



**DEMOGRAPHICS, DIVERSITY AND ACCOUNTABILITY:
THE HEALTH OF NEW JERSEY'S COMMUNITIES IN 1999**

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ISSUE: The demographic make-up of America is undergoing significant changes and on a microcosmic level, New Jersey is experiencing similar changes. Recent census data indicates that with the growth of global immigration, a basic reconfiguration of American society is taking place, shifting from a predominantly bi-racial society to one characterized by multi-racial and multi-ethnic diversity. These demographic changes create significant challenges to policymakers in the areas of social, health, cultural and economic programs and policies. Specifically regarding health care and health care policy, what level of accountability is necessary to ensure that the goal of health care – i.e., to improve health status and provide access to appropriate and quality health care services – is maintained for all populations?

INTRODUCTION: DIVERSITY - AMERICA'S LEGACY

Look into the face of professional golfer Tiger Woods, and you see America; look into the face of Supreme Court Justice Ruth Bader Ginsburg, and you see America. The diversity of our racial and ethnic makeup as individuals, which forms and informs the fabric of our collective identity, is apparent. Statistically, Native Americans -- the indigenous people of this country -- currently comprise only about one percent of the total population.

Diversity in America is represented by the demographic shifts in the racial and ethnic composition of our society.¹ "Diversity, whether racial, multiracial or ethnic, is rapidly characterizing the United States," creating a racial and ethnic reconfiguration of American society (Matherlee and Burke, 1997, at 3). A reconfiguration which is not limited to the urban Northeast, or southern California alone; even in traditionally homogenous rural areas, there are new enclaves of residents from various countries, such as Vietnam, Mexico and Africa.

THE NUMBERS – WHO ARE WE COUNTING?

Beginning in 1790, when the U.S. government began a census count in order to collect demographic data about its citizens, census-taking efforts have been affected by complex factors influencing the accuracy, validity, and reliability of the data collected. Even in light of these known limitations, census collation and data analysis have long been used to inform decision-making in the arena of public policy. At the outset, this writer acknowledges the inherent problems that characterize racial identification and classification, and further, the range of issues which surround research in health status, race, and socioeconomic status. Although a discussion of these specific factors is outside the scope of this issue brief, reference is made to various articles that have offered extensive treatment of the subject.²

In many ways, New Jersey's demographic profile at the end of the century parallels that of the nation along many dimensions, including racial composition, age-related demographics, unemployment rates and percentages of those who are not covered by health insurance (see Appendix, Table 1, "State and National Sociodemographic, Economic, and Health Characteristics")³. According to 1998 Census Bureau projections, by 2050 the composition of American society will shift to 50 percent white (from 73 percent in 1998), 25 percent Hispanic (the second largest ethnic group) and 14 percent African-American (a slight increase from 12 percent in 1998). The percentage of the Asian population is projected to double from 4 percent to 8 percent, with the Native American population to remain relatively stable at about 1 percent. Put in an historical context, between 1981 and 1991, there was a 90 percent increase in the Asian population, a 50 percent increase in individuals of Hispanic origin; a 43 percent increase in Native Americans, Eskimos and Aleuts; a 15 percent increase in the African-American population, and a 4 percent increase in the white non-Hispanic population (U.S. Bureau of the Census, 1997).⁴

"Immigration to the U.S. has acquired a demographic and public policy significance not seen since the early decades of the 1900s" (Espenshade, 1997). In 1995, an estimated 23 million foreign-born were residing in the U.S., comprising 8.8 percent of the U.S. population (Espenshade, citing Hansen, 1996). In 1997, that number increased to 25.8 million, or nearly one in ten U.S. residents (Chesanow, 1998; U.S. Bureau of the Census, 1998). By comparison, from the latter part of 19th century to 1920 (the period of highest immigration activity in this country), the proportion of foreign-born fell between 12 and 15 percent (Espenshade, 1997).

HEALTH STATUS – A LONG HISTORY OF RACIAL AND ETHNIC DISPARITY

In responding to the fall 1998 Census Bureau Report that the number of Hispanic children under the age of 18 has surpassed the number of African-American children of the same age, a researcher from Tomas Rivera Policy Institute, in California, commented that "as the turn of the century approaches, we (policymakers) are going to have to grapple with the issue of moving from a biracial to a multiethnic society" (*NASW News*, November 1998). "Grappling" with this issue carries the challenge of addressing new issues, as well as old; in particular, the issue in health care of racial and ethnic health disparities.

The true overall "health" of a population can be measured only by the health status of all groups that comprise the whole. Research over time indicates that race and ethnicity correlate with persistent and often increasing health disparities among racial and ethnic minorities. As part of its *Healthy People 2010* objectives, the U.S. Department of Health and Human Services has called on policymakers to appreciate the significance of these disparities in light of the projected demographic changes in this country. "Groups currently experiencing poorer health status are expected to grow as a proportion of the total U.S. population; therefore, the future health of America as a whole will be influenced substantially by our success in improving the health of these racial and ethnic minorities" (Department of Health and Human Services *Fact Sheet on Healthy People 2010 Objectives*, 1998).

An overview of selected maternal and child health data serves to illustrate the scope of such health status disparities. Table 2 (below) offers a look at some comparative natality statistics for various racial groups for New Jersey and the nation. Health status is not static; compromised health in neonates and infant children will have an effect on the overall health status of the individual throughout the life cycle.

Table 2

State and National Birth Statistics		
	New Jersey	United States
Number of births	113,902	3,914,953
Birth rate, all women, per 1,000 population	14.3	14.8
Birth rate, 15-19 years, per 1,000 females	38.0	56.8
Live births to women < 20 years, %	7.7	12.9
Live births to unmarried mothers, by race/ethnicity, %		
Total	27.9	32.4
White	20.5	25.7
African-American	66.8	69.8
Hispanic	49.5	40.9
Low birth weight infants, by race/ethnicity, %		
Total	7.6	7.4
White	6.4	6.3
African-American	13.0	13.0
Hispanic	7.1	6.3
Women receiving late or no prenatal care, by race, %		
Total	4.2	4.2
White	2.8	3.5
African-American	10.4	7.6

Sources: Jacobs Institute of Women's Health (1998), National Center for Health Statistics (1996)
(All data is for 1996/1997)

Health policy researcher Sara Rosenbaum points out that the evolution of the nation's health care system from fee-for-service to managed care holds both promise and challenges for persons who have in the past faced major health care barriers (Rosenbaum et al, 1997).⁵ Although the integration of the financing and service delivery of health care and the implementation of preventative health care "potentially represents a major step forward in basic health care access...managed care also has the potential to continue past discriminatory practices in new forms" (ibid at 100).

A recent article in *American Medical News* (a publication of the American Medical Association), focuses on "managing diversity" by addressing the Health Care Financing Administration's (HCFA) revision of its Medicaid managed care rules (Kim, 1998). In September 1998, HCFA proposed new regulations mandating that states establish cultural competence guidelines for Medicaid managed care plans. Within the context of the proposed new rules, states would have the authority to define cultural competence.

CULTURAL DIVERSITY AND CULTURAL COMPETENCY

"Culture is not like a coat. You cannot take off your own culture when you leave your country and put on someone else's. Culture is woven into each of us as into a piece of cloth. You pull out and discard the vital threads of culture, the whole cloth falls apart."

-- A researcher in multiracial, multi-ethnic health care issues, in describing the effects of moving to a new country and entering a new culture -- with its established institutions and behaviors (Schott and Henley, 1996).

Just as our culture affects our views on raising children and how we dress, it has a direct impact on how we view health and our beliefs about it, such as where and when to seek treatment for illness. Specific cultural and social meanings shape the health and illness belief systems of all individuals (Julia, 1995). In their book on multi-ethnic, multi-cultural health care, Schott and Henley (1996) point out the types of differences that exist in cultures where Western medicine dominates by using the example of how low blood pressure is viewed in much of Europe as a dangerous condition requiring aggressive treatments. In contrast, in the U.S. and Great Britain, people with low blood pressure are considered healthier and a better insurance risk than those with high blood pressure. Diversity has a prismatic quality to its nature; within racially and ethnically diverse communities there exist social and cultural differences, conflicts and similarities between and among groups and sub-groups. These differences are just the "tip of the iceberg" regarding the various types of perceptions of health and illness among the various groups, especially those in which Western medicine is not the dominant method for diagnosing or treating illnesses.

Barriers to health care services for members of individual racial and ethnic minorities also emerge at the point when individuals interface with the health care system and its component services.

The inset Glossary defines some of the key terms used in planning and implementing a culturally competent health care practice. One example is connected to language barriers, i.e., when different languages are spoken and concise communication about diagnosis or medications may be compromised. Another example relates to cultural barriers, such as the client's comprehension of the "appropriate behavior" when a physician appointment may have to be rescheduled because of a loss in transportation or a change in child care schedules. The importance of medical interpreters, community health workers and health promoters is critical in "bridging" these potential gaps in health care access

GLOSSARY

1. **culture:** *A specific set of social, educational, religious and professional behaviors, practices and values that individuals learn and adhere to while participating in or out of groups they interact with.*
2. **cultural competency:** *A competency based on the premise of respect for individuals and cultural differences, and an implementation of a trust-promoting method of inquiry.*
3. **community interpreter service pool:** *A pool of trained and qualified interpreters providing interpreter services in several languages to a number of hospitals, private practices, and other local health and social services agencies.*
4. **interpretation:** *The act of receiving a message in one language and sending exactly the same message in another language through a verbal exchange. Interpretation also includes body language messages.*
5. **triadic interview:** *An encounter that occurs in a health care setting between a patient and a provider who do not share the same language and a bilingual medical interpreter who speaks both the patient's and the provider's language.*

Health policy analysts Karen Matherlee and Natalie Burke, writing on cultural diversity and health care, point to the comments of a feathered character from the cartoon strip "Shoe" as a symbol of American's "melting pot" (1997). In the story-line, the character asked how he should indicate "race and/or national origin" for a school form; his father "was red, his mother part-yellow and part-brown, one grandfather was black and orange and the other was blue and white, while both grandmothers were half-gray and half-green. So what was he?" The response: "That would make you American" (ibid.). Their research focused on cultural competency in a managed care environment, and they acknowledged that: "the pressure on the 'majority' health culture has come from all sides" (Matherlee and Burke, 1997). Consequently, it is critical for policymakers in federal and state government, purchasers and providers of health care services to become proactively involved in monitoring the health needs of ethnic and racial groups and addressing the issues inherent in them (ibid.). As one physician group explains it, the establishment of cultural competency skills on a policy level and on a practice level is an ongoing and interactive process of education, research, re-learning and dialogue. This process informs on both a microcosmic level -- through the education of culturally competent health care providers and their application of these skills in their practice of health care -- and on a macrocosmic level, through the development and implementation of culturally sensitive programs and policies in both the public and private sectors (American College of Obstetricians and Gynecologists, *Committee Opinion*, 1998).

Cultural awareness and cultural competence have been identified by the Association of American Medical Colleges as essential skills for providing quality health care to a diverse patient population (*Robert Wood Johnson Medicine*, 1998). The Center for Healthy Families and Cultural Diversity at the Robert Wood Johnson Medical School reports that applying culturally competent skills in dealing with patients "can make the difference between adherence and non-adherence, with consequences for not only the patient's health, but for the cost of treating the patient. [These skills] include four main components: cultural awareness, cultural knowledge, cultural skills and the ability to deal with different types of interpersonal encounters" (*Robert Wood Johnson Medicine*, 1998).

At the individual state level, there is wide variation among the states as to their level of responsiveness to the health care and health policy issues raised by both racial and ethnic demographic changes. Those states with significant numbers of minority and ethnically diverse populations, such as California and New York, have been more responsive than other states. Massachusetts is another state -- through its Office of Refugees and Immigrant Health and its initiatives to legislatively mandate cultural competency standards -- which has developed innovative outreach programs in efforts to "balance" disparities in health care among diverse populations (Matherlee and Burke, 1997; NCLS Legislative Tracking Service, 1999).

FEDERAL INITIATIVES

At the federal level of government, the Department of Health and Human Services has a number of agency offices that address issues related to minority health, including the Office for Civil Rights (Civil Rights Act of 1964); the Office of Minority Health; and the Health Resources and Services Administration (HRSA).

One primary objective set forth by the U.S. Department of Health and Human Services in its *Healthy People 2010* initiative (the Department's public health promotion and disease prevention "blueprint") is to reduce health disparity among racial and ethnic groups in six areas of health status. Gaps in health access and outcomes have been identified between racial and ethnic populations and white Americans in the following six health categories:

- Infant Mortality
- Cancer Screening and Management
- Cardiovascular Disease
- Diabetes
- HIV/AIDS infection rates⁶
- Child and Adult Immunization⁷

In February 1998, President Clinton announced his goal to eliminate these disparities in health outcomes and access as part of his "One America" Initiative on Race. *Healthy People 2010* activities that aim at eliminating racial and ethnic disparities in health cut across several disciplines, including data collection and standardization (in order to identify high risk populations and monitor the effectiveness of interventions in an accurate manner); the development of research tools and projects; strategies to improve access to health care and the development of culturally sensitive and appropriate prevention and intervention health services.

One of the Initiative's 1999 activities is the conducting of regional workshops focusing on "Decreasing the Gap: Developing a Research Agenda on Socioeconomic Status, Environmental Exposures and Health Disparities." Workshop goals will include the design of action plans to lessen adverse health impact of hazardous environmental exposures on populations of lower socioeconomic status and the development of appropriate research tools to assess and monitor these populations.

Healthy People 2010 will benefit from the new standards for racial and ethnic data that were promulgated through the federal Office of Management and Budget's Directive No. 15 in October 1997. While the new standards represent the efforts of researchers over many years to address limitations in data collection and analysis for these groups, data analysis and appropriate utilization of data still pose many problems. The Office of Minority Health at the federal level cautions that racial and ethnic data "are descriptive and do not get at the underlying reasons behind disparities. Additional information on socioeconomic status, program participation, behavioral risk factors, cultural differences...and the effects of racism and discrimination are needed" (*Closing the Gap*, October 1998).

NEW JERSEY – RESPONSES TO CULTURAL DIVERSITY

As a fitting symbol of New Jersey's changing demographics, the state prevailed last May (1998) in a Supreme Court case in holding claim to Ellis Island, the nation's gateway for its newly arrived immigrants. In December 1998, the U.S. Census Bureau reported that New Jersey ranked 25th in the rate of population growth from July 1997 to July 1998, reaching a population of 8,115,011 (a growth rate of 0.7 percent). A closer look at the general statistics shows that New Jersey registered a net loss of 0.5 percent in domestic migration, i.e., more people left for other states than arrived from them (*The Star-Ledger*, December 31, 1998). However, international migration to New Jersey grew by 0.7 percent, placing New Jersey behind California, the District of Columbia, and New York as a prominent place for international "newcomers."⁸

New Jersey's immigrant population is different from those in California and Texas for several reasons: they are heterogeneous in origin and consist of both recent and longer-term residents. In this way, is more like the immigrant populations in New York, Massachusetts and Illinois (Espenshade, 1997). In a broad picture, they comprise a heterogeneous racial and ethnic mix because their origins can be traced to all parts of the world.

While New Jersey has a high level of non-citizen immigrants, it differs from other high-immigration states in that no one nationality dominates in its population (Urban Institute, 1998). For example, 14.4 percent of our state's population is comprised of non-citizen immigrants, yet the national average is 9.3 percent. California leads the states in this category, followed by New York, Florida, Texas and New Jersey. New Jersey, however, is the state with the highest number of its immigrants naturalized, at 48.7 percent (Espenshade, 1997). Almost 60 percent of New Jersey's foreign-born are white; 30 percent reported that they are of Hispanic origin, 21 percent are Asian and 10 percent are African-American (ibid.).

The Department of Health and Senior Services in New Jersey addresses health issues related to racial and ethnic minorities through activities in its Office of Local Public Health and its Office of Minority Health. Public health objectives are in compliance with those set forth at the federal level through its *Healthy People 2000* and *Healthy People 2010* initiatives. In New Jersey, its *Healthy New Jersey 2000 Update* was released in 1996 and its second revised update is due out in March 1999. (Reference is made to New Jersey Policy Forums *Issue Briefs* on Public Health in New Jersey, dated June 21 and July 31, 1996.)

The Office of Minority Health was established in New Jersey in 1992 (under N.J.S.A 26:2-160; PL 1991, c.401). As part of its charge, it develops activities to address priority areas and issues related to *Healthy People 2000* and *2010* objectives. One *Healthy People 2000* objective focuses on the health and medical problems associated with asthma, which is the leading chronic disease among children and has a disproportionate toll among racial and ethnic minorities. Nationally, the death toll for African-Americans is three times as high as it is for whites. The national *Healthy People 2000* objective is to reduce asthma hospitalizations for African-Americans and other non-whites to no more than 26.5 per 10,000 population, based on a 1987 baseline of 33.4 per 10,000 population. New Jersey's Office of Minority Health was recently awarded a \$30,000 grant by the Public Health Service, Region II, to launch a project aimed at increasing asthma awareness through outreach, education and training targeting ethnic and racial minorities in Newark, New Brunswick and Trenton.

Assembly Joint Resolution No. 52 (September 17, 1998) marked that September 1998 was New Jersey's Sixth Annual Observance of "Minority Health Month" (Assemblyman Conaway and Assemblyman Blee). In addressing some of the disparities associated with the health status of racial and ethnic minorities, the joint resolution noted that "many analysts assert that the major disparities between African-Americans and other in regard to morbidity and mortality arise less from inherent differences between races than from attitudes toward the races and the provision of unequal health care." As the September 1997 New Jersey Blue Ribbon Panel Report on Black Infant Mortality recognized: "In the United States and in New Jersey, a black infant is more than two times as likely to die before his or her first birthday than a white infant." Various outreach activities and events during Minority Health Month focus on raising awareness of the complex issues amongst public and private sector entities throughout the state.

In the area of cultural competency in health care services and health care education, the Department of Family Medicine at the Robert Wood Johnson Medical School, is both a nationally recognized program and a lead player in New Jersey in promoting cultural competence. Through its Multicultural Education Program and Center for Healthy Families and Cultural Diversity, it offers educational workshops on developing clinical and organizational cultural competence (*Robert Wood Johnson Medicine*, 1998).

RELATED POLICY ISSUES:

Minority Physician Workforce

Although managed health plans in both the public and private sectors have advanced enrollment of racial and ethnic minorities, there is a severe shortage of minority physicians to provide services to these populations in their communities. In the case of California, many managed health plans launched aggressive and successful enrollment campaigns to attract minority patients; however, there was no infrastructure of representative physicians to serve them (Kim, 1999). These shortages hold true across all health professional groups, including nurses, social workers, community health promoters and health educators.

The current shortage in African-American physicians serves as one example of this pervasive problem. These shortages are being particularly affected by changes in the health care and employment arenas: the rise of managed health plans, a reduction in the number of training slots for new physicians and policy decisions on affirmative action in education and employment (Friday, 1997). Historically, "from the end of slavery to the present day, the pool of African-American doctors has never come close to reflecting the proportion of African-Americans in the U.S. population" (ibid.). In the 1930's, they comprised only 2.7 percent of the country's doctors; and in 1997 (despite decades of affirmative action programs, which are currently under critical assault), they comprised only 3.6 percent of the total. (As a whole, African-American comprise approximately 12 percent of the population.)

In a 1997 paper looking at the physician shortages within all racial and ethnic groups, the question is asked: "Will Minority Physician Supply Meet U.S. Needs?" (Libby et al, 1997). The researchers address the goal of the Council on Graduate Medical Education (COGME) that "one of its highest priorities was that the racial and ethnic composition of the physician population should reflect the overall population's diversity" (ibid.). The goal is based on empirical research findings that "minority providers are more likely to locate their practices in areas with large minority populations, are more likely to care for undeserved populations, and are better able to provide culturally competent care, which is of growing importance as we focus on health promotion and disease prevention strategies" (Ibid; Cantor et al, 1996; Goldsmith et al, 1989). Researchers point out that although a number of public and private organizations have identified racial and ethnic equity in the physician and allied health professional workforce as an issue of high priority, policies designed to address the issue are not unified or consistent. In light of this inconsistency, analysts believe there is a need for public policy action at both state and federal levels to meet the challenges created by these delivery system gaps.

Insurance Coverage for Minority Populations

At the end of 1998, U.S. Bureau of the Census reports indicated that the number of Americans without health insurance coverage increased to 43.4 million, or 16.1 percent. Of this total number, Hispanic Americans had the highest chances of being uninsured -- 34 percent of Hispanics lacked insurance, compared to 21.5 percent of African-Americans and 12 percent of non-Hispanic whites (Fronstin, 1998; *The New York Times*, September 28,

1998).⁹ Table 3, below, which sets forth New Jersey's "Health Insurance by Race" for its residents who are under 65 years of age reflects such disparities.

Table 3

Health Insurance Coverage By Race New Jersey Residents Under 65 Years Of Age 1996					
Race	No Coverage		Coverage		Total
	Number	Percent	Number	Percent	Number
White Non-Hispanic	672,316	14.7	3,894,118	85.3	4,566,434
Black Non-Hispanic	249,728	26.8	683,473	73.2	933,202
Hispanic	270,406	29.6	641,755	70.4	912,162
Other Non-Hispanic	113,170	26.0	321,288	74.0	434,458
Total	1,305,621	19.1	5,540,635	80.9	6,846,255
Source: Current Population Survey of March, 1997 U.S. Bureau of the Census					

In a recent report compiled by the Kaiser Commission on Medicaid and the Uninsured, the researchers analyzed the erosion of employment-based health insurance coverage over time (O'Brien and Feder, 1998). The decrease in coverage is a "widespread phenomena" that is not only limited to low-wage workers; however low-income workers and their families -- "who started out at a disadvantage, with low rates of coverage" -- have experienced the brunt of this trend (ibid. at 11). In examining this trend over time -- from the period of 1979 through 1993 -- employer-provided health insurance coverage fell 6 percent for whites (from 72 percent to 66 percent) and 5 percent for African-Americans (from 66 percent to 61 percent); the most significant drop was experienced by Hispanics, whose coverage decreased from 63 percent to 47 percent, or 16 percent.

CONCLUDING REMARKS

The 18th century philosopher Immanuel Kant once said, in describing one of the defining (and often self-defeating) problems in human nature, "We don't see things as they are, but as we are." At the end of the 20th century, his words have new meaning in a discussion of a starting point in addressing the policy decisions emerging from a "new world" of shifting demographics characterized by racial, ethnic and cultural distinctions and opportunities.

In a piece entitled "Heading into 1999: The View from Three Health Policy Vantage Points," Dr. John Lumpkin (Public Health Director for the state of Illinois; past President of the National Association of State and Territorial Health Officers) was asked by interviewers: "What areas of public health will command the most attention and resources going into the new century?" (*State Health Notes*, December 1998). Lumpkin identified as a key issue: "disparities in health between minority and majority populations . . . ferreting out those inequities will be key to our ability to have an impact upon the health of the population." Meeting the goal of resolving the inequities that have existed throughout our history requires the commitment of resources towards research, education, training and outreach for health promotion and prevention activities. Such a commitment requires a paradigm shift upon which our healthy future is at stake.

POLICY IMPLICATIONS

The issue of language differences as a barrier to accessing health care services is prominent in the area of cultural competency. While a small number of states -- California (which is the lead state in this area), Hawaii, Illinois, Massachusetts, New Jersey, New York and Washington -- have enacted some type of legislation that address cultural competency, efforts at present are not so broad in scope (Matherlee and Burke, 1997).¹⁰ For example, most laws focus on a medical interpreter requirement; in New Jersey, hospitals are required -- as to their ability -- to have interpreters "if 10 percent or more of the residents of its service area speak a language other than English" (ibid.). What is the future of New Jersey's legislative vision to address issues related to cultural competency as its population continues to grow more racially and ethnically diverse?

In what ways can policymakers address the trend of the erosion of employer-sponsored health insurance coverage, the brunt of which is falling most heavily on minority workers? Although Medicaid allows for health insurance protection for low-income families, eligibility for the program is limited to the poorest of the poor, and many low-income working families remain ineligible for coverage, even with Medicaid expansions (O'Brien and Feder, 1998).

One innovative program funded by the Henry J. Kaiser Foundation and the Robert Wood Johnson Foundation is *Opening Doors: A Program to Reduce Sociocultural Barriers in Health Care*. In a report released October 1998 -- *Lessons Learned* -- the program summarized outcomes from several of its funded projects. One lesson on strategies for reducing barriers included the finding that "Lack of respect from health care personnel is a major sociocultural barrier to care" and that both community health workers and interpreters can reduce such barriers (*Health Affairs*, January/February 1999). What level of commitment is there for the education and training of such culturally sensitive health promoters?

One of the fastest-growing components of national health expenditures is prescription drugs: in 1960, prescription drugs accounted for 1.0 percent of total health expenditures (\$2.7 billion) and by 1997, this percentage increased to 7.3 percent (or \$78.9 billion). Many of the health conditions affecting minorities at a disproportionate rate, such as diabetes and heart disease, require consistent medication compliance and monitoring. What level of public sector oversight is required to monitor that those who require these medications will have access to them at an affordable level, especially in a managed care environment?

End-of-life issues -- such as advance directives and living wills -- are prominent for individuals of all races and ethnic backgrounds. However, it remains important to possess cultural awareness and sensitivity regarding discussion about decisions such as when and how to end medical treatment for a terminally ill family member. In what ways do our general policies about end-of-life issues affect those from different cultural backgrounds?

Minority/white disparities proliferate in the area of mental health services as well as acute and chronic health care. Snowdon (1998) in addressing the issues related to managed behavioral health care and minority populations, points out that African-Americans are only 61 percent as likely as white to have received mental health care and Latinos only 49 percent as likely. He further notes that the epidemiological evidence provides "little justification on the basis of differential need for such marked differences in utilization" (ibid; Vega & Rumbaut, 1991). As managed mental health care continues to become the norm in both private and public sectors, how will these groups have access to appropriate services? What type of research is necessary to track trends and utilization patterns across all groups?

In October 1998, a summit of northeastern colleges and universities was held to develop strategies for promoting diversity in their communities (Bevins, 1999). Hosted by Yolanda Moses, the president of City College in New York, the summit focused on educating and sensitizing students to the issues related to functioning in a multiethnic, multicultural environment. What is New Jersey's commitment to promote this kind of educational awareness campaign to an even younger group of students in its middle and high schools, who are so responsive to early intervention strategies?

Catalyzed by the President's Initiative on Race, many inter-racial dialogue groups have organized in communities around the country. Many critics argue that such groups are not effectively addressing the social problems related to racial tensions. A 1998 study conducted by the Center for Living Democracy evaluated 85

interracial dialogue groups in 30 states and found that the most successful programs "brought together community, business and spiritual leaders who were committed to resolving racial problems. They followed a structured format and set concrete goals for making changes in the community" (Specht, 1999). Is a public-private partnership viable to develop these dialogue programs in New Jersey's communities?

In a lead article printed in the beginning of this new year, the *New York Times* profiled New Jersey's approximately 30 foreign language newspapers -- from small free "shoppers" to substantial, paid-circulation publications with local and national advertisers. Various readers who were interviewed for the articles were from groups as diverse as Taiwan, India, China, Mexico and Guatemala. Most preferred the newspapers for offering "news about the old country and news about their new community that is not available in the mainstream press" (James, January 3, 1999). In what ways can these newspapers be proactively used as a means of outreach for health promotion and education activities?

ENDNOTES

¹ For purposes of this paper, the issue of diversity applies to all representative racial, multiracial and ethnic groups living in the U.S. and in New Jersey. The significant size of this group is exemplified in the statistic that 28 countries composed 1 percent of New Jersey's foreign-born population in 1990 (Espenshade, 1997). All efforts have been made to meet the challenge of "inclusivity" in the issues raised herein. It is also important to note here that health status disparity issues related specifically to gender (i.e., women's health issues) or sexual preference (i.e., gay men and lesbians) fall outside of the scope of this paper.

² Matherlee and Burke, "Cross-Cultural Competency in a Managed Care Environment." National Health Policy Forum *Issue Brief* no. 705. September 12, 1997; *Federal Register*, 60 (1995), no. 166:44674-93, "Standards for the Classification of Federal Data on Race and Ethnicity," Office of Management and Budget; Edmonston et al, *Spotlight on Heterogeneity: The Federal Standards for Racial and Ethnic Classification* (Washington, DC: National Academy Press, 1966); Williams, David R. and Chiquita Collins, "U.S. Socioeconomic and Racial Differences in Health: Patterns and Explanations" *Annual Review of Sociology*, 21 (1995).

³ NB: Some statistics represented on this chart may vary from those referred to in other sections of this Issue Brief, especially as relates to naturalized and non-naturalized immigrants. This variation is statistical in nature.

⁴ In the most recent elections held across the country, the Hispanic population was identified as the "swing vote" in several key races, including those in Texas, California, Florida, New York, Arizona, Nevada and Colorado.

⁵ Reference is made to National Health Policy Forum *Issue Brief* no. 705, which offers a list of some managed health plans that have developed "model" cultural competency programs (1997). The list includes both private plans and public health systems.

⁶ Latest data released from a research study looking at newly infected blood donors indicated that there is "a growing racial divide in AIDS cases" (February 3, 1999). The analysis showed that 2 of every 100,000 white donors annually are newly affected, compared to 51 per 100,000 among African-Americans, and less than four among Hispanics and Asians. Dr. Martha Rogers of the Centers for Disease Control in Atlanta reported that the new data "reflect the well-recognized shift in the epidemic to people of color" (AP Online, February 3, 1999).

⁷ For specific statistics on these disparities, please refer to *Healthy People 2010 Draft Report and Public Health Reports*; July/August 1998.

⁸ Nearly one-quarter of foreign-born U.S. residents came between 1990 and 1995, and another 35 percent arrived during the 1980s. Immigration accounted for 28 percent of U.S. population growth in the five years following 1990.

⁹ Using an analysis of the March 1998 Current Population Survey, Fronstin reported that the high rate of uninsured lives among the Hispanic population could be correlated to that fact that 57.4 percent of the Hispanic population "reported income of less than 200 percent of the federal poverty level. However, even at higher income levels, Hispanics were generally more likely to be uninsured than other racial groups and were less likely to be covered by private health insurance" (EBRI *Issue Brief* no. 204, December 1998).

¹⁰ Nationally, the National Council on Interpretation in Health Care is organizing educational and standard-setting activities for medical interpreters. California and Massachusetts have launched interesting model programs; for example, the Boston-based Massachusetts Medical Interpreter Association has over 350 members nationwide and works with universities, foundations, government agencies and other organizations in interpreter training and education.

Appendix

Table 1

State and National Sociodemographic, Economic and Health Characteristics		
Sociodemographic	New Jersey	United States
Population (1996) (in thousands)	7,988	265,179
Percent under 18 (1996)	24.7%	26.0%
Percent 65+ (1996)	13.8%	12.8%
Percent Hispanic (1996)	11.5%	10.7%
Percent Non-Hispanic Black (1996)	13.2%	12.0%
Percent Non-Hispanic White (1996)	70.4%	73.1%
Percent Non-Hispanic Other (1996)	5.0%	4.2%
Percent Non-citizen Immigrant (1996)	9.0%	6.0%
Percent Non-metropolitan (1996)	0.0%	20.2%
Population Growth (1990-96)	3.0%	6.3%
Economic		
Per Capita Income (1997)	\$32,654	\$19,241
Percent Change in Per Capita Personal Income (1992-97)	21.3%	24.1
Unemployment Rate (1997)	5.1%	4.9%
Percent below Poverty (1996-97)	8.7%	13.5%
Percent Children below Poverty (1996-97)	12.5%	19.9%
Health		
Percent Uninsured -- Non-elderly (1996)	19.1%	17.6%
Percent Medicaid -- Non-elderly (1996)	7.0%	12.0%
Percent Employer-Sponsored -- Non-elderly (1996)	67.2%	63.9%
Percent Other Health Insurance -- Non-elderly (1996)	6.8%	6.8%
Smokers among Adult Population (18 and over) (1997)	21.4%	23.2%
Low Birth-Weight Births (<2,500 g) (1996)	7.5%	7.4%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1996)	6.9	7.3
Premature Death Rate (Years Lost before age 65 per 1,000) (1996)	49.1	50.3
Violent Crimes per 100,000 (1996)	531.1	634.1
AIDS Cases Reported per 100,000 (1996)	37.0	25.6
Sources: New Jersey State Data Center, U.S. Bureau of the Census, U. S. Bureau of Labor Statistics, Current Population Survey, Behavioral Risk Factor Surveillance System, New Jersey Center for Health Statistics, New Jersey State Police.		
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Black Health Network: www.blackhealthnet.com

Center for Healthy Families and Cultural Diversity
Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School:
www2.umdnj.edu/fmedweb/ctrhlfam.htm

DiversityRX (sponsored by the National Conference of State Legislatures; Henry J. Kaiser Foundation and Resources for Cross Cultural Health Care): www.diversityrx.org

Minority Health Network: www1.pitt.edu

National Multicultural Institute: www.ncmi.org

Good Links To Federal Minority Health Activities:

Office of Minority Health Resource Center: www.omhrc.gov

U.S. Dept. of Health and Human Services, Initiative to Eliminate Racial and Ethnic Disparities in Health:
<http://raceandhealth.hhs.gov>