address.

The following is a report on the Institute's progress to date. While we have not yet attained stable funding we have been very active.

MINORITY HEALTH TASK FORCE ACTIVITIES

The Minority Health Task Force (MHTF) is comprised of Minority Professional staff. The Minority Health Task Force meets monthly, to discuss issues of importance to the Institute. For example, the MHTF has been concerned about the lack of "cultural sensitive" training within the educational process which medical students undergo. As a result, the Minority Health Task Force circulated a paper, authored by Dr. Billie Slaughter, to the Deans and Chairs of the curriculum development committees within the University for their review. The Deans expressed a willingness to address the Task Force's concerns. The MHTF hopes to undertake a major effort to bring to the University faculty's attention the need for greater cultural sensitivity through a major faculty conference.

The Task Force has also undertaken an effort to identify faculty within the University who share the concerns of the Task Force and are willing to assist in working on specific research, education and data collection activities.

Several individual members of the MHTF are involved in health services research projects which focus on minority health problems or access to health care. We hope to complete in the near future a paper on the Health Insurance status of children in New Jersey. The Task Force has also been involved in the development of a proposal to establish a series of culturally relevant health education brochures for members of minority communities in New Jersey.

PUBLICATIONS

Members of the Minority Health Task Force have authored a number of articles addressing the health problems of minorities including:

Hampton, G., Morgan, D., Slaughter, B., Minority Health Status in New Jersey. UMDNJ Confronts the Problem, New Jersey Medicine

Slaughter, B., Ph.D., The Health Status of Minority and Poor Americans and Patient Noncompliance. Black in New Jersey: Health Concerns of New Jersey's African American Community. NJPPRI, Absecon, New

Jersey. September, 1989

Johnson, R., M.D., Upperman, J., Dixon, C., The Teenage Father. Blacks in New Jersey: Health Concerns of New Jersey's African American Community. NJPPRI, Absecon, New Jersey. September, 1989

Nichols, R., M.D., Adolescent Pregnancy. Blacks in New Jersey: Health Concerns of New Jersey's African American Community. NJPPRI, Absecon, New Jersey. September, 1989

King, V., JD., V., Morgan, D., Abortion. Blacks in New Jersey: Health Concerns of New Jersey's African American Community. NJPPRI, Absecon, New Jersey. September, 1989

INTRAORGANIZATIONAL ACTIVITIES

A. The Executive Director of the Institute has participated in the development of a number of proposals authored by other units within UMDNJ including:

- A grant proposal to the Health Resources Services Administration to establish a regional AIDS training center. The grant was developed by the UMDNJ division of Continuing Education, headed by Robert Moultrie, Ph.D.

- A grant proposal to develop a Minority Community Clinical Oncology Program for the Newark area. The proposal was developed by Thomas Hall, M.D., Director, TEX ICT. The proposal, submitted to the National Cancer Institute, is currently under review.

B. The Institute has been asked to join the Focus Group on Community Based and International Health Education, a subcommittee of the New Jersey Medical School Curriculum Development Committee.

C. The Institute met with faculty of the School of Osteopathic Medicine, Camden to discuss their Sickle Cell Anemia program and the establishment of a linkage with their group.

D. Institute staff have also met with several faculty and clinicians within the Newark complex who are providing excellent service in response to community/minority problems.

INTERORGANIZATIONAL ACTIVITIES

A. The Executive Director of the Minority Health Institute has met with the Director of the Rutgers University Institute for Health, Health Care Policy, and Aging Research, to discuss collaborative relationships.

B. The Executive Director has also met with Michael Greenberg, Ph.D., Co-director of the UMDNJ-Rutgers Public Health Program. Dr. Greenberg has indicated a strong interest in working with the Institute regarding

ongoing research in health areas affecting minorities. Through Dr. Greenberg, the Institute has learned of a number of State funded Cancer research efforts operating in Newark targeted to minority populations.

The Institute has a meeting planned to discuss the concept of linkages with faculty of the Harvard School of Public Health. Our discussions will involve faculty from the Department's of Maternal and Child Health and Health Policy and Management in School of Public Health.

FUNDING ACTIVITIES

Developed a proposal for funding by the U.S. Department of Health and Human Services, Office of Minority Health under their program for Community Based Coalitions for Minority Health Services. The proposals were not funded.

Submitted request for core support to the Geraldine R. Dodge Foundation and The Commonwealth Fund. Both organizations declined to provide core support for the Institute.

Submitted a request to North Jersey Chapter of the March of Dimes for a small grant in the area of health education. The grant was declined because another UMDNJ unit submitted a proposal to conduct a similar project for less money.

The Institute has approached The Robert Wood Johnson Foundation which has indicated that they are not interested in providing core support to the Institute. However, the Foundation indicated that they are interested in supporting specific service projects in areas like Substance Abuse or AIDS. We have some indications that they may be interested in supporting a project that would provide information regarding the health status of minorities in the State.

The Institute has developed a small grant request for the UMDNJ Foundation to develop a Culturally Sensitive Series of Health Educational Materials. The grant is currently under review.

COMMUNITY RELATIONS ACTIVITIES

A. The Institute has established linkages with a number of community based organizations including:
   - State of Black Health Committee
   - Health Mothers/Health Babies Coalition of Essex County
   - March Dimes Partnership for Maternal and Child Health
   - Black Men's Health Network
   - State Health Commissioner's Minority Health Advisory Committee
   - The Newark Community Project For People With AIDS

B. The Institute has also participated in or co-sponsored several events including:
   - Crisis of the Minority Male Conference (March 1989)
   - State of Black and Minority Health Conference (June 1989)
   - New Jersey Black Issues Conference (September 1989)
   - Community Seminar on Child Safety Seats and Injury Prevention (November 1989)

The Honorable Senator Richard Codey and members of the Senate Institutions, Health and Welfare Committee:

I am Dr. Stanley S. Bergen, Jr., the President of the University of Medicine and Dentistry of New Jersey and I address you this morning on Senate Bill #2063. I wish to express the wholehearted support of the University for this legislation which will establish an Office of Minority Health.

In addition, and for the record, we similarly support the companion legislation introduced by Assemblyman Charles in support of this action.

For many years it has been recognized that there are unique problems of health among minority populations within the United States. Many studies have been conducted that identify these unique minority health care problems in various regions and states of our union. New Jersey is no different. There are specific problems of health and patterns of disease, unique disease processes and health care delivery access issues that affect minority populations in a different manner, scope and quantity from those affecting the majority population of our state.

Some of these unique health problems are limited to Black citizens, others are manifest in Hispanic groups and still others are evident in migrant farm workers and recent new immigrant populations from Asian countries and elsewhere. Sickle cell anemia, other forms of anemia and blood disorders, hypertension, unusual forms of heart disease, the incidence of diabetes mellitus and many other diseases have significant impact and intensity of manifestation among minority populations.

The February 9, 1990 issue of the Journal of the American Medical Association, reported upon a study by a group from the Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control in Atlanta, Georgia. They noted that "the effect of known risk factors on the excess mortality of Black adults in the United States" was not merely explained by risk factors alone but at least 31% of the incidence of disease among minority Blacks was left unexplained. The authors urged that broader social and health system changes and research be targeted at the cause of the mortality gap, coupled with increased efforts aimed at modified risk factors so that all segments of our population would receive equal access and health care through our public system.

Lastly, let me note that the well-established risk factors among minorities include smoking and other use of tobacco, high systolic blood pressure, high blood cholesterol levels, increased body mass, excess

alcohol intake and diabetes mellitus. All these diseases and parameters of health maintenance should receive special consideration. Therefore, the establishment of an Office of Minority Health within the Department of Health, State of New Jersey, would seem critical and essential for the well-being of our minority populations and the long-term health and economic stability of our state.

Thank you for the opportunity to appear before your committee and state the position of the University and my personal beliefs in this matter.

2/13/90.

SSB:pk

THE CITY OF ORANGE TOWNSHIP
29 NO. DAY STREET • ORANGE, NJ 07050 • (201) 266-2174 • 266-4080
DEPARTMENT OF COMMUNITY SERVICES
Division of Health

Alice Kelly-Stevens, R.N., M.A. February 13, 1990

I WORK AS A PUBLIC HEALTH NURSE FOR THE CITY OF ORANGE. AS ONE OF THE SITES FOR THE HEALTHY MOTHERS/ HEALTHY BABIES COALITION OF ESSEX COUNTY, OUR TEAM SERVICES THE HI-RISK CHILDBEARING WOMEN OF ORANGE. I HAVE BEEN WITH THE PROGRAM FOR ABOUT A YEAR. OUR TEAM CONSISTS OF MYSELF AND TWO HALF TIME OUTREACH WORKERS. THEY ARE BOTH ORANGE RESIDENTS AND ONE IS BILINGUAL, TO SERVICE OUT SPANISH SPEAKING CLIENTS.

EACH MONTH WE ADD APPROXIMATELY 15 TO 20 NEW CLIENTS TO OUR CASE LOAD. THIS LAST QUARTER OF 1989, WE ADDED 52 NEW CLIENTS. THEIR ETHNIC BREAKDOWN WAS SIMILAR TO MONTHS PAST:

52 % Afro- americans OF WHICH HALF ARE TEENAGERS
21 % Caribbean- Haiti or the former English Colonies
23 % Hispanics- Central and South America
4 % European or Asian

THE HISTORY, BACKGROUND, AND PROBLEMS OF EACH OF THESE CULTURAL GROUPS IS UNIQUE AND REQUIRES DIFFERNT STATEGIES AND SOLUTIONS TO HELP THEM HAVE SUCCESSFUL PREGNANCIES AND HEALTHY BABIES.

ABOUT HALF OF OUR REFERRALS ARE FROM THE CLINIC AT HOSPITAL CENTER AT ORANGE (48%) WITH THE REST FROM OTHER COMMUNITY AGENCIES, FOR EXAMPLE : ORANGE HIGH SCHOOL, THE YWCA, and THE ORANGE HEALTH DEPARTMENT (52%).

OUR PROGRAM STRIVES:

TO IDENTIFY WOMEN AS EARLY AS POSSIBLE IN THEIR PREGNANCY

TO SEE THAT SHE IS REGISTERED FOR PRENATAL CARE EARLY AND KEEPS HER APPOINTMENTS

TO EVALUATE HER PARTICULAR SITUATION BY A VISIT TO HER HOME

TO REFER HER TO THE APPROPRIATE SUPPLEMENTAL PROGRAMS: WIC, N.J. CARE, WELFARE, FOOD STAMPS, ETC.

TO BE HER ADVOCATE WHEN BARRIERS OCCUR AT VARIOUS AGENCIES

TO VISIT HER AT HOME AFTER THE BABY IS BORN FOR A REEVALU. ATION AND REFERRALS

TO ASSIST HER IN MAKING APPOINTMENTS FOR BOTH FAMILY PLAN NING AND THE BABY'S IMMUNIZATIONS

TO FOLLOW THE BABY FOR ONE YEAR TO CHECK IMMUNIZATIONS AND IDENTIFY ANY DEVELOPMENTAL DELAYS

OUR CASE LOAD HAS BEEN GROWING FOR THREE YEARS BUT FOR THE LAST SIX MONTHS IT HAS REMAINED FAIRLY STABLE

WE CURRENTLY HAVE 109 MATERNITY CLIENTS

127 PEDIATRIC CLIENTS

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236 TOTAL 12/31/89

IF A WOMAN ENTERS CARE EARLY, OR WE RECEIVE HER REFERRAL EARLY IN HER PREGNANCY, WE CAN MAKE THE NECESSARY CONNEC- TIONS FOR HER AND WE FIND THAT THE OUTCOME IS BETTER FOR HER AND THE BABY.

OUR TEAM MADE 44 INITIAL PRENATAL VISITS THIS QUARTER. IN ADDITION , THERE WERE 20 FOLLOW-UP PRENATAL VISITS. THESE VISITS WERE NECESSARY BECAUSE MANY OF THE WOMEN WE SEE HAVE A VAST ARRAY OF ECONOMIC AND SOCIAL PROBLEMS IN ADDITION TO THEIR PREGNANCIES AND PERHAPS OTHER CHILDREN. PROBLEMS OF INADEQUATE HOUSING, LIMITED FOOD AND CLOTHING, AND LACK OF DAY CARE.

OUR TEAM VISITED 35 WOMEN FOR THE FIRST TIME AFTER THEIR BABIES WERE BORN. THESE WERE WOMEN WHO CAME TO THE HOSPITAL WITHOUT PRENATAL CARE OR WOMEN WHO DID NOT START THEIR CARE UNTIL THEY WERE 8 MONTHS PREGNANT. THERE WERE 26 FOLLOWUP VISITS TO POSTPARTUM WOMEN AS WELL. THIS TOTAL OF 61 VISITS REFLECTS THE GREAT NEED FOR HEALTH TEACHING AND SOCIAL AND EMOTIONAL SUPPORT THAT OUR CLIENTS EXPRESS. THEY ARE POORLY INFORMED ABOUT PARENTHOOD. THEY NEED TO LEARN HOW TO CARE FOR THE BABIES AND THEM SELVES. SOME DON'T KNOW HOW TO MIX FORMULA, HOW TO CARE FOR THE UMBILICUS, HOW TO HOLD THE BABY. OVER FEEDING CAN BE AS BIG A PROBLEM AS UNDERFEEDING. WE'VE SEEN BABIES FED RICE WATER BECAUSE THE MOTHER RAN OUT OF FORMULA AND HAD NO MONEY AND OTHERS FED SOLID FOOD AT 1 MONTH BECAUSE SHE CRIED TOO MUCH.

THIS QUARTER WE SAW FOUR OF OUR BABIES DIE AND ONE WAS A STILLBORN.
THOUGH WE ARE DISCOURAGED BY THIS WE SEE THESE NUMBERS AS AN INDICATION OF JUST HOW NEEDY OUR CLIENTS ARE.

OUR CLIENTS GAVE BIRTH TO 66 BABIES THIS QUARTER AND 15 OF THEM OR 22.3% WERE BELOW 2500 GMS. AS LOW BIRTH WEIGHT BABIES WE KNOW THEY ARE IN DANGER.

THESE 15 BABIES WERE BORN TO MOTHERS WHO WERE TEENS, OR WHO HAD STARTED PRENATAL CARE VERY LATE IN THEIR PREGNANCY, OR WERE SUBSTANCE ABUSING WOMEN. THOSE THAT WE SAW EARLY HAD A MUCH BETTER OUTCOME.

WE NEED TO BE ABLE TO MAKE CONTACT WITH THE EXPECTANT WOMAN EARLIER, AND WE NEED TO HAVE THE AVAILABLE SERVICES BARRIER FREE. MULTIPLE REGISTRATIONS, APPLICATIONS, CERTIFICATIONS, AND ELIGIBILITIES MAKE THE JOB OF GETTING THE NECESSARY CARE A FULL TIME OCCUPATION FOR EVEN THE MOST MOTIVATED WOMAN. THE COMPLEXITIES OFTEN DETER THE YOUNG, THE IMMIGRANTS, AND THOSE LEAST ABLE TO HANDLE THE STRESS OF BUREAUCRATIC RED TAPE.

THE ONE STILL BORN AND TWO OF THE LOW BIRTHWEIGHT BABIES WERE TO WOMEN WHO USED DRUGS. TWO OF THESE WOMEN ASKED FOR HELP WITH THEIR DRUG PROBLEM BECAUSE THEY WERE AWARE THAT THE DRUG USE WAS HARMING THEIR BABIES. THERE WAS NO PLACE THAT I COULD SEND THEM FOR APPROPRIATE SERVICES. THE THIRD WOMAN ALSO TESTED HIV POSITIVE. THERE WAS NO PLACE FOR HER TO GO TO GET APPROPRIATE TREATMENT EITHER. THESE WOMEN ENTERED PRENATAL CARE BECAUSE THEY WANTED HELP WITH THEIR PROBLEMS AND WE COULD OFFER THEM VERY LITTLE.

THE NUMBER OF WOMEN COMING TO THE HOSPITAL WITH NO PRENATAL

CARE IS INCREASING . MANY FEEL THEY SHOULD HAVE GOTTEN CARE BUT WERE UNABLE TO OVERCOME THE MANY BARRIERS THAT STOOD IN THEIR WAY .

WE NEED BROAD BASED COMMUNITY AND GOVERNMENTAL SUPPORT TO ADDRESS THESE PROBLEMS. IN ORANGE THE MAYOR'S WIFE AND THE LEAGUE OF WOMEN VOTERS HAVE OFFERED TO HELP.

WE MUST PROVIDE EVERY WOMAN WITH THE CARE SHE NEEDS FOR A SUCCESSFUL PREGNANCY.

WE NEED EASY ACCESS TO PRENATAL CARE

WE NEED A PRENATAL CARE THAT IS CULTURALLY RELEVANT AND ADDRESSES THE SOCIAL, EMOTIONAL, AND PHYSICAL ASPECTS OF THESE ECONOMICALLY DISADVANTAGED PREGNANT WOMEN.

ONE OF MY MOTHERS IS A 15 YEAR OLD HIGH SCHOOL STUDENT WHO HASN'T BEEN IN SCHOOL THIS YEAR. SHE STAYS HOME TO CARE FOR HER SON. HE WAS BORN 1 LB. 13 OZ.AND WAS IN SPECIAL NURSERIES FOR MONTHS. DISCHARGED IN AUGUST TO HIS MOTHER'S CARE, HE REQUIRES SUCTIONING, 6-7 MEDICATIONS DAILY, AND IS DEVELOPMENTALLY DELAYED AT 9 MONTHS. SHE IS ONE OF A 25 TEENAGE WOMEN I HAVE GOTTEN TO KNOW THIS YEAR. THEY NEED SCHOOL BUT THERE IS LITTLE DAY CARE AVAILABLE FOR THEIR CHILDREN.

ANOTHER MOTHER, A YOUNG WOMAN FROM MEXICO, WEIGHS 93 LBS. HER BABY IS 3 MONTHS OLD. HER HUSBAND WAS LAYED OFF JUST BEFORE CHRISTMAS. SHE IS PREGNANT AGAIN EVEN THOUGH SHE STARTED BIRTH CONTROL PILLS. THERE WAS A MISUNDERSTANDING AND POOR COMMUNICATION ACROSS THE LANGUAGE BARRIER. SHE HAS

NO FAMILY HERE AND HAS NOT YET HAD TIME TO DEVELOP ANY FRIENDS.

EACH OF THESE WOMEN HAVE DIFFERENT NEEDS THAT ARE AGAIN DIFFERENT FROM THE SUBSTANCE ABUSING WOMEN.

BY MEETING THESE DIFFERENT NEEDS OF PREGNANT WOMEN, WE CAN PROVIDE ALL OF THEIR BABIES WITH THE ONE THING THEY NEED- A HEALTHY START IN LIFE.

FOR IMMEDIATE RELEASE
February 13, 1990

FOR IMMEDIATE RELEASE
February 13, 1990

Health Outcomes and Costs for Minorities in New Jersey

Blacks and hispanics had greater mortality, higher hospital cost, and a higher emergency admission rate compared to white patients in the State of New Jersey in 1987. Analysis of 982,378 hospitalized patients demonstrated:

RACE	*SAMPLE SIZE*	*ALOS* (days)*	*HOSPITAL COST**	*EMERGENCY ADMISSIONS*	*MORTALITY*
Black *(adult)*	*181,776*	*8.0*	*$4,489*	*49.1%*	*3.68%*
White (adult)	*800,606*	*7.0*	*$3,882*	*36.5%*	*2.86%*
Black *(Pediatric)*	*21,194*	*13.9*	*$3,942*	*----*	*1.16%*
Hispanic *(Pediatric)*	*10,546*	*14.3*	*$3,452*	*----*	*0.46%*
White *(Pediatric)*	*71,933*	*13.3*	*$3,060*	*----*	*0.36%*

**per patient (adjusted by DRG weight index)*

The data above demonstrate that blacks and hispanics have a longer hospital length of stay (ALOS) compared to whites, a higher hospital cost per patient compared to whites, a greater proportion of emergency admissions, and a higher mortality. Minorities hospitalized in New Jersey have significantly greater morbidity and mortality compared to whites. Mechanisms to improve health outcomes for minorities are urgently needed.

The Minority Health Institute-UMDNJ
and
The University Hospital (UH) Data Consortium

TESTIMONY TO THE
SENATE INSTITUTIONS, HEALTH AND
WELFARE COMMITTEE
REGARDING SENATE BILL 2063,
ESTABLISHING AN OFFICE OF MINORITY HEALTH
FEBRUARY 13, 1990
NEWARK, NEW JERSEY

PRESENTED BY:
DOUGLAS H. MORGAN
EXECUTIVE DIRECTOR
MINORITY HEALTH INSTITUTE
U.M.D.N.J. NEWARK, N.J.

GOOD MORNING SENATOR CODEY AND MEMBERS OF THE THE COMMITTEE.

IN 1985, THE THEN SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, MARGARET HECKLER ISSUED THE FIRST COMPREHENSIVE REPORT DETAILING THE HEALTH STATUS OF MINORITY POPULATIONS IN THE UNITED STATES. THE REPORT IDENTIFIED MAJOR DISPARITIES IN HEALTH STATUS BETWEEN MINORITY POPULATIONS AND WHITES IN THE UNITED STATES.

THE REPORT OF THE SECRETARY'S TASK FORCE ON BLACK AND MINORITY HEALTH IDENTIFIED SIX MAJOR CAUSES RESPONSIBLE FOR THE DISPARITY HEART DISEASE AND STROKE, CANCER, HOMICIDE AND ACCIDENTS, INFANT MORTALITY, CIRRHOSIS AND DIABETES.

TODAY ALMOST 5 YEARS LATER NOT ONLY DOES THE SITUATION REMAIN THE SAME, BUT WE CAN NOW ADD A NEW ILLNESS TO THE LIST-ACQUIRED IMMUNE DEFICIENCY SYNDROME OR AIDS. WHILE NEW JERSEY HAS BENEFITED FROM A BOOMING ECONOMY, IN RECENT YEARS WITH LOW UNEMPLOYMENT, THE HEALTH STATUS OF NEW JERSEY'S MINORITY POPULATIONS LIKE THE UNITED STATES EVIDENCES GROWING DISPARITIES WITH THAT OF WHITES IN THE STATE.

FOR EXAMPLE THE INFANT MORTALITY RATE FOR NON-WHITES IN NEW JERSEY IS OVER TWICE THAT OF WHITE INFANTS. THE RATE OF VERY LOW BIRTH WEIGHT IS 2.9 TIMES HIGHER FOR BLACK INFANTS THAN WHITE INFANTS.

HISPANIC AND BLACK FEMALES EVIDENCE HIGHER RATES OF

CERVICAL AND BREAST CANCER THAN THAT OF THEIR WHITE COUNTERPARTS IN NEW JERSEY AS WELL.

THESE ARE JUST A FEW EXAMPLES OF THE HEALTH STATUS DISPARITIES THAT EXIST IN NEW JERSEY TODAY.

WHILE RECOGNITION OF THE PROBLEM, IS THE FIRST STEP IN ANY PROCESS OF CORRECTION, THE NEXT STEP IS THE DEVELOPMENT OF MECHANISMS FOR PROBLEM SOLUTION. THE DEVELOPMENT OF A STATE OFFICE ON MINORITY HEALTH IS A VITAL NEXT STEP.

AN OFFICE OF MINORITY HEALTH CAN BEGIN TO FOCUS ATTENTION WITHIN STATE GOVERNMENT ON MINORITY HEALTH PROBLEMS AND COORDINATE THE IMPORTANT PROGRAMS THAT CURRENTLY ADDRESS MANY OF THE PREVENTABLE ILLNESSES WHICH TROUBLE MINORITIES. THE OFFICE OF MINORITY HEALTH CAN WORK WITHIN THE STATE DEPARTMENT OF HEALTH, THE STATE'S PUBLIC HEALTH AGENCY AND WITH OTHER STATE DEPARTMENTS LIKE HUMAN SERVICES, ENVIRONMENTAL PROTECTION AND COMMUNITY AFFAIRS TO INSURE THAT THE MANY PROGRAMS AND ACTIVITIES THAT THESE DEPARTMENTS OPERATE OR MANAGE DO NOT WORK AT CROSS PURPOSES IN ADDRESSING MINORITY HEALTH PROBLEMS.

THE OFFICE OF MINORITY HEALTH CAN ALSO BE A STRONG ADVOCATE FOR THE DEVELOPMENT OF A COMPREHENSIVE AND CULTURALLY SENSITIVE STATE HEALTH CARE POLICY. THE OFFICE CAN PROMOTE POLICIES THAT STRESS THE IMPORTANCE OF PREVENTIVE SERVICES, AS WELL AS THE NEED FOR GREATER ACCESS TO PRIMARY CARE SERVICES.

FINALLY THE OFFICE OF MINORITY HEALTH CAN EVALUATE THE EFFECTIVENESS OF THE PROGRAMS THAT ARE CURRENTLY FUNDED BY STATE AND FEDERAL DOLLARS TO DETERMINE THEIR PROGRESS

IN MEETING THE HEALTH PROBLEMS OF MINORITIES.

IN ORDER TO MEET THE CHALLENGE BEFORE IT, THE OFFICE OF MINORITY HEALTH MUST HAVE A CLEAR MANDATE TO CARRY OUT THE FUNCTIONS I HAVE JUST OUTLINED. WHILE SENATOR CODEY'S BILL PROVIDES A GOOD GENERAL STRUCTURE, I WOULD LIKE TO RECOMMEND THAT THE BILL BE STRENGTHEN BY ADDING LANGUAGE AS FOLLOWS:

1. ADD LANGUAGE TO SECTION 2 OF THE BILL ESTABLISHING THE OFFICE AT THE LEVEL OF ASSISTANT COMMISSIONER IN THE DEPARTMENT OF HEALTH, WITH THE ASSISTANT COMMISSIONER REPORTING DIRECTLY TO THE COMMISSIONER OF HEALTH.

2. ADD LANGUAGE TO SECTION 3(C): THAT STIPULATES THAT THE OFFICE OF MINORITY HEALTH SHALL HAVE THE AUTHORITY TO NOT JUST REVIEW BUT TO EVALUATE CONTINUOUSLY, PROGRAMS IN THE DEPARTMENT OF HEALTH, HUMAN SERVICES, COMMUNITY AFFAIRS AND ENVIRONMENTAL PROTECTION TO DETERMINE THEIR EFFECTIVENESS IN ADDRESSING MINORITY HEALTH PROBLEMS.

3. ADD LANGUAGE TO SECTION 3(B): THAT REQUIRES THE OFFICE OF MINORITY HEALTH TO EVALUATE ALL ACTIVITIES THAT ARE FUNDED UNDER ITS OWN AUTHORITY.

4. ADD LANGUAGE TO SECTION 5: THAT ALLOWS THE OFFICE OF MINORITY HEALTH TO CONTRACT WITH OTHER STATE AGENCIES, INSTITUTIONS OF HIGHER EDUCATION OR

APPROPRIATE PUBLIC BODIES TO CONDUCT STUDIES OR RESEARCH AS DIRECTED BY THE OFFICE OF MINORITY HEALTH.

FURTHER I SUGGEST THAT TWO NEW SECTIONS BE ADDED TO THE BILL: THE FIRST NEW SECTION SHALL FORMALLY RECOGNIZE THE COMMISSIONER'S MINORITY HEALTH ADVISORY COMMITTEE AS THE ADVISORY GROUP FOR THE OFFICE OF MINORITY HEALTH.

AND THE SECOND NEW SECTION SHALL DIRECT THE OFFICE OF MINORITY HEALTH TO SUBMIT RECOMMENDATIONS FOR THE UNIFORM CATEGORIZATION OF RACIEL/ETHNIC GROUPS IDENTIFIED IN HEALTH STATUS INFORMATION COLLECTED BY ALL HEALTH DEPARTMENT UNITS. THE OFFICE OF MINORITY HEALTH SHALL MAKE SIMILAR RECOMMENDATIONS TO THE DEPARTMENTS OF HUMAN SERVICES, COMMUNITY AFFAIRS AND ENVIRONMENTAL PROTECTION.

FINALLY I WANT TO SAY THAT THE MINORITY HEALTH INSTITUTE HERE AT THE UNIVERSITY DOES NOT VIEW THE DEVELOPMENT OF AN OFFICE AS DUPLICATIVE OUR ACTIVITES. RATHER, WE SEE THE ROLES OR AGENDAS OF THE TWO AGENCIES AS COMPLIMENTARY.

WE BELIEVE THAT A CLOSE WORKING RELATIONSHIP BETWEEN THE TWO AGENCIES WILL INSURE SUCCESS IN ADDRESSING THE HEALTH PROBLEMS OF MINORITY POPULATIONS IN NEW JERSEY.

THANK YOU FOR THE OPPORTUNITY TO TALK WITH YOU TODAY.

ASSOCIATION FOR
CHILDREN OF NEW JERSEY
ACNJ

17 Academy St., Suite 709, Newark, NJ 07102
201/643-3876

P.O. Box 634, Bellmawr, NJ 08031
609/854-2661

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TO: The Honorable Richard Codey, Chairman
Members, Senate Institutions, Health and Welfare Committee

FROM: Ciro A. Scalera, Executive Director
Cecilia Zalkind, Assistant Director
Association for Children of New Jersey (ACNJ)

DATE: February 13, 1990

RE: **PUBLIC HEARING ON SENATE BILL 2063 ESTABLISHING AN OFFICE ON MINORITY HEALTH**

The Association for Children of New Jersey (ACNJ) is a statewide, nonprofit organization which advocates on behalf of New Jersey's children, particularly those who are vulnerable and depend on state services for their well-being. I am here before this committee today to express ACNJ's support for Senate Bill 2063 which would establish an Office of Minority Health in the Department of Health (DOH).

Although we strongly support the concept of a special office to emphasize minority health issues, we do have some concerns about the status of minority children's health needs and the relationship of this office to other divisions within DOH and to other state departments involved with children's services.

For these reasons, we wish to address three specific recommendations to strengthen this bill: the need to prioritize children's health issues, the need to define the relationship of this office to the line operations in the DOH and the need to coordinate the activities of this office with other state agencies.

HEALTH NEEDS OF MINORITY CHILDREN

While this new office would address the health needs of both adults and children, ACNJ is most familiar with the unmet health needs of the minority children of our state. Today in New Jersey:

*The infant mortality rate for minority infants is 17.6 per 1000 births -- more than double that of white infants.

*Minority infants are more than twice as likely as white infants to be low birthweight babies.

*Three-quarters of the almost 200 pediatric AIDS cases as of May, 1989 are African-American and Hispanic children.

*Births to non-white adolescents are two to three times greater than births to white adolescents.

*Non-white mothers are four times less likely to receive adequate prenatal care than are white mothers.

Many of these problems are linked to poverty. Minority children are four times more likely to live in poverty than white children. They account for a disproportionate percentage of the over 200,000 poor children without health coverage. For them, prenatal care is inadequate or nonexistent and routine medical care must be postponed until health problems become an emergency.

Other needs related to good health, such as adequate nutrition, are also linked to poverty, leaving minority children at greater risk. Poor families must spend a great deal of their income on fixed costs, such as housing, leaving too little money for food. Government programs such as the Women, Infants and Children Food Program (WIC) and the school nutrition programs are inadequately funded on the federal and state level, leaving many eligible children unserved.

For these reasons, we believe that an Office on Minority Health would be a critical unit within the DOH. We feel strongly, however, that children must be a priority concern for this office. Strengthened approaches to prevention, early intervention and access to adequate health care are critical to improving the health of minority children and their families. This office can fulfill that role.

RELATIONSHIPS WITHIN THE DEPARTMENT OF HEALTH

Although the bill addresses the functions and responsibilities of this new office within DOH, we feel that greater specificity is needed. We are concerned about the section of the bill which addresses coordination of services among the various operating units of DOH.

The bill directs the Office on Minority Health to make recommendations to DOH on minority health issues. It does not, however, describe the relationship of the office to other line operations within the DOH. Language is needed in the bill and in subsequent regulations to specify what these other entities must do once a recommendation is made by the Office on Minority Health.

We are also concerned about how this office will coordinate its activities, especially its grant funding role, with other entities in DOH. This is a critical issue since most of DOH's direct services functions are done through local grants. In the past we have been very critical of the "turf" problems among the various

DOH divisions. Some language must also be included here about coordination within DOH.

COORDINATION WITH OTHER DEPARTMENTS

Other state departments also see an over-representation of minority children in their at-risk populations. Minority children represent the largest percentage of the 27,000 children in out-of-home placement, particularly in the foster care and juvenile justice systems. They also tend to be the children who live poorer school districts with the least resources to spend on their students.

Health issues are a concern for these children as well. The availability of health care is a serious issue for children in out-of-home placement. Not only is access a problem but often the service plans for these children and families completely ignore health issues.

Many health issues surface in school. Schools can serve a vital role in identifying and treating particular health needs. Immunizations, for example, are a serious problem for the urban areas. In Newark alone, the rate of full immunization among preschool children is only 23%. With appropriate direction and support, the schools could be a successful place to identify children without immunizations and to follow up on the necessary inoculations.

Coordination among the various state departments is necessary both to identify health needs and to provide a way to address such needs. Although the bill directs the Office on Minority Health to review the programs of other departments and make recommendations, it does not adequately address coordination among the various state departments. How these recommendations are made and, more importantly, acted upon, must be spelled out more fully in the bill. Further, the Department of Education should be included in the list of departments with which the new office must interact.

SUPPORT FOR AN OFFICE ON MINORITY HEALTH

Aside from our recommendations to strengthen this bill, ACNJ is pleased to express our support for Senate Bill 2063. The health concerns of minority children and families have been a priority of our organization for some time and we urge that the committee fully support this bill.

Presented by: Lawrence D. Frenkel, M.D.

Chair, New Jersey Maternal and Child Health Advocacy Coalition

Before the

New Jersey Senate Institutions and Welfare Comittee

February 13, 1990

10:00 a.m.

March of Dimes, Central Jersey Chapter
Office Center, Building 200
666 Plainsboro Road
Plainsboro, NJ 08536

(609)-275-1201

TESTIMONY FOR THE NEW JERSEY SENATE INSTITUTIONS AND WELFARE COMMITTEE

Good morning, I am Dr. Lawrence D. Frenkel, Professor of Pediatrics and Microbiology at the UMDNJ-Robert Wood Johnson Medical School. I am speaking today on behalf of the N.J. Maternal and Child Health Advocacy Coalition. The coalition represents organizations interested in the welfare of pregnant women, infants and children, and includes: The Association for Children of N.J., N.J. Section of the American College of Obstetrics and Gynecology, Perinatal Association of N.J., March of Dimes, N.J. Academy of Pediatrics, N.J. Primary Care Association, N.J. Section Nurses Association of the American College of Obstetrics and Gynecology, N.J. Healthy Mothers/Healthy Babies Coalitions, N.J. Hospital Association, N.J. Human Genetics Association, N.J. Planned Parenthood Association, and N.J. Business and Industry Association.

Without strong leadership now, the quality of life as most of us know it in New Jersey may soon disappear. Each year 100,000 babies are born in New Jersey. Of these, 10,000 are born critically ill or with birth defects, and 1000 die within a month after birth. Infants in 18 other countries and 19 other states have a better chance of living to celebrate their first birthday then a baby born in New Jersey. A disproportionate number of these unfortunate beings who start out life at a disadvantage are minorities. The cost of these tragedies is high; both in direct economic terms and in lost human potential. Infant mortality for white infants in New Jersey is 7.9/1000 and for non-white is 18/1000. Here in Essex County, for non-whites, this infant mortality is 21.4/1000 and at the other end of our state, in Camden County, it is 21.0/1000.

During the past decade, it has become apparent that low birth weight is a significant cause of infant death! A low birth weight infant is 40 times more likely to die during the first month of life than a normal birth weight infant. Lack of prenatal care is clearly associated with low birth weight, as are teenage pregnancy, poor maternal nutrition, drug and alcohol use and abuse, and smoking. Early prenatal care can identify 80% of women at risk for having a low birth weight baby. Low birth weight infants, on the average, cost society $25,000 in their first year of life but these extra costs can approach hundreds of thousands of dollars. Low birth weight infants also contribute to the roles of children who require special and expensive long term care. The State of New Jersey pays 100% of early intervention programs for children 0-3 years of age which equates to 12 to 13 million dollars per year. Early intervention programs for children three to five years of age are paid for by local school districts, and represent one of the factors that adds to the heavy municipal tax burden. In New Jersey, nearly 30% of non-white mothers receive no prenatal care in the first trimester, this again is double the incidence for their white counterparts.

The major barrier to prenatal care is lack of financial access, for non-insured or under insured, pregnant, often non-white, women. One fourth of women of reproductive age have no insurance to cover maternity care, two thirds of this group have no insurance at all. Uninsured women are likely to obtain prenatal care late in pregnancy and four times more likely to get no prenatal care. Stress, fear, and disillusionment with our health care system act as barriers for these pregnant women in accessing the appropriate care that could often prevent tragic outcomes of their pregnancies. The bureaucratic barriers that pregnant women in New Jersey must endure before

they are informed that they quality for prenatal care, is distressing if not unforgiveable. These include limited financial eligibility, assets test, complicated long forms, unpleasant environment, etc. Once they quality for prenatal care they often have to wait for weeks for an appointment to be seen at our overburdened prenatal clinics. These clinics are overburdened largely because we have not kept our promise to increase reimbursement for health care providers, to anywhere close to realistic levels. There are counties in New Jersey where obstetric care for women without "private" insurance is almost unavailable. Other barriers to access to care include lack of transportation, lack of child care, waiting time, homelessness, drug abuse, illiteracy, and fear of deportation.

Prenatal care is cost effective! Every dollar spent on prenatal care saves in excess of three dollars on the cost of caring for low birth weight infants. The efforts of the citizens of New Jersey to address some of these issues of low birth weight have clearly demonstrated that appropriately funded and managed programs can make a difference. In the ten target areas within New Jersey with partially state-support Healthy Mothers/Healthy Babies Coalitions, the rates of low birth weight and infant mortality have been dramatically reduced among the non-white population.

Medicaid is the main source of public financing for many health services to uninsured low income women and children. It is estimated that 24,000 women in New Jersey are eligible for medicaid at 100% of the poverty level. An additional 16,000 women who delivered in New Jersey were documented by our hospitals to be "self-pay" last year. Approximately 10,000 of these had incomes between 100 and 250% of the poverty level". Currently, pregnant women

whose incomes fall between these levels are eligible for Health Start services, on a sliding scale, and for the N.J. "Moms" program. The costs of the N.J. "Moms" program are paid entirely through the Uncompensated Trust Fund, which increases the hospital cost of all New Jersey Residents. This program funds care provided only through the already over hundred hospital based clinics. It does not cover any cost of care to infants and children, and can not take advantage of matching federal dollars.

As of April 1, federal regulations will mandate Medicaid eligibility to 133% of the poverty level. The expansion of Medicaid eligibility in New Jersey to 185% of the poverty level, would provide prenatal, postnatal, and infant care to over 7,000 additional women and infants, with 50% of the costs paid by federal funds. These matching federal funds will result in a direct savings of over $34,000,000 from the Uncompensated Trust Fund. There would be potential savings of additional millions of dollars through prevention of low birth weight. A crucial element in all of our efforts to provide better access to prenatal infant, and child care is a realistic increase in medicaid reimbursement to the health care providers in New Jersey.

In conclusion, we strongly feel that the overall social and economic viability of our state requires the improvement in minority prenatal care. A realistic and economically sound way to achieve this goal includes the following: expansion of medicaid eligibility for pregnant women and children to 185% of poverty level, increased provider reimbursement, expansion of funding for the Healthy Mothers/Healthy Babies Coalitions, and an effort to streamline the welfare procedures for determination of eligibility and facilitation of access to care.

State of New Jersey
DEPARTMENT OF HEALTH
CN 360, TRENTON, N.J. 08625-0360

February 14, 1990

Honorable Richard J. Codey
State Senator - District 27
331 Main Street
West Orange, New Jersey 07052

Dear Senator Codey:

The serious health issues facing New Jersey's minority community are of paramount importance to this Administration. Governor Florio has publicly stated his support of the creation of an Office of Minority Health, within the Department of Health, to better focus our attention and efforts to this problem.

The June, 1989 Conference on the State of Black Health pointed to the serious consequences of the gaps that exist between the health status of white New Jerseyans and minority populations. Dramatic differences in disease, death, and injury rates have been evidenced in several major areas, many of which are referenced in your pending legislation before the Senate Institutions Health and Welfare Committee.

The dimensions of this problem have historically been masked by inconsistencies in definitions, underreporting, and other data deficiencies. An important concern is the lack of reliable data specific to New Jersey's Hispanic community, a population which is growing nearly five times faster than the state population as a whole.

The Department of Health recognizes both the important and immediate need for the development of new strategies and interventions to close these gaps in services and quickly effect more positive outcomes. To accomplish this the Department also realizes that a multi-disciplinary problem solving approach must be utilized in the effort to improve the health status of minority populations. All of the public agencies which provide health related services to minority communities including the Departments of Health, Human Services, Education, and Corrections must be involved. As well, local providers and community leaders should be welcome participants in developing and executing needed solutions.

The Department of Health is working with the Governor's Office to develop a method of instituting an Office of Minority Health by redirecting and consolidating some existing budget positions. This will, hopefully, allow us to address this initiative while recognizing the budget constraints in the 1990 budget and anticipated 1991 revenue.

We would welcome the opportunity to discuss this plan with you, the Committee, and your staff when we have further information regarding the 1991 budget.

Senate Bill 2063 brings to the forefront the necessity of developing a meaningful strategy for this important health care problem. We applaud your continued leadership in resolving New Jersey's health care issues and stand ready to participate in these endeavors.

Sincerely,

Leah Z. Ziskin

Leah Z. Ziskin, M.D., M.S.
Acting Commissioner of Health

F.E. Blackman M.D 2/13/90

Report to Senate Committee Hearing on the Office on Minority Health

Mr Chairman, members of the committee, I am Francis E. Blackman, a physician duly licensed to practice medicine in this State. I have been the president of the local chapter of the National Medical Association for the past few years and participate nationally as Chairman of the North-East Region.

We appreciate you giving us this opportunity to present our position on an Office for "Minority" Health. We assume that "minority" in our State will be clearly outlined in terms of ethnicity. You understand that while we fully support and work for the advancement of all disadvantaged people we present today as descendants of Africans, enslaved and transported to these shores where we provided the free and cheap labor that built this country.

There is no doubt sir that our presence here was catalysed by the publication of the Malone-Heckler Report which came out of the National Institutes of Health in 1985. The scandalous findings within this document stimulated States other than ours to pay particular attention to the health of the racially oppressed groups within their borders. New Jersey is among the leaders at this stage and it is our sincere wish that we remain there.

An Office of "Minority" Health is probably the one remaining tool available to us to interrupt the deterioration in the health of our African-American and Minority peoples. In its sincerest and most effective form it will be open to a broad based input from the population it directly serves and will be accountable to the same through our elected representatives. IT MUST NOT BE PATERNALISTIC! It should not be conceived to appease. While recognizing other aspects of "Minority" health that are at least as important, I will now confine my remarks to the obscene underrepresentation of African-Americans in the healthcare professions and particularly the physician population. You will recall that this absence is said to be one of the reasons for the poor health of our population.

We are unable to attract young persons into the field and it is becoming increasingly difficult to compete for these minds in a capitalistic society where there are much easier ways to prepare to make much more money with far less stress. We must recognize that in the middle of the so-called "First World" there are pockets of so called "Third World" and as such we may need to look at tested methods used to attract and keep physicians services in some developing countries. These centre not only around financing education and providing practice locations within the community of origin but also recognizing the need that we all have for advancement

opportunities within our chosen fields. How do we institute and monitor any system which attempts to pursue this goal. This would be within the purview of the office whose skeleton I outlined in my third paragraph. I am talking about a powerful entity. The profession of medicine is as racist as they come. It is dominated by white males who use any means possible to exclude even the least threatening of black medical students. Where this fails sir you will find that these deans and assistant deans, professors and assistant professors conspire to ensure failure on the part of medical students and residents. Lest you may think that I take this opportunity to mouth irresponsible diatribe I offer you the chance to receive more detail at another time from others who have survived our own medical school which is alleged to be among the more progressive of institutions. It is presently a vicious cycle for at the end of this process, should one be successful, ~~you~~ one gets out and stays away from this hostile white environment where ~~your~~ one's so called white peers are anything but that. Should one elect to pursue academics for personal fulfillment as well as for the positive effect one can have on the African American student and resident it is further exposure to the malignant racists who are very often embedded in these institutions. Our own medical school is sorely lacking in tenured professors, heads of departments and deans who are Black. You must one day ask the Department of

Neurology in this school about the number of black residents that have completed training. Ask the same of Cardiology. There are other areas that refuse to acknowledge the presence of black people except as patients. The correction of these gross imbalances is beyond the ability of any Commissioner and well within that of a broader based Office of "Minority" Health.

In closing sir may I again state the serious commitment which my organization has to the establishment of an office of "Minority" Health where the consumer and provider can conceptualize, establish and run models of healthcare delivery systems aimed at reducing the huge disparity between indices of health between the African American and the White populations in this country. In your deliberations kindly encourage your conservative colleagues to look at the effect of drugs throughout our society and ponder if, a generation ago, they could imagine this great scourge and its offspring journeying beyond the boundaries of our inner cities. Finally, sir may I thank you for allowing me the opportunity of appearing before you.

North Jersey Medical Society
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