PUBLIC HEARING

before

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

SENATE BILL No. 2063

(Establishes an Office on Minority Health in the State Department of Health)

March 20, 1990
Education and Research Bldg.
UMDNJ-Camden
Camden, New Jersey

MEMBER OF COMMITTEE PRESENT:

Senator Richard J. Codey, Chairman

ALSO PRESENT:

Eleanor H. 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
STATE HOUSE ANNEX, CN-068
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February 27, 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, March 20, 1990
Beginning at 10:30 A.M.
Room 240
Education and Research Building
UMDNJ-Camden
401 Haddon Avenue
Camden, New Jersey

The Senate Institutions, Health and Welfare Committee will hold a public hearing on Tuesday, March 20, 1990 beginning at 10:30 A.M. in Room 240 of the Education and Research Building, UMDNJ-Camden, 401 Haddon Avenue, Camden, 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, I'd like to start today's hearing. I'm Senator Richard Codey of Essex County. The reason for the hearing today is Senate Bill No. 2063, calling for the creation of an Office on Minority Health within the Department of Health. Our first witness this morning will be Ms. Pat Jones of Senator Walter Rand's staff. Pat.

P A T J O N E S: Thank you, Senator. I'm just here to bring you greetings and welcome from Senator Rand for holding this very important hearing here in the Fifth Legislative District. He does regret that he could not be here, but his schedule precluded that, and he wishes you well in pursuing the goals of this bill, and if he can help you in any way, his support is certainly there. Thank you.

SENATOR CODEY: Thank you Pat. Our first witness this morning is Cathy Hurlenberg. I don't see her. Okay, Mr. Hardge Davis of the State Public Health Council, Mr. Davis.

H A R D G E D A V I S, JR.: Thank you, Senator. I am Vice Chairperson of the Public Health Council. For those of you who are not familiar with the Public Health Council, it is comprised of eight members who are appointed by the Governor and approved with the consent and advice of the Senate. Each member serves on the Public Health Council for seven years. It is a statutory position. The statute states that there must be at least two doctors on the Public Health Council who are duly licensed to practice in the State of New Jersey and also one dentist. Senator, I am here to say that with regards to the Office of Minority Health Bill, we, the Public Health Council, are in favor of the principle and the concept of focusing efforts and money on high risk categories. And those categories that we are particularly concerned with are infant mortality, teenage pregnancy, substance abuse, hypertension, sickle cell anemia, and also lead poisoning. And it has clearly been shown that these categories are very high among minorities. The Public Health Council has spent a great

deal of our time plugging health for the indigent and the minorities, and we feel that many of the programs that we have instituted reflect this. That is the reason that we are in agreement with your bill. We feel that your bill may have difficulty in passage because of the one-half million dollar allocation that you have and we feel that if that is the case, then we still believe that the office should be created and even if necessary created on a shoestring so that the office can get a start. Since the office is going to be in the Department of Health, we feel that there may be some shifting of the staff into the Department of Health to the Office of Minority Health in order to get it established, and then once we are out of this budget crisis, then we would like to see the half million dollars allocated. One of our main concerns is the price tag, especially with the statement that the Governor may cut the priority funding. If the Governor cuts the priority funding, then we feel that your bill may have some trouble being passed. But even with the price tag that you have, if the Department has to be created, and has to be created with less funding so that the principle can take effect in some point in time later on in the road that money is allocated, we feel that this is the bill that is long overdue. Thank you very much, Senator.

SENATOR CODEY: Okay, Thank you Mr. Davis. Ms. Phyllis Diggs, the President of CAMcare Community Mental Health Center, Camden. Good morning, Ms. Diggs.

P H Y L L I S D I G G S: Good morning, Senator. My name is Phyllis Diggs and I am President and Chief Executive Officer of CAMcare Community Mental Health Center serving Camden County. Our main location is in Camden City where most of our population are minorities. Although there have been major breakthroughs in health care in at least the last four decades, the reality is that in our nation there are startling disparities between health care for the poor, most of whom are

black and Hispanic and the health care for the mainstream society, most of whom are white. In a report compiled in June 1989 by the then Commissioner of Health, Dr. Molly Coye, it was pointed out that the preliminary findings of a review of health statistics from New Jersey were unfortunately similar to those for the rest of the nation.

One of the most startling statistics in that report pointed out that black infants were dying at a rate more than two-and-one-half times that of white infants. This is the one area in which there are significant differences in the health status of minority versus white populations in our State. For example, among blacks in New Jersey, there are higher rate of teen pregnancy, AIDS deaths, homicides, cancer deaths, hypertension, and sexually transmitted diseases than among whites.

Unfortunately, there are inadequacies in data collection, so that the true extent of the problen is not known. In most instances, data is collected in only two categories, whites and nonwhites. That makes it impossible to determine specific problem areas by ethnicity. And incidently, as far as Hispanics are concerned, they are counted among both white and nonwhite populations.

In order to talk about health status, we have to look at associated problems such as poverty, inadequate housing, unemployment, and poor education. Poor individuals who are undereducated and underemployed, often have poor health habits, as well as inadequate, if any health benefits. Furthermore, entitlement programs penalize people for working, while rendering them ineligible for medical assistance, even though their earnings may place them below poverty level.

In the black community alone, nearly one of every three blacks in our country has income below poverty level, and poor black families are poorer than poor white families. Blacks are more likely than whites to be hospitalized and less

likely to be insured; more likely to be smokers, to be overweight, to drink heavily on a regular basis, to be underemployed or unemployed, and to be undereducated.

Although there are some steps that can be taken to improve the health status of minorities, the problem cannot be fully addressed without a frontal assault on the systems that have an impact on health; namely poverty, housing, and education. While in the short run we may not be able to correct these problems, there are some problems about which we may be able to do something, such as the shortage of minority individuals in the health care delivery system. We may not be able to increase the number of minority providers in a short time, but we can educate those who are already in place. Little effort is made in 1990 to help providers become sensitive to cultural differences and the value systems of different cultures in spite of the fact that there is as little understanding of these differences today as there was at the turn of the century.

Today, as in the past, the majority of health care professionals are white middle class individuals who have a value system that is often 180 degrees away from that of the poor or minority individuals to whom they provide services. Ethnic differences are more than just a matter of language differences. Value judgments made by providers often influence the quality of care given to the minority individual, and quality of care has a direct impact on informed utilization of services.

I have worked in the health care field for more than 25 years and one thing that has been constant is that when money is tight, services to those who need them the most, the underpriveleged, are cut back. Keep in mind that services which are cut were not adequately funded in the first place. Health care programs in poor communities are typically underfunded, have staff who are less well-trained and less well

paid than their counterparts in more affluent areas, and are often located in blighted areas in run-down buildings, and have delapidated furniture and used equipment. Health services may be operated as businesses in affluent communities, but they are usually expected to be missionary outposts in poor communities.

We have become adept in our society at blaming the victim for their plight. This is as true in health care as it is in any other field. Too many of us believe that if people do not demand better services, it's because what they are getting is acceptable to them. This is simply not true. Poor people tend not to demand better services, but instead, tend to stay away from services that are not responsive to them. Health problems that might be resolved easily or prevented become crises when not resolved, and then they are solved in hospital emergency rooms. This is a very expensive alternative. This, of course, drives costs up further and results in service reductions elsewhere.

In my view, it is now time to do fewer studies and take more action to get better health care to those who need it and don't get it. This is not to say that research and study efforts are no longer needed. On the contrary, some of this needs to go on, but we need to retrieve our past studies from the round files into which they were placed and implement the recommendations.

We need to recruit more minorities into health care at both policy-making levels where priorities are decided and at direct service levels. Training money has to be made available, again, in order to attract more minorities.

Our system of health care does not provide adequately for poor minorities, and as a result we have more severe health problems than any other country in the free world. Even if we don't want to improve this situation because it's the right thing to do, we cannot afford to ignore the problem if we want to survive. If our infant mortality rate continues to soar. If more people succumb to major illnesses and die younger, who

will our work force be? From what pool will we draw our future leaders?

In the short run, additional funds need to be allocated to adequately staff and operate community health and mental health programs. More comprehensive health programs need to be made available to teens in high schools. Public health education regarding such things as AIDS, cancer, smoking, and substance use need to be concentrated in minority communities, especially those which have been targeted by advertisers to increase cigarette and alcohol sales. The education needs to be planned by minorities so that the messages will be appropriate to their audiences. Plans with realistic goals and objectives do exist. I have personally served on several task forces through the years that have formulated such plans. Let's dig them out, review them for relevancy in 1990, fund them, and put them into operation.

In the long run, we need to encourage our legislators to give health care for the poor the highest priority and appropriate enough money to accomplish what has to be done.

Life is what happens while we are making other plans. In view of the depressing statistics about the health status of the poor, death is what happens also. I am personally very much in support of the creation of an Office on Minority Health and offer my cooperation and help in any way that I can. Thank you very much.

SENATOR CODEY: Ms. Diggs, you had mentioned in your testimony about the emergency rooms. As we both know, in the minority community they use the emergency room much more so than in other communities. I was wondering what were your thoughts on how we could get more physicians into those areas -- to stop the running to the emergency room and hopefully going to physicians like other communities do?

MS. DIGGS: Some of the things that have worked have included designating areas as medically underserved areas and

crisis areas for medical purposes and offering incentives to physicians who come to work in those particular areas for limited periods of time. That is one way that certainly has been done in many of the very depressed areas in the south. I know some physicians personally who have worked in those kinds of programs.

SENATOR CODEY: Okay, because I have been told that the incentives that we have offered so far really have not worked, which is sad to hear. But it is just obvious that we have to do something more than we have done so far to get those physicians in those areas.

MS. DIGGS: I have a daughter who is a physician, and I am just trying to think of what would turn her on. Certainly an adequate salary would, possibly; a university appointment of some kind; a teaching responsibility. That frequently is a motivator. Adequate housing allowance is sometimes a factor, especially if the physician has a family. That can be a problem in depressed areas.

SENATOR CODEY: Okay. Thank you very much. Our next witness is Dr. Nathan Freed, Chief of Division of Hemotology/Oncology, Director of Sickle Cell Centers. And you're Shirley Mendolia? Okay.

D R. N A T H A N F R E E D: Senator, I have a vicious sore throat today, so I have a statement which I've typed for you and passed out. I'm going to ask Shirley to read this statement. I will be happy to answer any questions, however, that you may have.

S H I R L E Y M E N D O L I A: We have combined our statements for the sake of time. The U.S. Census Bureau estimates that the minority population is growing at a rate of 13% per year and will reach 33,199,000 black Americans by 1995. Black Americans in New Jersey are presently estimated to be 1,336,000. Of this number, 6680 will be born with a sickle cell disease and 167,000 will be born with sickle cell trait.

As you know, sickle cell disease and other hemoglobinopathies are associated specifically with minority peoples -- black, Hispanic, Italian, Greek, and Asiatic.

Sickle cell disease is a group of inherited conditions which is caused by the presence of abnormal hemoglobin in the red blood cells of a person. Generally, one out of 10 black Americans have sickle cell trait, and one out of 400 black Americans have sickle cell disease. There presently is no cure for the sickle cell diseases, but the symptoms and complications can be controlled with comprehensive, preventive health care including regular office visits, proper diet, rest, hydration, temperature control, and protection from environmental extremes. The disease is best managed by a multidisciplinary team and experienced physicians specializing in hematological disorders.

The University of Medicine and Dentistry's School of Osteopathic Medicine has supported a comprehensive effort to bring improved health care aimed at education and crisis prevention for a population of people often motivated to seek medical intervention only under extreme circumstances. This effort began in the fall of 1986 and has seen the benefits accrue for these patients as the program has grown, and the patient numbers have increased. Thanks to the combined support of the Dean's office, the Chairman of the Department of Medicine, and the Camden County Department of Health, this program is now attracting outside referrals and is becoming recognized as the only comprehensive wellness program available to persons in southern New Jersey afflicted by sickle cell disease and related disorders of the red blood cell. We expect that over the next decade, unless a cure avails itself, the numbers of those afflicted will increase based on estimations of population growth and more children with these disorders reaching adulthood. The latter is related to the fact that more newborns will be surviving the first year of life with the

clinical recognition that prophylactic penicillin during that year reduces infant mortality from opportunistic infections by fourfold. There has been no comprehensive adult care program in this part of the State and none with comprehensive wellness education available anywhere in the State. Many patients who have access to transportation find the need to seek this care in the Philadelphia area, while others less fortunate, had formerly sought crisis care at the closest available emergency facility, but were unable to identify any specific holistic care team approach. Without patient advocates, they often found themselves looked at with suspicion as potential drug abusers, often had to wait unduly long periods for attention in local emergency room facilities while others, tired and angered by the system, chose to suffer alone in their homes. There have even been instances resulting in loss of life at facilities less familiar with the clinical picture of painful crisis or other risk factors affecting these patients, resulting in undue time delays toward offering appropriate treatment. Although two comprehensive programs for the pediatric aged patient exist, one at Cooper and the other at the Children's Hospital of Philadelphia, these patients too frequently have nowhere to turn to beyond the pediatric years.

There has been no statewide coordinated effort to find support for these individuals, comprehensive programs or even any agreement as to what is needed.

We would like to stress the importance of adult education as well as service, so that these people can feel more in control as well as more functional and productive.

We fully support the creation of an Office for Minority Health Issues so that we can have a mechanism of working to find means of greater support, including financial needs. Our goal is to increase public consciousness of the problems, fully assess the needs, and better educate the patients, their families with wellness and prevention as our

main stress while involving area health care providers, school officials, and employers.

SENATOR CODEY: Thank you very much. A couple of questions. In your testimony-- Is it your testimony that there are more people coming down with sickle cell anemia, or is it because we are identifying it more readily and we're able to get those numbers?

DR. FREED: The pediatric programs certainly are offering earlier identification, Senator. Still, one in 10 patients are affected by trait, and one in three to four hundred by the disease. The population is growing, people are living longer, and we expect that the numbers are going to increase on that basis. Presently with 1.3 million people in the State of New Jersey -- that's the latest census -- over the next decade it's going to exponentially increase, as are the number of cases, unless a cure is brought forth in the meantime.

SENATOR CODEY: Do you have any idea to the number of dollars that are dedicated to finding a cure, on the national level?

DR. FREED: Presently there are 10 comprehensive centers throughout the United States working on this problem. I have no figures on the dollars. I know that most of the dollars have been directed towards a find for a cure for an earlier diagnosis and appropriate screening programs, such as the one going on at Thomas Jefferson under Dr. Biloss and the pediatric programs at Children's, where they are working diligently on finding various agents to decrease the rate of sickling. There are protocols available presently, but as far as a dollar expenditure, I think that if there is any money going in, it's toward finding a cure, but there are not service dollars available which is where the real problem arises. For the last decade or so, all of the dollars have been directed towards screening and finding a cure, but there is very little out there for service.

SENATOR CODEY: How do you see the creation of this office helping your centers?

DR. FREED: I would hope by having a task force down in South Jersey, we could have a closer ally to take our problems to, to discuss some of the issues, and with our input and theirs, we can find ways and means to solve the problem. I think it's a multifaceted problem. We're a "Johnny Come Lately" in the Camden area, and I think there are people here who have a number of years of experience who we are turning to, including two councils that we have invited patient advocates who sit on the committees that we've developed and also professional committees. It's a problem which I think we need to work through. From the standpoint of your office, I would hope that you see the need for a task force where we feel we have a better voice for the needs of programs such as this in South Jersey we can approach directly.

SENATOR CODEY: Okay. Thank you both very much. Our next witness will be Mr. Robert Andrews, the Freeholder Director for Camden County.

F R E E H O L D E R R O B E R T E. A N D R E W S: Good morning. Senator, thank you for this opportunity this morning, and let me welcome you to Camden County and to our city of Camden on behalf of our residents. We know that you are not geographically close to us, where you represent, but we feel that you are very close to us in the kind of issues that you have advocated in the New Jersey Senate. I wanted to thank you for your work, particularly in the area of promoting the Health Care of New Jersey residents. We are very honored to have you here today. I am always remiss if I don't note for the record when I am in this facility, the debt of gratitude that my constituents owe to our Senator, Walter Rand, for his efforts to bring this University to the City of Camden. I know he's not here today, but I want the record to reflect our gratitude to him. I'm here today --

SENATOR CODEY: He's always got bills in for Camden.

FREEHOLDER ANDREWS: All the time, all the time. We can always count on Walter. I'm here today to speak in favor of your proposal. I think it's a good idea for two reasons: First, and foremost, I think it addresses the major health care needs of our community, particularly as they impact disproportionately on the minority community. Second, I think it's good public policy because I think it saves money. I think this has to be looked at as a budget restraint mechanism in the long run. Permit me to elaborate.

If I were to identify the four or five major health care concerns in our community of one-half million people, which as you know is similar to Essex County in that it has its urban centers and suburban areas, and a little different from Essex County in that it has some rural centers as well, but we are alike, and I think the areas of concern that I would identify are ones that you would identify around the State.

There are gaps in our system providing general care to the indigent through the Medicaid program. There is a crying need to provide better long-term care, particularly for the elderly. There is a desperate need to deal with the health care concerns of many working constituents that we have, who work, but do not have any kind of health care insurance. There is the whole problem of dealing with the AIDS epidemic, both from the point of view of education, social services, and from research and treatment. And there is the problem that you might call the whole web of issues that are perhaps negligent infanticide; where we are going through a process here where we are ignoring our children, and this is a city where infant mortality rates approach those of the third world. This is a city where infant low baby birth weight problems mirror those you find in the third world. This is a place where we have an appalling lack of resources for the needs of teenage mothers, many of our childen who are having children. If those are

problems that affect the broader community here -- and they do -- then they clearly affect our minority population to a much greater degree. If our general population has this as a problem, then our minority population has these issues as a crisis.

I think that it is long overdue that the State Health Department focus its resources and its policy planning process on the minority community in these and other areas. And we would welcome that. Most particularly, because our own County Health Department -- that is very well staffed by professional men and women who are very dedicated to these causes -- really needs to have a counterpart at the State level and Federal level for what they are doing here. We are fortunate that the commitment we have from our people in the Health Department has helped address some of the problems that I have outlined.

Our Health Department works very closely with our nonprofit community, our Human Services Advisory Council, and we are doing the very best we can to fill the gaps. But it would be helpful if, when our nonprofits and our professionals in our Health Department speak to Trenton, that they have an office up there; or a policy forum up there that is geared to the same kinds of concerns that we have. So I think your proposal is extremely well-founded, and I know that it would have a positive impact on our community almost immediately.

I suppose that the criticism you may get from some of your colleagues or others in the capital would be; well, does it make sense to be launching a new venture at a time when State spending is in such a period of crisis? I would argue that it would be a tremendous problem not to make this new venture. If you think that providing health care services is expensive, try not providing health care services to this community. It would be a lot more expensive. And I can see many ways that if we are able to deal with better prenatal care, then we will save money in DYFS costs, in Medicaid

costs, in AFDC costs. I can see many ways that if we get involved in providing a focus on AIDS education in the minority community among Hispanics and among blacks where there is a real need for this, I can see that if we invest a few dollars in that in 1990 we'll avoid investing many, many dollars in that in 1992 or 1994.

So I would urge you to not only advocate your proposal on its merits as public health policy, but also on its merits as good budget policy for the State of New Jersey, because I think the one-half million dollars that you are suggesting, be appropriated. To support this will save us that amount many many times over in the future. So I want to lend to you our support and our assistance and commend you and thank you for the effort in proposing this legislation.

SENATOR CODEY: Mr. Andrews, the point you just touched on, the money saving aspect of this is really very true, because as taxpayers we will save money with healthier communities. Just looking at uncompensated care, healthier people in that particular slot, we pay that not through our taxes, but through our health insurance and we could save literally millions of dollars where we'd have healthier communities. One of the questions I want to ask you, in Camden County, do you have a Healthy Mothers/Healthy Babies Program?

FREEHOLDER ANDREWS: Yes, we do. We have a very active Coalition for Healthy Mothers/Healthy Babies that's been started by folks in our Health Department who have reached out to the nonprofits, to the community itself, and that is an effort you are going to hear a little bit more about later from some of our professionals. We are very active advocates of that program.

SENATOR CODEY: Because I know in Essex County they seem to be doing a very good job, and I just think it's a great program where everybody wins, when they succeed.

FREEHOLDER ANDREWS: I would express it this way, that across the street from this institution is Cooper Hospital/University Medical Center. We have this paradox in our community where if the child of an indigent family gets very very sick and has pneumonia or some problem that requires acute care hospitalization, that child will get treated. But if tomorrow morning, another child in that same family develops the sniffles or a cold, there isn't anywhere to go. You have to wait until the child gets very very sick to get the kind of assistance that is needed. That's a problem that affects every aspect of our community, not just the minority community. But the minority community I think there is an inappropriate proportion of the burden for that. And I think that having a planning office in Trenton that's going to focus on that would pay great dividends, both in terms of public health and in terms of fiscal dividends for the State budget. So we offer our support, Senator.

SENATOR CODEY: Okay. Thank you very much Mr. Andrews. Our next witness is Sandi Davis, Regional Director of the American Diabetes Association. Ms. Davis.

S A N D I D A V I S: Good morning. I'm Sandi Davis, I'm the Regional Director of the Southern Regional Chapter of the American Diabetes Association, New Jersey affiliate. Our chapter covers all seven counties in South Jersey. And I am representing the ADA here this morning.

Today in this country there are approximately 11 million people with diabetes, five million of whom remain undiagnosed. Three hundred thousand people every year die from diabetes, and every year 500,000 thousand people are being diagnosed. In the minority community the statistics that the Department of Health and Human Services put together are startling. It crosses all socio-demographic parameters, and in the black community, the prevalence of diabetes both diagnosed and undiagnosed in black Americans is 9.9% of the

population. Diagnosed cases have increased fourfold in the last 20 years from an estimated 228,000 in the '60s to approximately one million in the '80s. The rate of non-insulin dependent diabetes, melitis or Type II, in blacks, is 50% to 60% higher than in whites. It is considered epidemic in black women. One in four black women older than 55 has diabetes, which is double the rate in white women.

Blacks with diabetes experience higher rates of at least three of the serious complications of the disease; blindness, amputation, and end-stage renal disease. Prevalence of diabetes for blacks is highest among women, older people, less educated, the formally married, persons living alone, and persons and families with low incomes. Compared with the general population, blacks have a higher prevalence of obesity, a strong risk factor for Type II diabetes. Of all Americans diagnosed as having Type II diabetes, 82% of adult black women are obese, compared to 62% of white women. Among men, 45% of blacks are obese, compared with 39% of whites.

Blacks tend to have less access to financial, social, health, and educational resources that would help improve their health status and health awareness. Studies on diabetes education demonstrate the need to develop materials and approaches that are culturally sensitive and relevant, to reach this population.

The diabetes prevalence among Hispanics-- Currently Hispanics comprise the second largest minority in the United States, with the population estimated at almost 19 million in 1988. By the year 2000, Hispanics are projected to be the largest minority in the United States with a population of 30 million. Hispanics are three times more likely or 300% more likely to develop diabetes than a non Latin person. Compared with a rate of 6.1% in whites, the prevalence of diabetes is 13.2% in Puerto Ricans, 12.6% in Mexican Americans, and 9.2% in Cubans. Half of all Mexican Americans have non-insulin

dependent diabetes, melitis or Type II, or have an immediate family member with it. Insulin dependent diabetes, or Type I, accounts for only 2% to 5% of all Hispanic cases. Studies report that Hispanics with diagnosed diabetes have higher rates of complications including severe retinopathy, eye disease that can lead to blindness, end-stage renal disease, severe high blood sugar, and higher rates of gestational diabetes or diabetes during pregnancy, resulting in birth complications.

In Texas, a state with one of the largest populations of Mexican Americans, it was reported 52,906 residents were diagnosed with diabetes in 1986. Of these, 72% or 38,000 were Mexican American. Low income, lack of information, and the inability to understand English, remain the largest obstacles to overcome in diabetes detection and awareness in the Latin community. Currently 25% to 30% of Latins do not understand English or their physician's instructions.

Today, March 20, is Diabetes Alert Day and the American Diabetes Association has put out,in the State of New Jersey over 80,000 diabetes alert tests to make people aware of their high risk for diabetes, and approximately 40,000 of those pamphlets went out in Spanish. In Camden, Gloucester, Burlington Counties, I have been able to distribute over 20,000 of these pieces. One of the keys to this disease is the education of the people and how to take care of it. I feel that an Office of Minority Health could really be the hub for all nonprofits to work together to help educate the minority community to their risks for this disease. Thank you.

SENATOR CODEY: In your testimony you mentioned one out of every four black females over the age of 55 have diabetes. That's a really shocking statistic.

MS. DAVIS: Yes, it really is. It's epidemic in black women.

SENATOR CODEY: Do you think this office can help get the word out in the minority community?

MS. DAVIS: Well, as an organization, the American Diabetes Association has established a minority initiatives program. But also as an individual organization, we need help in disseminating the information, and I feel the Office of Minority Health would be able to help us with the dissemination of this information.

SENATOR CODEY: Okay. Thank you very much, Ms. Davis. Our next witness will be Ava Brown, Executive Director of Blacks Against AIDS. Is Ms. Brown here? (no response) No? Okay. Martha Chavis from the Camden Area Health Education Center. Ms. Chavis.

M A R T H A C H A V I S: Good morning, Senator Codey. I'm happy to be here today as Director of Program Development for the Camden Area Health Education Center. We are a health education training center providing programs to health care and human service professionals in the community at large. We are very proud of our work in the community, particularly with regard to outreach activities in providing education and information to both youth, women, adults, blacks, and Hispanics, young and old, and we have been out there. I think that's what makes us both unique and different. We have also been very cooperative in tying in with most of the nonprofit and health care providers in this county, and working in that cooperative spirit in terms of providing conferences and workshops and other activities to help promote good health education.

My position here today may sound a little different and a little strange, but I for one do not agree with your proposal for the Office of Minority Health. And my reasons are twofold. Number one, what is wrong with the existing Department of Health in terms of providing these services that are needed, that has been so well explained and detailed by our previous presenters in terms of being aware culturally, being

sensitive, outreaching, providing public education, in terms of promoting the health for everyone? To have an Office of Minority Health really continues to parallel the plight of minority health crises in this country today. I mean if you look at it historically speaking, both blacks and Hispanics have been two cultures that were either denied and ignored in terms of public health, any kind of health services. We have lived with it for generations to the point of being able to have certain expectations and an acceptance that the services were not only not available to us, but not accessible to us. They were obviously very cost prohibitive as we stand today. You have individuals in the community that are part of the community. They are human beings like anyone else. To separate them out in terms of saying that they need a special office, which I assume if it's going to be an Office of Minority Health, you will have minorities working there, as opposed to having those minorities work in the existing offices already under the Department of Health.

The other thing is that if you are having this Office of Minority Health for it to make a difference, because in concept and principle, I do agree that what you have proposed can have an impact. The one place you shouldn't put it is in the Department of Health because it will no longer, or no more improve the already existing structure that has somewhat immobilized services that need to be provided to the minority community. What is really at stake here is first our values and our attitudes about health.

We as a country number one, despite what the statistics show for black and Hispanics among the white cultures compared to all the other industrialized nations, we are the pits. We spend more on health care per person to have little outcome and impact. The only thing that is guaranteed is death and taxes, so the saying goes. We have a system that is designed as Jesse Jackson would say, "For sick care, not for

health care." So our values and our focus have to change to promote good health and preventive health. In being able to accomplish that, we need to do what we already have in existence, which is mainly to utilize the resources that are there effectively across-the-board. We have a situation where we need to promote health education and prevention. But, like anything else in this nation, we are more crisis interveningly dominated than we are proactive or preventive dominated. So health education and prevention programs oftentimes get subjugated or deprioritized or canned for the purposes of crisis intervention, treatment, and services. The circle will never stop unless we promote health education early on.

The other thing that we must do is that we really must focus on our health providers' outreach activities. Here in Camden City, we can say that our health providers have services that are accessible and available to the community. Most of that community that surrounds them is the minority community. But those services are available from 8:30 to 12:30, 1:30 to 4:30. If you don't get sick within that time period, you won't get served. And even if you do, you may still not qualify because the first letter of your last name doesn't fall on a Tuesday or Thursday, or the last four digits of your Medicaid card can only be serviced in the afternoon. So you have a system that is here to provide, yet, it doesn't, because we are not meeting the needs of the community because we have not taken our time to access those needs and to find out where they are coming from.

There are different strokes for different folks and what has worked as tradition, what has worked as mainly middle-class, what has worked for the white culture in general, does not necessarily hold true for blacks and Hispanics. We too are families and that's another problem because our health service providers, as well as our education system and our businesses, do not look at the black and Hispanic family as a

whole, mainly because we don't fall into that emulated Cleaver family concept that goes to visit Dr. Welby on a periodic pre-appointed time basis. But that doesn't mean we don't care about health.

We at Camden AHEC, along with the Camden County Health Department, the Mayor's office, Dr. Carmen Barres, and the Hispanic Camden County Task Force, put on a bilingual, biannual health fair right here in City Hall last year on Saturday, June 3. Four hundred people showed up. We had no funds. We got the volunteerism of 19 doctors and 73 nurses, but the real success of that fair was not those volunteers, but the fact that we had the value and attitude towards that community that they were interested and concerned in their health, and we empowered them to make the change. They were at the door before we sat the tables up. Families came in. Granted they did not look like Ward Cleaver and the Beav, but they were families all the same. And they were much more knowlegeable about health care than even we gave them credit for. They were sending their children to get their vision taken care of, while they went to have their cholesterol checked. They were interested in finding out about mammographies, and definitely getting their blood pressure tested. We are not talking about a people that have to be scraped up from the barrel and plugged over someplace for purposes of having an office take care of all their needs. That is subjugating them, and that is letting everyone else off the hook.

Last, but not least, I'd like to say that if we really do want to do something besides give lip service to the minority health crisis here in the State of New Jersey as well as in this county, then what needs to be done is the focus of looking at ourselves. As health care providers, as human service providers, as educational systems, we need to lock into each other and take a look at the people we are supposed to be serving. I'm still bothered by the fact that we sit in these

facilities as a fortress, where the people must come to us at our appointed times because we think it is too unsafe to travel in the community. But for some reason or other we can sit there long enough to collect a paycheck and then fly out-of-town at 5 p.m. on the dot. I have a problem with that, and therefore, I have a problem with the Office of Minority Health creating, and stagnating, and maintaining that same kind of attitude.

Concept and principle Senator; you were right on target. My hat's off to you because you are aware of the health care crisis among minorities, and something needs to be done. However, with the millions and millions of dollars that we have for our existing health department system, where it's already mandated and legislated that they have to serve the public in times of its health and for its good, I, as a member of an Afro-American community, associated with the Latino community, want to be part of that public, not an exception to the rule. Thank you very much.

SENATOR CODEY: Ms. Chavis, just let me say that the reason for creating this office is an awareness that we have not addressed the problem and that just by looking at statistics, there is quite a problem, there is quite a disparity, and we should be doing something about it. By creating this office, we are highlighting that fact -- highlighting the failures of the Department of Health not to do something about it, although in quite candor, this is a problem throughout our nation, not just the State of New Jersey. But I think it is an important step to take, to recognize the problem and recognize that we have not done anything with it. Hopefully, years and years from now we can say that we made an effort and that we did effectuate some kind of a change.

MS. CHAVIS: Well, what I'm hoping for is that that effort will be taken by the Commissioner of Health. If you have to create an office to create awareness, I am still

wondering why that awareness is not already pervading through our existing health system? Because it's only through that act, mode, and method that we really are going to be able to get at what we truly need to service. Thank you very much.

SENATOR CODEY: Is Norma Rosa-Santos here? (no response) No? Okay. Dr. Francis Blackman. Good to see you again, Doctor.

D R. F R A N C I S B L A C K M A N: Good morning. As this Chairman, members of the Committee, I am a duly licensed physician in New Jersey. I have been President of the local chapter of the National Medical Association for the last five years. And I also participate nationally as the Chairman of the Northeast Regional Group of the NMA. We, for any of those who may not know, are a national group in excess of 16,000 physicians, most of whom are descendants of slaves. We formed this association because there was another medical association in this country who excluded us. This isn't-- They are not a part of the century earlier -- many early years in this century.

We appreciate your giving us this opportunity to present our position on the Office of Minority Health. We assume that the minority in our State will be clearly outlined in terms of adversity. You understand that while we fully support the advancement of all disadvantaged peoples, we present today as descendants of Africans, enslaved and transported to these shores, where we provided a free and cheap labor on which this great nation is built.

There is no doubt that our presence here was capitalized by the publication of the Malone Heckler Report which came out of the National Institutes of Health in 1985. This report did go into some details on the situation which black, Latin, and other so-called minority peoples find ourselves today, and it led to some trouble for Margaret Heckler who released it. She was fired. 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 of this stage. 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 deterministic. 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 health care professions, particularly the physician population.

You will recall from data deemed by the National Institutes of Health by Dr. Malone and Margaret Heckler, that the absence of black African American health care professionals is said to be directly related to the poor health seekers of said communities. We are unable to attract young persons into the field. And it is becoming increasingly difficult to compete for these minds in the 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 physician services in some developing countries. These center 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 would tell us to pursue this goal? This would be within the purview of the office whose

(inaudible) I outlined in my third paragraph. I'm talking, sir, 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 fairs so, 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, sir, that I take this opportunity to mouth irresponsible diatribe, I offer you the chance to receive more detail at another time. For others who have survived our own medical school, which is alleged to be among the more progressive institutions-- It is presently a vicious cycle, for at the end of this process, should one be successful, one gets out and stays away from what is a hostile white environment where your so-called white peers are anything but peers. 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 (inaudible), 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 African American. You must one day ask, sir, ask the department of neurology in this school, of only the number of black residents who have completed training. Ask the same of cardiology. And I choose these two at random, sir, because I'm sure if you went through each of these departments and asked, you will find that they look up at the roof, they look at their feet, and they start to talk, or they are unavailable; you know the same crap that people chat when you ask them why they can't find any black anything.

There are other areas that refuse to acknowledge the presence of black people, except as patients. The correction

of these gross imbalances, sir, is beyond the ability of any commissioner, and well within that of a broad based Office of "Minority Health." At this point, sir, I will add that many of the research papers coming out of black communities don't have, very often, black professionals listed on them. And they're set up within such so-called institutes of higher learning, as one of publish or perish. And guess who perishes first?

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 health care delivery systems aimed at reducing the huge disparity between the indices of health of African Americans and the white populations in this country.

In your deliberations, sir, kindly encourage your conservative colleagues to look at the effect of drugs throughout our society and ponder if a generation will grow that can imagine this great scourge on its offsprings, such as is journeying beyond the boundaries of our inner cities? Finally, sir, may I thank you for allowing us the opportunity of presenting a partial paper before you. Thank you.

SENATOR CODEY: Thank you very much, Doctor. Our next witness will be Ms. Sharon Shields, Project Director, School Based Youth Services, Camden County Health Department.

S H A R O N S H I E L D S: Good afternoon and welcome to Camden County, Senator. On behalf of Dr. Jung H. Cho, Public Health Coordinator, Camden County Division of Health, we are in favor of Senate Bill No. 2063, and I will be speaking on behalf of him.

The time is ripe to develop an Office on Minority Health aimed at promoting health and the prevention of disease among the minority population. The ultimate goal is to reduce the great disparity that exists between the health status of minorities and the white population of this nation.

Why is it important? Because minorities are a growing viable and productive part of this society. We have no moral or practical choice but to make the health status of minorities a serious concern in this State as well as in our nation. The mounting crisis of minority health is a rebut to everything America professes to be. This crisis will cause discord and will bring America to its economic knees. Only two of 10 new work force entrants in the 1990s will be white males born in the United States. If we are to compete effectively in the world economy, we need minority and poor youngsters to produce, rather than become dependent on us or shoot at us. Those who do not want to invest in black or brown or poor children must remember this.

Black infants in New Jersey are dying at a rate more than two-and-one-half times that of white infants. AIDS deaths among infants 14 times greater, fertility rates among young black adolescents are almost seven times greater than young white adolescents. Syphilis rates, homicide, esophageal cancer, chemical poisonings; all these kinds of things are going on in New Jersey and we need to address these things. Cancer -- There are disproportionate mortality rates for heart disease. Black physicians are almost nonexistent. There aren't that many, only 3.0% of all physicians practicing in the United States. These statistics are atrocious. We need to begin to look at them. Not only do we need doctors, but we need other health professionals who can address these kinds of things and will look at the health status of our people in this country, and we need to begin to really galvanize on this issue.

These are just a few of the examples of the differences in death, disease, and injury rates between white and minority populations. Although this data is deficient, there's very few data on Hispanics or Pacific Islanders and Native Americans, so an office like this would be much needed,

especially in Camden County. When we look at the rates in Camden County alone, they're worse than some of the -- they're lower-- The rates are worse than some of the developing countries, underdeveloped countries. It's just atrocious, and we, at Camden County Health Department, are much in favor of addressing this issue.

SENATOR CODEY: Okay. Ms. Shields, I wonder if you could for my benefit just explain to me what the School Based Youth Services does?

MS. SHIELDS: Okay. We provide services to adolescents between the ages of 13 and 19 who are housed at Camden High School. Camden High School has enrolled about 2100 kids and we have enrolled in the program about 82% of the population there. We provide health care, mental health counseling, career counseling, education -- those kinds of things.

SENATOR CODEY: Oh, you're funded by the county?

MS. SHIELDS: We are funded by the Department of Human Services.

SENATOR CODEY: Oh, funded by the State?

MS. SHIELDS: Yes.

SENATOR CODEY: Okay, how long has the program been in existence?

MS. SHIELDS: This is our second year in existence.

SENATOR CODEY: Okay, so it's really too early to glean any statistics.

MS. SHIELDS: Well, we--

SENATOR CODEY: What do you think? You think you have some?

MS. SHIELDS: We have a few. You know, I think that we are addressing a lot of the issues. A lot of the kids are coming in who are not insured. We think a lot of kids have some type of medical insurance. We're finding a lot of kids coming in there have no kind of insurance and we are

detecting things like heart murmurs, diabetes, all kinds of different diseases that we're picking up. Let's face it, most kids do not go to doctors; they can't afford it, and they usually go to the emergency room. And by having a school based program there in the high, they are allowed to go in. But this is just one school. We need to do things in the lower county. There are all kinds of things that we need to look at in terms of that kind of stuff. We can expand--

SENATOR CODEY: When someone comes in, you refer them to a clinic or physician, or how does it work?

MS. SHIELDS: Yes, we have a physician on board. You have to make an appointment, yes. He comes a certain amount of days.

SENATOR CODEY: Daily, after school? He comes on certain days. So they come in and make an appointment for that day that the physician would be there?

MS. SHIELDS: Right. We also have a nurse practitioner who can also see them and provide medical care for them as well.

SENATOR CODEY: Who's there the whole school day?

MS. SHIELDS: Yes, the whole school day.

SENATOR CODEY: Sounds like a good program.

MS. SHIELDS: And we have a mental health counselor to provide mental health counseling as well.

SENATOR CODEY: Thank you very much.

MS. SHIELDS: You're welcome. Thank you.

SENATOR CODEY: Our next witness is Joyce Kurzweil, Associate Director, Planned Parenthood for Camden. Good morning.

J O Y C E K U R Z W E I L: Good morning. My name is Joyce Kurzweil and I am the Associate Director of Planned Parenthood, Greater Camden Area. First of all, I would like to take this opportunity to thank the Committee for allowing me the time to address the issue of family planning and the needs of the

community which is the focus of this hearing.

I have not had the chance to study this bill, so while I will not address the issue of support or nonsupport for establishing an Office on Minority Health, Planned Parenthood, Greater Camden Area does feel that it is important for this Committee to have testimony about the importance of family planning services and how minority health issues are addressed within the New Jersey State Department of Health.

1987 statistics show that there are over one million New Jersey women in their reproductive years. Some 200,000 of these women are at risk of an unwanted pregnancy and in need of free or subsidized family planning services. Over 100,000 of these women receive medical contraceptive services from organized family planning clinics, 38.6% of those at risk and in need. Looking at this broad picture of a large unmet health need, we need only to narrow our focus to get a clear picture of that portion of the minority community located in urban areas and headed by a single parent.

For the women mentioned above, the problem is basic. They don't have access to a core set of facts and services, an environment that supports prevention, the extra measure of counseling and follow-up from a caring professional that can mean the difference between opportunity and an unwanted or unintended pregnancy. If a woman has the ability to space between pregnancies, it certainly enhances her health, her child's health, and the health of the family.

Cost is one barrier. These women have no insurance, Medicaid, or adequate income to pay for quality preventive health care. Culture and the environment are other barriers. We live in a society that promotes sex, but bars information about handling it responsibly, and scares us about birth control methods that are safe and effective for most people. These facts are true for all women whether they are of majority age or not. And the fact for society is that for every one

dollar spent on family planning, taxpayers save $4.40 on other social welfare costs.

In 1989, Planned Parenthood, Greater Camden Area provided medical services for over 5000 individual women in Camden County. Over 2000 of these women live in Camden City. As proud as we are of our 50-plus years of services, these figures reflect that more women need to be reached. And the bottom line is that more funding needs to be appropriated for family planning services, for family life, and AIDS education in our schools. That is the message that we implore you to take back to Trenton.

I am leaving a packet of information about the wide array of programs and services offered by our affiliate. Time will not allow me to cover these programs in depth. Please read the materials and you will get a picture of what we do and what we could do if additional government funding is available. Thank you.

SENATOR CODEY: Ms. Kurzweil, what percentage of your funding is private, versus public?

MS. KURZWEIL: In the packet is our annual report, and in there it sets out what our funding levels are like. We receive about 61% of our funds from governmental sources and a much smaller percent, around 12% from private sources. The entire breakdown is in there in the annual report.

SENATOR CODEY: Thank you very much. Our next witness is Ms. Margaret Woods, Chairperson of Children's Budget Coalition. Is Ms. Woods here? (no response) No. Is James Lee Budd here? Mr. Budd, Health Officer for the City of Atlantic City.

J A M E S L E E B U D D : My name is Jim Budd, and I am the Director of the Atlantic City Health Department. I am also here on behalf of the New Jersey Health Officers' Association. Before I get into my prepared remarks, I would like to say that Ms. Chavis and Dr. Blackman, though they said it in a different way than I would, are really right on target. Because the

issues in the minority community with health care are very complex, and they can't be addressed unless we talk about structural racism, community empowerment, and familial dysfunction. So that what they have to say is an important aspect.

In your bill S-2063, I would say that you need to put in some stronger language to really get local and county governments actively involved in the minority affairs. The one section of your bill really addresses community based organizations but other than saying that -- I guess it's number five that the office is entitled to call on its assistance to employees of any State, county, or municipal government -- I think that that language should be made stronger, so that we don't get a two-tiered system, and an institutional system like Ms. Chavis says. And it doesn't really address the complexities of these issues.

I don't think that we can say now that the disparities in health status between the minority community and the white community is just related to access to health care, and unless we can deal with the issues that Dr. Blackman talked about in terms of structural racism and community empowerment this is something that we have to do. And addressing issues like-- In terms of just providing more programs, it's almost like from a public health perspective addressing malaria and colera without providing -- addressing the sanitation needs in the community.

We have to get down to some of these, so rather than discuss the statistical differences, I'd just like to talk to you about the consequences of working in a city with a large minority population and relating some of my experiences. You know, New Jersey is regarded nationally as having an adequate health care system and by some it is said to be a model health care system, particularly as you referred to the DRG system and things like that. But the problems really arise in the pockets of poverty and the pockets of minority problems that don't get

addressed. And one of the tendencies that is occuring now, as money is getting in less and less supply, is that the money is getting spread over larger and larger population areas. And as these-- It's logical that it is spread over larger population areas. What happens, is these small pockets of problems get buried further and further down. We need a structural way to deal with this problem, and we need an Office of Minority Health Affairs, and I think we need it within the Health Department.

Public health does not have enough decision makers that are minorities. And one of the efforts that the Office of Minority Health Affairs should do, is that they should train and they should educate, and develop leadership from minorities within government. Because we do have to play a role here, and we should encourage that role. I would recommend to you, again, to authorize local governments to become actively involved in these issues. And other than what Ms. Chavis had to say and Dr. Blackman had to say, I kind of thought that the discussion here was a little too narrowly focused in terms of what the definition of health care is, and that to really address these you have to employ more broad definitions of health so that we can get into some of the problems that actually affect the minority community.

You know, we hire-- We do actually hire minority physicians in our health centers and we try to recruit them and we have difficulties in terms of recruiting because of not qualifying under National Health Service Corp. and not being able to go out and get people to work in the city and believe in what they do. I mean it takes a lot of time and effort to find people like that. And I think that if this office can help in that regard, in terms of educating and raising the sensitivity particularly of local governments to the problems in the minority community, it will go a long way. So I would say that I agree that you need to -- that the office needs to be an advocate for minority health concerns. I would

tell you that it needs to be a trainer, and increase the number of minority professionals in public health. It needs to be a coalition builder between organizations in order that the appropriate level of services can come together to address these pockets of need that often cross geopolitical boundaries, and also I think they need to be an educator, both the public and professionals in health care. Thank you.

SENATOR CODEY: Okay. One of the things hopefully down the road, Mr. Budd, that we hope the office could do is to promote in the minority community those individuals going into the health profession, in all kinds of ways; not just as physicians, but in the many many areas. As we both know, there are employment opportunities for all people within the health profession, and it is a growing percentage of the work force, not only here in the State of New Jersey, but nationally. The other thing I wanted to mention is here in the State of New Jersey, unlike almost every other state in this country, we don't turn away people at a hospital because they don't have health insurance.

MR. BUDD: Well, you don't turn away people at the hospital because they don't have health insurance, but the people that work at the hospital are so much concerned about what the financial base is that they don't get a sensitive reception. And even though you have programs that are required to serve everyone by requiring a 10% to 15% set-aside in terms of certificate of need applications for the indigent, that just becomes a code word. And it becomes a code word in some ways just to exclude others based on adequacy of health insurance, and/or location of facilities in suburban areas that are really -- Their need is based on problems of the poor, but their location is out in an area that is convenient to the providers of care. And those kinds of issues are going to have to be addressed.

SENATOR CODEY: That bill is paid whether or not the

person has health insurance, is indigent, and that is something that we in New Jersey can be proud of.

MR. BUDD: Well, that bill is paid to the institution, but the physician that provides the care doesn't necessarily get the payment. And that is the person that directs it.

SENATOR CODEY: No, I'm talking about a hospital bill, which is paid for by everyone who purchases health insurance, subsidizes that care, and I think we in New Jersey can be proud of that.

MR. BUDD: Oh we can. I'm not here to criticize that.

SENATOR CODEY: We all contribute too. Okay. Thank you very much Mr. Budd. Ms. Betty Waters, School Nurse. (no response) All right-- Is Ms. Tirado here or Kathy Freudenberg? **K A T H Y F R E U D E N B E R G** Here. It's now afternoon, so I will say good afternoon, Senator Codey. My name is Kathy Freudenberg, and I work for the Gloucester County Educational Services Commission which is located in Sewell, New Jersey, as the Director of Special Projects. And under my office falls two regional migrant child education projects that we operate covering Burlington, Camden, Gloucester, Salem, and Atlantic Counties. I have been working in migrant education for over 12 years, and I am here today to speak to you about migrant workers, a unique, but very often forgotten minority in the Garden State of New Jersey.

The migrant worker represents an important link in the food production chain of our State. These seasonal laborers help the farmers to plant, cultivate and harvest a variety of agricultural products, all types of orchard fruits, and vegetables. They also work in packing houses, poultry plants, things like that. They supply our tables abundantly with the fruits and vegetables for which New Jersey is so well noted. It is ironic, though, that while migrant workers help to provide us with healthy, and nutritious foods, as a group they have significantly greater health problems than the general

population. Just a few examples: 1) The infant mortality rate is up to 25% higher than the national average, 2) The death rate from influenza and pneumonia is 20% higher than the national average, and deaths from tuberculosis and other communicable diseases are 25 times higher, 3) The hospitalization rate from accidents is 50% higher than the national average, 4) Parasitic infections afflict migrant adults and children an average of 20 times more than the general population.

According to a study of the National Rural Health Care Association on the occupational health of migrant and seasonal farmworkers, the health problems most frequently reported at migrant health clinics include dermatitis, injuries, respiratory problems, musculoskeletal ailments -- especially back pain, eye problems, gastrointestinal problems, hypertension, and diabetes. Many of these ailments can be linked directly to the migrant life-style -- be it from overcrowded housing conditions, poor sanitation both at home and in the fields, lack of proper potable drinking water, exposure to poisonous pesticides, improper nutrition, or farm implement accidents.

Many of the migrant workers who travel into and through our State bring their most valued possession with them -- their children. The children suffer from the same types of health problems, and, in fact, many conditions are exacerbated by lack of adequate pre and postnatal care and follow-up. I say adequate, but sometimes they don't receive any pre or postnatal care. Poor health, coupled with a transient life-style and irregular school attendance, often result in poor academic performance by migrant children. The most recent statistics available indicate that fewer than half of them graduate from high school which is far above the national average.

Our migrant education program has made great strides

in meeting the special educational needs of the children, but we are very limited in what we can do to meet their health care needs. The fact is, most migrant families cannot afford routine health care. We do our best to link them with other agencies and health care providers, but we have very little funding with which to pay for services directly. Poverty, lack of insurance, and even language differences can greatly curtail their access to health care. And a lot of times they live in remote areas where they are even more cut off from available services. One concern we see repeatedly with migrant families is that even if they are Medicaid eligible, they often cannot find providers who will accept Medicaid patients. Generally, migrant families end up seeking treatment only for acute problems rather than chronic conditions or preventive services.

And so I appeal to you today not to overlook migrant workers and their families as a significant minority in great need. In fact, migrants represent a minority within most other minority groups. The traditional minorities we usually think of, such as blacks, Hispanics, Asians, Pacific Islanders, Haitians, and even Native Amerians, can all be found within the migrant population. In New Jersey, better than 70% of our population is Hispanic.

Migrant families are among the most underprivileged, underrepresented segments of our society, even though they work hard and are an integral part of the economic machinery that has made American agriculture successful. They present us with a serious health care challenge, and they must not be forgotten or excluded from any plan concerning minority health issues in New Jersey. Thank you.

SENATOR CODEY: I just want to thank you for bringing to our attention the important segment of the population that obviouly is forgotten when we look at or think about these health statistics. Obviously, they should be included and there should be some programs to aid at helping them.

MS. FREUDENBERG: I agree, and I believe that a lot of times even though they do fall within certain other minority categories, they have even less access to the services because of their location, because they are not an empowered people in general. A lot of them don't know how to advocate for themselves. They have no real power base. A lot of them don't even vote because they can't even establish residency for any period of time.

SENATOR CODEY: In addition, because of the nature of their profession, they have different health problems than the rest of the minority population does.

MS. FREUDENBERG: Yes, they do. Pesticide safety is an important consideration. We don't even know yet statistically, some of the effects, but we do have a lot of children who have scoliosis. We've had a couple of kids in the last year who have had brain tumors; a lot of dermatitis and skin conditions and other kinds of ailments that could result from exposure to pesticides.

SENATOR CODEY: Thank you very much.

MS. FREUDENBERG: Thank you.

SENATOR CODEY: That ends our hearing this morning. I'd just like to take a second to thank the University of -- UMDNJ for their hospitality here this morning as well as in Newark at our last hearing. Hopefully, we expect to see passage of the bill some time this spring. Again, thank you very much.

(HEARING CONCLUDED)

APPENDIX

THE PUBLIC HEALTH COUNCIL OF THE NEW JERSEY STATE DEPARTMENT OF HEALTH

March 17, 1990

With regards to the "Office of Minority Health" bill, we are in favor of the principle and concept of focusing efforts and monies on high risk health categories, both prevention and treatment. It has been clearly shown that minorities form a major part of the following categories: infant mortality, teenage pregnancy, substance abuse, hypertension, etc. We have spent a great deal of our efforts on plugging help for the indigent. We feel that many of our programs reflect this, but, in order to obtain factual data, we have asked Dr. Ziskin to furnish a rough breakdown of monies already being spent on these programs but that information is not available for this meeting.

If the bill has difficulty in passage, we feel it will be because of it's 1/2 million dollars allocation. If this bill is passed, we hope that the vast majority of this money will be spent for programs and patients' services, and that a bare minimum be set aside for a "director" and his/her needs. As a matter of fact, we would like to see such an office even if the fund are not available just to get it started, and have it run it "on a shoestring" if necessary. We would try to encourage a cadre of volunteers committed to the cause, and it could share clerical and administrative resources with other areas of the health department. At least the principle will have been accomplished, a foundation will have been started, and you can build from there.

We can foresee overlapping of this "office" with other community services, and coordination will be necessary to a central source, recognizing the needs of all indigent persons who cannot afford optimum quality health care.

In summary, we are in favor of the bill, but we feel that, if necessary, it can still "get off the ground" with less money allocated to it, especially in light of our present budget crunch.

Respectfully submitted,

Hardge Davis, Jr., Esquire
Vice-Chairman, Public Health Council

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Although there have been major breakthroughs in health care in at least the last four decades, the reality is that in our nation there are startling disparities between health care for the poor, most of whom are black and Hispanic, and health care for the mainstream society, most of whom are white. In a report compiled in June, 1989, by the then Commissioner of Health, Dr. Molly Coye, it was pointed out that the preliminary findings of a review of health statistics for New Jersey were "unfortunately similar" to those for the rest of the nation.

One of the most startling statistics in that report pointed out that black infants were dying at a rate more than 2 and 1/2 times that of white infants. This is but one of the areas in which there are significant differences in the health status of minority vs white populations in our state. For example, among blacks in New Jersey, there are higher rates of teen-age pregnancy, AIDS deaths, homicides, cancer deaths, hypertension and sexually transmitted diseases than among whites. This is by no means a complete list.

Unfortunately, because of inadequacies in data collection, the true extent of the problem is not known. In many instances, data is collected in two categories - white and non-white - thus making it impossible to determine specific problem areas by ethnicity. This deficiency in data collection is true for all minorities, including Hispanics, (who incidentally are listed with both white and non-white groups), Asian/Pacific Islanders and Native American populations.

To discuss health status without looking at associated factors such as poverty, inadequate housing, unemployment, and poor education is to isolate health from other human needs. This distorts the picture. Poor individuals who are undereducated and underemployed or unemployed often have poor health care habits as well as inadequate, if any, health care benefits. Furthermore, entitlement programs penalize people for working by rendering them ineligible for Medical Assistance benefits, even though their earnings may place them below the poverty level.

In the black community alone, nearly one of every three blacks in our country has an income below the poverty level and poor black families are poorer than poor white families. Blacks are more likely than whites to be hospitalized and less likely to be insured. Blacks are more likely to be smokers, to be overweight, to drink heavily on a regular basis, to be underemployed or unemployed and to be undereducated. Black families are more likely to be headed by a single, underemployed, undereducated female.

The 1987 population estimates placed blacks at 15% of the total New Jersey population. One-fourth of the State's population lives in South Jersey. In Camden County, blacks accounted for 14.3% of the population. Income data shows that nearly 40% of blacks in Camden County are below the poverty level and most of these reside in Camden City.

Although there are some steps that can be taken to improve the health status of minorities, the problem cannot be fully addressed without a frontal assault on the systems that have an impact on health - namely, poverty, housing, and education. While, in the short run, we may not be able to correct these problems, there are some problems about which we may be able to do something, such as the shortage of minority individuals in the health care delivery system. We may not be able to increase the number of minority providers in a short time, but we can educate the ones already in place. Little effort is made in 1990 to help providers become sensitive to cultural differences and the value systems of different cultures, in spite of the fact that there is as little understanding of these differences today as there was at the turn of the century. Today, as in the past, the majority of health care professionals are white, middle-class individuals who have a value system that is often 180 degrees away from that of the poor and/or minority individuals to whom they provide services. Ethnic differences are more than just a matter of language differences. Value judgments made by providers often influence the quality of care given to the minority individual, and quality of care has a direct impact on informed utilization of services.

I have worked in the health care field for more than twenty-five years and one thing has been constant - when money is tight, services to those who need them the most - the un-privileged - are cut back. Bear in mind that services which are cut were not adequately funded in the first place. Health care programs in poor communities are typically underfunded, have staff who are less well-trained and less well-paid than their counterparts in more affluent areas and are often located in blighted areas in run-down buildings and have dilapidated furniture and used equipment. Health services may be operated as businesses in affluent communities, but they are usually expected to be missionary outposts in poor communities.

We have become adept in our society at blaming the victims for their plight. This is as true in health care as in any other field. Too many of us believe that if people do not demand better services it is because what they are getting is acceptable to them. This is simply not true. Poor people tend not to demand better services, but instead, tend to stay away from services that are not responsive to them. Health problems that might be easily corrected or prevented become crises which are then resolved in hospital emergency rooms - a most expensive alternative. This of course drives costs up further and results in service reductions elsewhere.

Most minorities in our state and in the nation live under the stress of inadequate, overcrowded, sub-standard or no housing; unemployment or underemployment; incomplete education; and/or racism and discrimination. These conditions alone or in concert provide a fertile ground for both physical-health and mental-health problems.

In my view, it is now time to do fewer studies and take more action to get better health care to those who need it and don't get it. This is not to say that research and study efforts are no longer needed. On the contrary, some of this needs to go on; but we need to retrieve our past studies from the "round files" into which they were relegated and implement the recommendations.

We need to recruit more minorities into health care, at both policy-making levels where priorities are decided and at direct service levels. Training money has to be made available again in order to attract more minorities.

Our system of health care does not provide adequately for poor minorities and, as a result, we have more severe health problems than any other country in the free world. Even if we do not want to improve this situation because it is the right thing to do, we cannot afford to ignore the problem if we want to survive. If our infant mortality rate continues to soar, if more people succumb to major illnesses and die at earlier ages, who will our work force be? From what pool will we draw our future leaders?

In the short run, additional funds need to be allocated to adequately staff and operate community health and mental health programs. More comprehensive health programs need to be made available to teens in high schools. Public health education regarding such things as AIDS, cancer, smoking and substance use need to be concentrated in minority communities, especially those which have been targeted by advertisers to increase cigarette and alcohol sales. The education needs to be planned by minorities so that the messages will be appropriate to their audiences. Plans with realistic goals and objectives do exist; I have personally served on several task forces through the years that have formulated such plans. Let's dig them out; review them for relevancy to 1990; fund them; and put them into operation.

In the long run, we need to encourage our legislators to give health care for the poor the highest priority and appropriate enough money to accomplish what has to be done.

Life is what happens while we're making other plans. In view of the depressing statistics about the health status of the poor, death is what happens also.

Phyllis A. Diggs, M.A., M.P.H.
President/Chief Executive Officer
CAMcare Community Mental Health Center, Inc.
March 20, 1990

MINORITY HEALTH ISSUES

The U.S. Census Bureau estimates that the minority population is growing at a rate of 13% per year and will reach 33,199,000 Black Americans by 1995. Black Americans in New Jersey are presently estimated to be 1,336,000; of this number, 6,680 will be born with a sickle cell disease and 167,000 will be born with sickle cell trait. As you know, sickle cell disease and other hemoglobinopathies are associated specifically with minority peoples - Black, Hispanic, Italian, Greek and Asiatic.

Sickle cell disease is a group of inherited conditions which is caused by the presence of abnormal hemoglobin in the red blood cells of a person. Generally, one out of ten (10) Black Americans have sickle cell trait and one (1) out of 400 Black Americans have sickle cell disease. There presently is no cure for the sickle cell diseases but the symptoms and complications can be controlled with comprehensive, preventive health care including regular office visits, proper diet, rest, hydration, temperature control and protection from environmental extremes. The disease is best managed by a multidisciplinary team and experienced physicians specializing in hematological disorders.

Consistent with the University of Medicine and Dentistry of New Jersey's long standing commitment to provide health care services to the medically indigent residents of the State, the School of Osteopathic Medicine, Department of Medicine, Division of Hematology/Oncology established Sickle Cell Centers in Southern New Jersey as of January 1989. These Centers' objectives are

to provide a comprehensive health care program to adult sickle cell patients and their families; to provide an educational component that encompasses the community, the patients and their families and professional health care providers; and to provide a clinical area that would offer a wealth of material for research in sickle cell disease.

The centers provide comprehensive health care to the adult patient with sickle cell disease. We emphasize outpatient management and wellness to avoid hospitalization, provide genetic counseling and involve other health providers as appropriate.

The ultimate goal of the centers is to maintain functionality of these patients, thereby decreasing income lost from work and reducing hospital costs by averting crises and other complications of sickle cell disease.

Our centers provide the following services:

- Comprehensive care to the sickle cell patient emphasizing preventive health maintenance.

- Patient education to facilitate better understanding of and coping with this disease.

- Coordination of care with the family physician and specialists when needed.

- Genetic counseling for patients who plan to start a family and for relatives who need information about sickle cell disease for their own needs.

- 24 hour answering service with continuous physician access to respond promptly in the event of a crisis or emergency by calling (609) 963-8248.

- Admitting patients from the center to four teaching hospitals: Kennedy Memorial Hospital/University Medical Centers in Stratford, Cherry Hill and Washington Township; and Cooper Hospital University Medical Center in Camden.

- Screening for those who are concerned that they may be carriers of the sickle cell gene.

- Research programs using the latest forms of treatment to improve our patients' quality of life.

- Information to patients regarding housing, employment and health care coverage.

- Continuing medical education for health care professionals in all aspects of sickle cell disease and related blood disorders.

- Community education programs utilizing video tapes, discussion and written materials to increase community awareness of sickle cell disease and our centers.

- Community Board comprised of patients and individuals in the community who share a common goal of better health care for those with sickle cell disease and related hemoglobin disorders.

Minority health issues are many and include such diseases as cancer, hypertension, AIDS, teenage pregnancy, addiction, and genetic diseases such as sickle cell disease.

We in the health care delivery system need the impetus and involvement of the Federal and State Governments. These Government agencies need to be involved in the resolution of discrepancies of the health care delivery system for minority peoples. There is a need for the legislatures to be aware of the plight of minorities in the health care market place.

AREA HEALTH EDUCATION CENTERS
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MINORITY HEALTH ISSUES IN THE STATE OF NEW JERSEY

(Prepared by: Martha Chavis, Director of Program Development and AIDS Education for Camden AHEC)

The offering of a public hearing on the "Issues of Minority Health" in the State of New Jersey parallels the state's present level of lack of services that is currently reflected in the health and mental health services targeted to the minority community. This public hearing forum offers the much needed opportunity and publicity that minority health issues assuredly deserves but will delivery of the needed services as the result of these hearings be more than a remembrance of a three-day old newspaper headline? Optimism dictates that we wait and see. Past experience tells us that we will just wait!

It is understandable that the "health crisis" continues to be a plight that Blacks and Hispanics bear mainly as the result of the lack of available services, affordability of services, and trust in the health care providers delivering the services. Percentages illustrate that higher numbers of Blacks and Hispanics live in low-income urban areas which in turn have fewer services available and accessible to these communities needs and living conditions. Blacks and Hispanics history in this country also demonstrates that we have continually been the last served and when finally served -- only provided the minimum service necessary -- about a notch above "cruelty to animals" -- thereby nurturing expectations and acceptance that services aren't available or affordable to us. As a result of these practices however, we have all been slapped in the face as we have been reminded that "God does not like ugly" and there are crosses to bear!

So our situation as it stands today sees a festering of the health crisis among minorities as its continues to spread and infect us all. We are now aware that we are paying for our lack of -- quality health services, promotion of preventive health, and practice of cost-saving health services. It is anticipated that the funds needed nationally to correct our past health mistakes may literally exceed our national debt! What we wouldn't consider or spend in the past to improve our health care is now costing us triple. This three time increase is not only in dollars but also in lives, labor, and our future generations. We have literally stepped back in time to the Dark Ages as we look at our health care system today. New Jersey like its sister states has helped to maintain this historical time capsule through its promotional ads and health care lures in -- "New Jersey and You" - SICK CARE guaranteed!

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What needs to be done is simple. We need to direct our health care values and resources towards health care prevention, health care maintenance and quality services at reasonable costs with special attention to minorities. Unlike some maybe led to believe, Blacks and Hispanics don't like to be sick anymore than anyone else. They get sick and remain sick because its cost-prohibitive to get and stay well. We see that the health care services currently available to most Blacks and Hispanics living in the inner cities (mainly Public Health clinics) only afford them the opportunity to get sick between 8:30 a.m. and 12 noon and 1:00 and 4:30 p.m. from Monday through Friday. Even under those time periods, one may not receive care because the first letter of their last name makes them available for appointments only on Tuesdays and Thursdays or their Medicaid card account number can only be served in the afternoon. The only exceptions are in the case of emergency care. We know how well America responds to "crisis intervention." Therefore, our minorities have learned get around our existing contrived health care system by waiting until they need emergency care.

New Jersey can make a difference in providing better health care to Blacks and Hispanics by implementing more efficiently and effectively the systems and resources that currently exist. In Camden for example, we have the county health department's Bergen Lanning Family Practice Clinic that has the staff and a facility to adequately serve the surrounding community. Yet, the clinic is under-used and almost non-existence by default. The clinic's doors are open and therefore accessible to the community yet the community does not see the clinic as a service for them. Why? The reasons are many but mainly because a lack of trust exists. This is a problem that pervades other health care organizations providing services to the minority community as well. Part of the solution to this problem and others that mark the deteriorating state of health of Blacks and Hispanics in New Jersey include:

1. HEALTH EDUCATION AND PREVENTION:

   Too often, education programs promoting "good health" and prevention get de-prioritized or canned in lieu of "crisis intervention" health care and treatment services. Our health care system is designed to take care of the "sick" not the "well." Its obvious that this focus needs to change beginning with all ages in getting people to practice "preventive health" care. The kind of educational programs need to be non-traditional in approach thereby recognizing and acknowledging cultural and age differences with the information provided.

2. HEALTH PROVIDER OUTREACH:

Community access to health services provided through the available of public transportation and location does not sufficiently qualify as true "access to care." Accessibility needs to include "outreach" of the provider to the community. Rather than expecting people to come to get the health care services, the services need to be taken to the people. As mentioned earlier, the minority community's distrust of health care providers and services can be eventually dissuaded by demonstrating care, involvement, and a sense of wanting to be there. Inner city minority communities already feel ripped-off, scapegoat, and abused by the system. Health care providers with staff that fortress themselves inside the walls of the facility and expect people to accommodate their schedules and pre-conceived notions of culturally appropriate behavior are also the ones most abusing the rights and dignity of others.

Outreach enables the provider to access the needs of the community it is serving and meet those needs with appropriate services. It continues to pervade my intelligence to understand how and why health care staff consider it to dangerous to go out and network in the community, yet not to dangerous commute to that community for a "paycheck." Greed conquers all!

3. CULTURAL AWARENESS/FAMILY FOCUS

Provider outreach in the community needs to be implemented and publicized by those individuals most comfortable with that community. This emphasizes the need for cultural awareness and sensitivity of the Black and Hispanic family, their health priorities, and empowerment for change. We have assumed for too long that Blacks and Hispanics don't have a family focus on health care because their family structure in many cases doesn't emulate the "Cleaver family" concept that visits Dr. Welby on a periodic and pre-set appointment basis. However, upon observation we see that the poorest of families when given the opportunity seek good medical care for their family members. Last year Camden AHEC in co-sponsorship with the Camden City Mayor's Office, Camden County Health Department, Dr. Carmen Barres, and the Camden County Hispanic Task Force coordinated Camden's First Bi-lingual/Bi-Cultural Health Fair. Working with limited resources, over four-hundred people attended, over half were Latino/Hispanic. These participants came as families seeking health care information and availing themselves of the diagnostic tests and screenings. The success of our fair was due in part to the 73 nurse and 19 doctor volunteers.

However, we think our real success was as the result of our attitude that "people care about their health" and have the initiative to do something about it when treated with respect and empowered to make the change! We are looking for to this year's health fair attracting thousand participants!

4. OFFICE OF MINORITY HEALTH:

There is movement in New Jersey for an Office of Minority Health. The objective of this office is to oversee the policies and services affecting minority health. What needs to be questioned about this office is the impact and uniqueness ii would serve as a better provider to our existing health care system. Would this office exceed our existing system? If so, then why can't we apply the funds and organization to improve the existing system? Duplication of efforts is what we don't want to do. Yet, we do need to focus our objectives and resources on our minority health crisis. However, to accomplish this goal, we need to enlist and demand that those systems and services already available meet the need. To empower another Office to handle minority affairs once again will be maintaining our historical past -- serve the minorities last and when you do give the what's necessary and minimum -- just a notch above what we provided them in the last century!

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DEPARTMENT OF HEALTH
AND HUMAN SERVICES

Michael J. DiPiero
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20 March 1990

The enclosure is submitted on behalf of Dr. Jung H. Cho, Public Health Coordinator, Camden County Division of Health and represents complete support of

Senate Bill No. 2063

Sharon Shields, M.P.H.
Director, School Based Youth Services

Michele A. Baqi-Aziz, RN, BSN
Program Coordinator
Obstetrics/Improved Pregnancy Outcome

March 19, 1990

The time is ripe to develop an Office on Minority Health aimed at promoting health and the prevention of disease among the minority population. The ultimate goal is to reduce the great disparity that exists between the health status of minorities and the white population of this nation.

Why is it important? . . .

. . . Because minorities are a growing viable and productive part of this society. We have no moral or practical choice but to make the health status of minorities a serious concern in this State as well as in our Nation. The mounting crisis of minority health is a rebut to everything America professes to be. This crisis will cause discord and will bring America to its economic knees. Only two of 10 new work force entrants in the 1990's will be white males born in the United States. If we are to compete effectively in the world economy, we need minority and poor youngsters to produce, rather than become dependent on us or shoot at us. Those who do not want to invest in black or brown or poor children must remember this.

Black infants in New Jersey are dying at a rate more than 2 1/2 times that of White infants. This very startling statistic, however, is only one of many health facts that plagues New Jersey's Black community - -

AIDS deaths among Black infants are 14 times greater than White infants

Fertility rates among young Black adolescents are almost 7

15x

times greater than young White adolescents

Syphilis rates among Black adults are 25 - 30 times greater than White adults

Homicide **death** rates among Black adults are almost 4 times greater than White adults

Esophageal Cancer death rates among Black males are 3 times greater than White males

Chemical poisonings (measured by frequency of hospitalization) among the employed Black population are almost 3 times greater than the employed White population.

Cancer is 25 percent higher among Black males, with Black men showing the largest increase in cancer mortality between 1978 and 1981

There are disproportionate mortality rates for heart disease as well. For Black men under age 45, the death rate from heart disease, between 1979 and 1981, was 34.9 per 100,000, as compared with a mortality rate for White men of 15.3 per 100,000.

In 1985, Black physicians were 3.0 percent of all physicians practicing in the United States. Projections for the year 2000 indicate that the percentage of practicing Black physicians will only increase to 4.1 percent of the total.

This dearth of minority health care professionals, both in clinical practice and health care policy development and administration points to the need for the development of minority internship programs and other concerted efforts to

encourage, recruit and retain minority students in the health professions. We can surmise that the situation for native Americans and Asian/Pacific Islanders are even more bleak.

Insufficient comprehensive research data on the overall health status of Hispanics and other minorities, particularly those living in large, urban areas, documents the need for a more detailed analysis of their mortality and morbidity data.

Obesity is a problem for a large proportion of American Indian Adults because of the lack of meat, eggs, cheese, and milk and increased consumption of refined carbohydrates, fats, and sodium. This may be associated with the high risk of diabetes in this population. Alcohol, and its related diseases, is also a concern among the American Indian population.

These are just a few of the examples of the differences in death, disease, and injury rates between White and Minority populations. Although data deficiencies limit our ability to analyze and accurately display the health status of New Jersey's Black population in comparison to the White population, information on the health of Hispanics is even more inadequate, as well as information on Asian/Pacific Islanders and Native Americans.

In Camden County our issues of minority health has reached a level higher than some of the third world nations. Each year more than 1,050 adolescents give birth in Camden County giving it one of the highest rates of adolescent fertility in New Jersey. Almost two-thirds of these births are to teens in the City of Camden. The remainder -- about 390 births per year -- occur to teens throughout the rest of the County.

The infant mortality rate for Camden City in 1988 was 22.5% and of that percent, 26.3% was Non-White and 18% was White. In Camden County the infant mortality rate was 11.4%, with the State being 9.8%. The infant mortality rate is a major indicator of a County health status and must be looked at carefully in developing programs within the Office of Minority Health.

Incidence of drugs and alcohol and AIDS cases is on the rise disproportionately in Camden County. In a recent analysis of United States Cities by the Brookings Institute listed Camden City as the seventh most distressed city studied.

Many of the ills that plague Camden County and Camden City are the same ills that plague the State of New Jersey and the Nation.

IN CONCLUSION . . .

We recommend that an Office of Minority Health be established to bridge the gap between the health status of Whites and the Minority population in this State, and to coordinate current State and local programs which seek to address minority health concerns. These gaps are not just difference in numbers, they are **real babies, children, teenagers, working adults, parents, and grandparents. They live in Camden County and New Jersey, and helping them to protect and improve their health is our job in the Department of Health.**

Respectfully submitted,

Sharon Shields, MPH
Director, School Based Youth Services

Michele A. Baqi-Aziz, R.N. B.S.N.
Program Coordinator
Obstetrics/Improved Pregnancy Outcome

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PLANNED PARENTHOOD, GREATER CAMDEN AREA
590 Benson Street, Camden, NJ 08103

PUBLIC HEARING RE: S#2063

Tuesday, March 20, 1990
Room 240

Education and Research Building
UMDNJ-Camden
401 Haddon Avenue
Camden, New Jersey

Comments on the need for family planning services

My name is Joyce Kurzweil and I am the Associate Director of Planned Parenthood, Greater Camden Area. First of all, I would like to take this opportunity to thank the committee for allowing me the time to address the issue of family planning and the needs of the community which is the focus of this hearing.

I have not had the chance to study this bill in depth,so while I will not address the issue of support or nonsupport for establishing an Office on Minority Health, Planned Parenthood, Greater Camden Area does feel that it is important for this committee to have testimony about the importance of family planning services and how minority health issues are addressed within the New Jersey State Department of Health.

1987 statistics show that there are 1,806,803 New Jersey women in their reproductive years. 290,150 of these women are at risk of an unwanted pregnancy and in need of free or subsidized family planning services. 112,061 women receive medical contraceptive services from organized family planning clinics, 38.6% of those at risk and in need. Looking at this broad picture of a large unmet health need, we need only to narrow our focus to get a clear picture of that protion of the minority community located in urban areas and headed by a single parent.

For the women mentioned above, the problem is basic--they don't have access to a core set of facts and services, an environment that supports prevention, the extra measure of counseling and follow up from a caring professional that can mean the difference between opportunity and an unwanted or unintended pregnancy. If a woman has the ability to space between pregnancies, it certainly enhances her health, the child's health and the family.

Cost is one barrier. These women have no insurance, Medicaid or adequate income to pay for quality preventive health care. Culture and the environment are other barriers. We live in a society that promotes sex, but bars inmformation about handling it responsibly, and scares us about birth control methods that are safe and effective for most people. These facts are true for all women whether they are of majority age or not. And the fact for society is that for every one dollar spent on family planning taxpayers save $4.40 on other social welfare costs.

In 1989, Planned Parenthood, Greater Camden Area provided medical services for 5,077 individual women in Camden County. 2,826 of these women live in Camden City. As proud as we are of our fifty plus years of services, these figures reflect that more women need to be reached. And the bottom line is that more funding needs to be appropriated for family planning services, for family life and AIDS education in our schools. That is the message that we implore you to take back to Trenton.

I am leaving a packet of information about the wide array of programs and services offered by our affiliate. Time will not allow me to cover these programs indepth. Please read the materials and you will get a picture of what we do and what we could do if additional government funding is available. Thank you.

JK/az

TRANSCRIPT OF TESTIMONY GIVEN AT CODEY HEARINGS BY:

Ms. Kathy Freudenberg
Director of Special Projects
Gloucester County Educational Services Commission
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My name is Kathy Freudenberg, and I am employed by the Gloucester County Educational Services Commission as Director of Special Projects. Our agency operates two regional migrant child education projects covering all of Burlington, Camden, Gloucester, Salem and Atlantic counties. I have worked in migrant education for over 12 years, and I am here today to speak to you about migrant workers, a unique and sometimes forgotten minority in our Garden State of New Jersey.

The migrant worker represents an important link in the food production chain of our state. These seasonal laborers help the farmers to plant, cultivate and harvest a variety of agricultural products, supplying our tables abundantly with the fruits and vegetables for which New Jersey is well known. It is ironic, though, that while migrant workers help to provide us with healthy, nutritious foods, as a group they have significantly greater health problems than the general population. For example:

* The infant mortality rate is up to 25% higher than the national average.

* The death rate from influenza and pneumonia is 20% higher than the national average, and deaths from tuberculosis and other communicable diseases are 25 times higher.

* The hospitalization rate from accidents is 50% higher than the national average.

* Parasitic infections afflict migrant adults and children an average of 20 times more than the general population.

According to a study of the National Rural Health Care Association on the occupational health of migrant and seasonal farmworkers, the health problems most frequently reported at migrant health clinics include dermatitis, injuries, respiratory problems, musculoskeletal ailments (especially back pain), eye problems, gastrointestinal problems, hypertension, and diabetes. Many of these ailments can be linked to the migrant lifestyle--be it overcrowded housing conditions, poor sanitation, exposure to pesticides, improper nutrition, or farm implement accidents.

Many of the migrant workers who travel into and through our state bring their most valued possession with them--their children. The children suffer from the same types of health problems, and in fact many conditions are exacerbated by lack of adequate pre and postnatal care and follow-up. Poor health, coupled with a transient lifestyle and irregular school attendance, often result in poor academic performance by migrant children. The most recent statistics indicate that fewer than half of them graduate from high school.

Our migrant education program has made great strides in meeting the special educational needs of those children, but we are very limited in what we can do to meet their health care needs. The fact is, most migrant families cannot afford routine health care. We do our best to link them with other agencies and health care providers, but we have very little funding with which to pay directly for services. Poverty, lack of insurance, and even language differences can greatly curtail their access to health care. One concern we see repeatedly with migrant families is that even if they are Medicaid-eligible, they often cannot find providers who will accept Medicaid patients. Generally, migrant families end up seeking treatment only for acute problems rather than chronic conditions or preventive services.

And so I appeal to you today not to overlook the migrant family as a minority in great need. In fact, migrants represent a minority within most other minority groups. The traditional minorities we usually think of, such as Blacks, Hispanics, Asians, and Haitians, can all be found within the migrant population. Better than 70% of our migrant population in New Jersey is Hispanic.

Migrant families are among the most underprivileged, underrepresented segments of our society, even though they work hard and are an integral part of the economic machinery that has made American agriculture successful. They present us with a serious health care challenge, and they must not be forgotten or excluded from any plan concerning minority health issues in New Jersey.

Sources: "Migrant Education: A Consolidated View," prepared by the Interstate Migrant Education Council, a special project of the Education Commission of the States, July 1987

"Health and Supportive Services for Migrant Students in New Jersey," a publication of the New Jersey State Department of Education, Division of Compensatory/Bilingual Education

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SENATE INSTITUTIONS, HEALTH & WELFARE COMMITTEE

TESTIMONY ON THE CREATION OF AN OFFICE OF MINORITY HEALTH WITHIN THE STATE DEPARTMENT OF HEALTH

I would like to thank you for allowing me the opportunity to comment on the creation of an Office of Minority Health as proposed in Senate Bill 2063. Since 1984, the Commission on Cancer Research has been seriously concerned about the discrepency in cancer rates between Whites and minorities. We have made this issue a major priority for the Commission and have awarded over $500,000 in recent years to provide seed money to establish a research base so that we might be better able to find answers to this most alarming problem. In addition, we have formed a special advisory committee including representatives from DOH, DEP, UMDNJ, Rutgers, as well as hospitals, business, and voluntary health agencies, so that we might better coordinate our efforts. I think our experience may be helpful as you strive to make this worthwhile concept a success.

First, I must state that this is a complex issue which requires a coordinated statewide effort if it is ever to be solved. It has been our experience that as long as a neutral umbrella is provided most agencies welcome the opportunity to work together to solve this problem.

However, coordination alone is not enough. Any serious effort to reduce the gap in health status between White and minority populations in the State will require substantial funding. In the experience of the Commission, innovative programs require nuturing. We have funded four research projects on differences in cancer rates in economically disadvantaged populations. We had expected to provide seed grants so that the projects could attract other funding sources. However, it is clear to us now that a major investment is required in order to truly establish the type of research infrastructure essential to understand why blacks die from cancer 26% more often than whites in New Jersey. Unfortunately, our resources have been seriously reduced and the progress we have made towards this goal has been threatened.

If New Jersey is serious about closing the gap between White and minority populations, it will need to make the resources available so that new programs can prosper and flourish. The Commission on Cancer Research applauds Senator Codey for his actions on this most pressing issue. It supports the creation of this office and promises to continue to do all it can so that the alarming differences in cancer rates between minority and white populations in New Jersey can be reversed.

Frederick B. Cohen, M.D.
Chairman

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TESTIMONY BY HON. ROBERT E. ANDREWS, CAMDEN COUNTY FREEHOLDER DIRECTOR, AT A PUBLIC HEARING SPONSORED BY THE SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE, AT UMDNJ-CAMDEN, TUESDAY, MARCH 20, 1990, CONCERNING SENATE BILL S-2063.

I would like to thank the Committee for the opportunity to speak concerning Senate Bill S-2063.

At the completion of a recent minority health care report, the Department of Health recommended increased grant assistance to community-based health groups. Accordingly, Senator Codey introduced S-2063, which will establish an Office of Minority Health within the State Health Department.

An Office for Minority Health will provide Camden County residents with a valuable opportunity to improve their health care and related health services. The Office may assist in forming answers to many serious health concerns in and around the County.

For example, the Camden County Health Department faces a severe infant mortality rate in Camden City. Infant mortality in the City has risen to 16.3 deaths per 1000 residents. Lack of prenatal care, nutrition problems, drug and alcohol abuse and inadequate family planning contribute to the birth of premature and unhealth babies. The County Health Mothers/Healthy Babies program helps considerably, but a chronic lack of revenue lessens the program's impact.

The Office for Minority Health may serve to increase public awareness of other serious health problems, such as:

* Cervical and Breast Cancer.

The program may assist in promoting cancer awareness and methods of early detection. By diagnosing the disease in its early stages, treatment can be initiated as early as possible, increasing the chances for leading a normal life.

- more -

* Lead poisoning.

It is important for parents to understand the dangers of lead poisoning and its symptoms. An Office on Minority Health could help to publicize such symptoms, to help parents determine if their children have come into contact with lead-based products, especially paint.

* Health Care Selections.

An Office for Minority Health may assist families in the selection of proper primary medical and health care. The Office may become part of the local community and establish working relationships with area firms as a referral service.

* AIDS Awareness & Outreach.

Testing has revealed that minorities are at a greater risk to contract AIDS. The Office may serve as a front-line outlet for testing, risk assessment, behavior modification, counseling and education.

* County Health Department Coordination.

An Office for Minority Health may provide coordination services with County health programs providing vision screening, diabetes screening, cardiovascular disease testing, hypertension screening, alcohol and substance abuse referrals and other related services.

An Office for Minority Health will create new ties to many different communities throughout Camden County. These ties will improve health care and promote health prevention. Accordingly, I would urge the Committee to support the passage of Senate Bill S-2063 and pass a favorable recommendation to the full Senate.

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FACT SHEET

DIABETES PREVALENCE AMONG BLACKS

The U.S. Department of Health and Human Services Statistics reports higher diabetes rates in blacks across all sociodemographic parameters.

- The prevalance of diabetes (diagnosed and undiagnosed) in black Americans is 9.9 percent of the population. Diagnosed cases have increased fourfold in the last 20 years from an estimated 228,000 in 1963 to approximately 1 million in 1985.

- The rate of non-insulin-dependent diabetes mellitus (type II) in blacks is 50 to 60 percent higher than in whites.

- Considered "epidemic" in black women, one in four black women older than 55 has diabetes -- double the rate in white women.

- Blacks with diabetes experience higher rates of at least three of the serious complications of the disease; blindness, amputation, and end-stage renal disease.

- Prevalence of diabetes for blacks is highest among women, older people, less educated, the formerly married, persons living alone and persons in families with low incomes.

- Compared with the general population, blacks have a higher prevalence of obesity -- a strong risk factor for type II diabetes. Of all Americans diagnosed as having type II diabetes, 82 percent of adult black women are obese compared with 62 percent of white women. Among men, 45 percent of blacks are obese compared with 39 percent of whites.

- Blacks tend to have less access to financial, social, health, and educational resources that would help improve their health status and health awareness.

- Studies on diabetes education demonstrate the need to develop materials and approaches that are culturally sensitive and relevant to reach this audience.

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FACT SHEET

DIABETES PREVALENCE AMONG HISPANICS

Hispanics currently comprise the second largest minority in the United States, with a population estimated at almost 19 million in 1988. By the year 2000, hispanics are projected to be the largest minority in the United States with a population of 30 million.

- Hispanics are 3 times more likely to develop diabetes than a non-latin person.
- Compared with a rate of 6.1 percent in whites, the prevalence of diabetes is 13.2 percent in Puerto Ricans, 12.6 percent in Mexican-Americans and 9.2 percent in Cubans.
- Half of all Mexican-Americans have non-insulin-dependent diabetes mellitus (type II) or have an immediate family member with it. Insulin-dependent diabetes (type I) accounts for only 2 to 5 percent of all hispanic cases.
- Studies report that hispanics with diagnosed diabetes have higher rates of complications including severe retinopathy (eye disease that can lead to blindness), end-stage renal disease, severe high blood sugar and higher rates of gestational diabetes (during pregnancy) and resulting birth complications.
- Texas, a state with one of the largest populations of Mexican-Americans, reported 52,906 residents as diagnosed with diabetes in 1986. Of these, 72 percent or 38,000 were Mexican-American.
- Low income, lack of information, and the inability to understand English remain the largest obstacles to overcome in diabetes detection and awareness for the latin community. Currently, 25 to 30 percent of latins do not understand English (or their physicians' instructions).

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TESTIMONY FOR PUBLIC HEARING
ON
SENATE INSTITUTIONS HEALTH AND WELFARE COMMITTEE
ON
SENATE BILL NO. 2063:

'Establishing an Office of Minority Health'

Senator Cody
c/o Eleanor H. Seel
Section-Chief
Human Services Health and Senior Citizens'
State House Annex
CN 068
Trenton, New Jersey 08625

Dear Senator and Members of the Committee:

I apologize for not being able to be at this hearing, as I also missed the one by a hair in Newark this month, and did want my comments read into the record.

Just to introduce myself, my name is Thomas R. Ortiz, M.D., a Fellow of the American Academy of Family Physicians and a Family Practitioner in Newark, New Jersey. I represent myself and my organization, the Boricua Health Organization of New Jersey, which is a group of Hispanic healthcare workers and consumers who are concerned with the quality of care provided to the Hispanic community in New Jersey. I, myself, was born and raised in New Jersey, am of Puerto Rican decent, and I have lived in the Greater Newark area for the past fifteen (15) years. I am a graduate and faculty member of the New Jersey Medical School - UMDNJ. I presently am in private practice in North Newark, and have been there for the past seven (7) years. In fact, I am the only Board Certified Family Physician now practicing in the entire City of Newark, the state's largest city.

I might also mention that I am on the faculty of the only state sponsored medical school in the country which does not have an official Department of Family Medicine operating and teaching the curriculum of Family Medicine to medical students and residents.

I identify the number one problem of the minority people, particularly the Hispanic minorities, as being the lack of access to quality primary care. With lack of access, people go undiagnosed in current diseases such as Diabetes, Hypertension, Cancer, take their toll on the population, as these diseases go unmodified, unchecked, and untreated due to lack of professional advice, with regard to health maintenance and prevention, other preventable and curable diseases go untreated, as well as the poor dietary habits of the minority community- again, due to ignorance of a proper nutrition. People do not seek proper pre-natal care in the early stage of their pregnancy, and therefore, there is a higher rate of infant mortality and poor outcomes in the delivery room.

There is lack of access to psychiatric counselling, and therefore chronic behavioral disorders, particularly in the children, go unrecognized, undiagnosed, and untreated, and therefore creating a whole generation of mentally impaired, socially impaired, and deviant individuals, whom are indulging in drug abuse, alcoholism, smoking, and other forms of self-destructive behaviors.

The second problem is that overwhelmingly, our population, particularly Hispanics, are employed in dangerous occupations. In other words, they are being exposed, on a daily basis, to toxins, fumes, gases, and are suffering the consequences of industrial accidents at a very high rates. Therefore, you will see an increasing number of bronchial asthmatics, people with respiratory problems and respiratory cancers, chronic allergies and infections, causing loss of time from work, and inability to provide for their families. Additionally, most of these workers who work in these dangerous areas go uninsured or underinsured, and therefore, never receive the proper rehabilitative care through a workman's compensation program in this state, which is only favored administrators and corrupt physicians who are not interested in the welfare of the particular community. They continue to abuse and take advantage of these individuals who undergo these accidents, without providing the proper rehabilitative surgical or physical therapy.

Third, there is an overwhelming lack of healthcare education at a level that reaches the individual and the target population about which we are speaking. Therefore, we have epidemics such as AIDS, which overwhelmingly effects Hispanic women, and therefore, a large number of children.

To me, Mr. Senator, all of this boils down to a need for more minorities in healthcare positions, acutely aware and sensitive to cultural nuances, with bilingual ability- from healthcare workers and administrators, to all levels of professionals, including physicians. Each year, we admit lower and lower numbers of minority students to medical school in New Jersey, due to a shrinking pool, as they say. And why?... Because the expensive college and medical school is in excess of $100,000.,

with people graduating with these kinds of debts as medical students, how can a poor minority family afford to send a child to school? This is a major obstacle for students, and they cannot therefore focus on their educational goals, and are not allowed the freedom to expand their minds, and develop them into high professional levels.

In New Jersey Medical School, those who get in, are presently not even exposed to the field of Family Medicine- the most sought-after, cost-effective type of physician today in this country. The Family Doctor, of which all areas, particularly the urban areas are in desperate need.

I presently serve as the Chairman of the Minority Affairs Committee of the New Jersey Academy of Family Physicians. In testimony to my Board, we have developed policy that states that we agree that the number one obstacle to the improvement of healthcare for the minority population in this state is directly related to the lack of minority Family Physicians in the state. This organization has met with and actually pressured the New Jersey Medical School Administration and Faculty to approve the development of the department. All we need now is the state's commitment to funding for this much-required department. Because of the lack of a Department of Family Medicine, the minority populations in this state will continue to suffer with this lack of good primary care, who becomes the advocate and the leader of the healthcare team to meet all of the needs of the minority community.

Fourth, the lack of affordable healthcare insurance. With the emergence of HMO policies, we have seen some 'dent' and progress made in attempt to provide access to healthcare. However, regulators, restrictions, paperwork, and low pay has not attracted quality physicians to participate with these HMO's. With regard to the crisis of insurance, the insurance can only get worse- especially with the present plan of Governor Florio, to shift the cost of accident-related injuries into the healthcare insurance carriers. We are having a tough time as it is, when attempting to collect for present medically necessary office visits and procedures, to now put a further burden on healthcare carriers on these types of injuries that require intense rehabilitative services. This means that more individuals will go untreated and will become disabled, and thus not allowing them to provide for their families and pay taxes to the state.

At present, there is no control over the insurance industry, and all populations are being abused and ripped-off. If all of the populations are being abused and ripped-off, then who gets the brunt of it, but the ignorant, the meek, and the poor- and thereby become the second-class citizen of the healthcare system. The doctors that are attempting to service and provide quality primary care suffer with them. Thus, there is never an improvement of the system.

My recommendations for a new Director of Minority Health Care Affairs would be that this person should be an experienced healthcare professional, with good knowledge of community affairs, the needs of all minority populations- Black and Hispanic.

There needs to be a demonstrated support for radical changes in the healthcare delivery systems. They must have the power to make recommendations directly to the State Legislature, the Commissioner of Health, the Commissioner of Higher Education, and the Governor, himself. There needs to be an integration of an advisory council composed of minority people, equally representative of all groups- including nurses, the home-health agencies, M.D.'s, D.O.'s, and more importantly, the health care consumers, young mothers with children, yuppies, elderly people with chronic illnesses should be represented on such an advisory committee.

This Director should represent the needs of all minority groups, which commonly overlap but do not, necessarily. S/he must deal with the mal-distribution of the healthcare worker in the state, by identifying the populations of greatest need and provide incentives for practitioners to go into these areas, such as loan-forgiveness programs, practice opportunities, financial incentives from the state, increased Medicaid payments, and tax incentives.

There must be a development of a 'grass-roots', culturally/linguistically sensitive approach to education in the areas of prevention, particularly with regards to AIDS, which is the only way to presently eradicate the disease and decrease the spread. As you know, there is no foreseeable cure, and no foreseeable vaccine. Prevention is the only way, and we have to find ways to do it.

The director must work as the facilitator- between the insurance industry, regulators, industry and the legislation to come to grips with the costs and the types of policies that are offered to deal with the uninsured population, to develop strategies and models for more cost-effective, ambulatory, comprehensive delivery systems that are accessible and affordable.

Finally, there must be a conscious effort for monitoring systems, whereby N.J. Medical School is helped in the development in the Department of Family Practice, and in the administration of the medical school, with regards to increasing the numbers of the minority students.

These are just a few of the recommendations for a job description, which would obviously be a tremendous undertaking, but in my opinion, is absolutely necessary in order to achieve the goal of improving the healthcare needs of the minority citizens of the state.

I join with my colleagues in the Boricua Health Organization and with my patients in the North Ward of Newark, in lending our strong support to the establishment to this Office of Minority Affairs, and the passage of Senate Bill Number 2063.

Thank you for your time and consideration.

Sincerely yours,

Thomas R. Ortiz, M.D., FAAFP

Medical Director,
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Associate Professor of Medicine,
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