The Scholar and The Feminist XIX
Women as Change Makers:
Building and Using Political Power
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Afternoon Panel:

7. Health Strategizing in New York City

Dr. Margaret Hamberg, Commissioner, New York City Health Department: *** If we're really going to insure adequate and appropriate healthcare for women, there are three critical areas from my perspective that I think really need to be focused on. There are many, many more as well, but I want to just touch briefly on the areas of research, training, and services, particularly primary care and preventive services.

Research is critically important to the overall structure of healthcare because it really undergirds the advances that constitute medical practice and the methods by which we treat people. Without an adequate research base we really don't know what are the most effective and safe treatment strategies. And unfortunately the health needs of women have really not been met by the research establishment and there has been some brief discussion on that already. Such critical concerns for women as contraceptive research and development, fertility research, breast and cervical cancer treatment and prevention research, osteoperosis, menopause, and the list goes on, have not really received the same degree of attention as measured in either research efforts or research funds that diseases with direct impact on male populations have. Nor do we adequately understand the manifestations of certain diseases as they appear in women as compared to men. You've heard the example of hypertension and heart disease, HIV is another prime example, and this is because numerous scientific studies have been done using only men, and this then leaves clinicians to just guess whether the findings from those studies can be extrapolated to the care and treatment of women as well. And furthermore, important characteristics of these disease processes that may occur only in women are lost all together. So without a doubt the problem of gender bias in research is very real and it's had far-reaching implications for women and their health. And one wonders why we came to this point at all, particularly me as a former biomedical researcher. It's hard for me to quite understand how women were so neglected.

So I think it's useful to briefly mention what were the reasons and to perhaps indicate why they were never valid or certainly are no longer valid. One reason was the concern that women of reproductive age were particularly vulnerable to possible harmful effects of new drugs or new therapeutic interventions because they might become pregnant and thus risk to their fetus would then occur. So women were excluded even if they had no intention of becoming pregnant, even if they weren't

sexually active, even if they were following appropriate birth control methods. It was this sort of paternalistic...but yet, one can understand where it comes from, this desire to protect women and their unborn, perhaps unconceived, fetuses from a potential threat.

The second reason really had to do with women and their bodies, our endocrine systems and the fact that we have these fluctuations that produce things like menstrual cycles, or that we can become pregnant, or menopause where hormones change over time, and these things researchers felt made study design more difficult and the analysis of data more difficult and messy. So again, they decided it would be easier to not include women.

There also was a belief that many disease conditions really weren't that relevant to women, certainly not as important to women as they were to men, so why not focus on men when you study them. And this was almost a self-fulfilling prophecy, because if you don't study it you often don't find it, or at least you don't find it until the burden of illness in those women with this disease that supposedly isn't relevant to them becomes so substantial that it can't be ignored. And I think the area of heart disease is one clear area where we now know heart disease is a very serious problem for women, and in fact, it's a leading cause of death, but unfortunately women are often diagnosed later in the course of their disease progression because their doctors don't take them seriously until they have very severe and far-progressed symptoms. And we now have done studies and documented it and this is the kind of thing that really should have been avoided and hopefully will be avoided in the future by not doing studies on one sex alone.

And finally the last belief, which I referred to already, was that many thought that gender specific effects weren't that likely to influence treatment and therefore, you know, why do these studies on these messier females. So clearly these reasons are not acceptable and they are undergoing change, but really until recently the inadequacies of women's health research were largely ignored by the government, by the medical establishment, and were not really visible or understood by the public at large. There are encouraging signs that things are changing. Political pressure and increasing public pressure have combined to result in more appropriate representation of women on clinical trials, as mentioned, and also more attention and more dollars for research on women's health. There's been very positive action by Congress. Many medical and scientific organizations are finally beginning to mobilize, and as many of you know, the National Institute of Health, in addition to establishing the office of Research on Women's Health, has also committed to a major women's health initiative where many millions of dollars will be put into some ongoing longitudinal studies of women's health issues over the next few years and should yield important results.

Obviously the changes that are going on in the area of women's health research reflect some important trends that are occurring more broadly. The ascendance of more and more women into positions of power and influence who are challenging the status quo and demanding appropriate attention to these kinds of needs, in addition, the voices of consumers and activists have been and will continue to be an important influence. And it's also very important now and in the future to increase the numbers of female researchers and practitioners because they really are in a position both as healthcare providers and researchers but also as women patients, to better understand what the stakes are both in terms of their own healthcare and their professional lives and the needs of other women and to advocate and to be sure that appropriate attention and action is taken. So that it's a coalition that's needed, of policy makers, practitioners, and consumers that will keep us moving in the right direction.

I want to turn now to look more specifically at the issue of healthcare services. And it is ironic to note that women actually spend more on healthcare, they visit their doctors more frequently, they spend more time in the hospital, they undergo more procedures, they take more medications, the list goes on, but basically they're really being short-changed by the healthcare system. The quantity of unnecessary or inappropriate medical encounters does not really substitute for quality medical care. But in fact if you look at those overall numbers of women as consumers of healthcare it really masks, I think, a more fundamental problem that I'm sure all of you are all too painfully aware of and that's that resources for healthcare are not evenly distributed throughout our city or throughout our country and that major gaps exist in the availability of health services for all women and particularly for poor women. Too many women have little or no access to primary medical services and we really need to work aggressively to make sure that medical services are created in communities that truly address the needs of poor and also working women in the neighborhoods where they live and work. And we have to confront the economic reality of the feminization of poverty which has a direct bearing on the health status of women in this country and certainly in New York City.

In New York City the majority of residents who live in poverty are in fact women and children and they have no health insurance. the on-duty resident in the emergency room often serves as their obstetrician, their pediatrician, their general practitioner. Preventive healthcare is not a reality for them either because of cost or access, or in most cases both, and even poor women with sufficient resources to spend on healthcare. The numbers are growing smaller every day as more and more women are seeking employment in a rather unfriendly economy and wages are declining, opportunities for gainful employment are declining. The ranks of the working poor are swelling and they find themselves at a particular disadvantage when it comes to obtaining medical care because many of them are marginally employed in small business, whatever, they may not get healthcare benefits through the workplace, and they're correspondingly too poor to pay for their own health insurance. So that they

find themselves in the difficult betwixt and between position. And of course even for those who are insured healthcare coverage is often inadequate. Maternity care services, a subject close to my heart at the moment, is one case in point. A recent report from the *** Guttmaker Institute indicated that only 7 to 8 percent of participants in group plans were fully covered for hospital maternity charges, and over 5 million women of reproductive age have private insurance that does not cover maternity care at all, and 2.7 million unmarried dependent teenage mothers and their babies also have no healthcare insurance.

You're also probably well-aware that routine preventive care for women, such as pap smears and mammographies, are inadequately covered under most healthcare plans despite their proven abilities to save lives and reduce healthcare costs, and the sky-rocketing rates of preventable diseases among women in New York and across the country bare witness to the impact of these policies. And the burden of premature and preventable disease and death is also a telling indicator of the tremendous problem we face with respect to inadequate access to healthcare and health information. And I want to focus a little bit more on some of those issues in the time remaining.

Breast cancer is, I think, one very good example to look at and here you can see the overlay of a number of important issues; issues of poverty, race, cultural and ethnic difference, and unequal access to medical services. Every year in New York City some 4000 women get breast cancer and it's the leading cause of death in women age 35 to 64 here in New York. The number of breast cancer deaths has risen over 20 percent over the past decade. The high death-rate from breast cancer in New York City is in large part due to late stage detection of the disease and we know that those at highest risk to late stage detection are the elderly, the poor, and racial and ethnic minorities. One in 8 women are likely to get breast cancer in their lifetime. Incidences of disease increase with age, but breast cancer and breast health is a life-long issue and it's really critical that women are educated to examine and alter behaviors which might influence breast health and reduce their risk for breast cancer and also to heighten awareness about the needs to seek early care and early detection.

I just want to talk a little about the history of our approach to breast cancer because I think it's interesting. It's clear that the emergence of an active, engaged, and politicized organization of breast cancer survivors and activists really stimulated the change in attitudes about and treatment of breast cancer and tells us something interesting about the relationship between women and the medical establishment. The early attempts to treat and prevent deaths from breast cancer relied on very aggressive surgical approaches, radical mastectomies and the like, and massive treatments with radiotherapy and chemotherapy. However, really in large part due to women becoming more involved with their own healthcare and challenging these traditional treatments along with some advances in research that perhaps might have occurred anyway, we've been able to develop far more tolerable interventions, such a lumpectomy and lower

dose chemotherapies. Things that men in the medical profession said would never work, but in fact they do and they have a very meaningful impact on both women's survival rates and on the quality of that increased life-expectancy. And the medical profession also began as a result of the combination of great understanding of the disease, but primarily the voices of health advocates to really focus on the area of early detection strategies, including breast self-exam, clinical breast exam, and mammography screening. And also now we're just beginning to enter the area of prevention: How can we prevent the onset of breast cancer disease in the first place? And this will be a very important area for research and hopefully for intervention in the years to come.

But it is really striking when you look at who's getting breast cancer and who's dying from breast cancer. And it's particularly poignant when you look at the breakdown of breast cancer mortality by race. Among African American women the overall breast cancer incidents is actually lower than that of their European White counterparts, but their mortality rate is higher. They're dying at higher numbers. And why is that? Well, it really has to do with this important issue of access to care at the stage at which diagnosis is made. A study done by the New York State Department of Health showed that in 1990 48 percent of White women with breast cancer were diagnosed while the disease was still localized in the breasts, yet only 38 percent of African American women were diagnosed at this earlier stage. African American women with breast cancer were 30 percent more likely to be diagnosed with breast cancer once it had already spread to distant organs and for Latina women they were 12 percent more likely to be diagnosed at this later stage and this obviously has very significant implications in terms of their life and medical treatment opportunities.

Cervical cancer is another preventable disease or condition that is readily treatable if detected early, but it is disproportionately lethal in communities of color. Among cases of invasive cervical cancer in Brooklyn, for example, 80 percent occur in women of Haitian origin, and in Central Harlem, whose population is over 90 percent African American, they have one of the highest rates of cervical cancer anywhere in the city. Overall African American and Latina women have twice the incidence of cervical cancer than that reported in their White counterparts. And unfortunately, the routine pap smear, which could save their lives, is not routinely offered in too many clinics that serve them or these women don't access services at all.

I was going to talk about New York City's infant mortality rate, which is another reflection of our system's inability to provide adequate healthcare services that we know can really make a difference to the women that need them, but I believe that Evelyn Longchamp is going to address that issue. So maybe in the interest of time I'll pass over that one.

It is important to mention AIDS. AIDS is having a very serious impact on women and also on children. The disease that, as I'm sure you know, when it first emerged was thought to almost exclusively involve men, particularly men having sex with men. But clearly, from the very beginning of the epidemic it was present in women as well, but we again were not adequately prepared to see it because of our impressions of what this disease was all about. But AIDS is in fact the leading cause of death among women of reproductive age in New York City and we've had over 7000 cases to date. Again, it disproportionately affects women of color. Almost 85 percent of the cases have occurred among African American and Latina women and it's inextricably intertwined with another serious health problem, that I don't think I have time to go into, but the problem of substance abuse. And about half of the women, more than half of the women infected with HIV and who have developed AIDS were infected because of intravenous drug use and a big chunk of the remainder were infected through sexual partners who were using intravenous drugs. So the intersection of those two epidemics is very, very problematic and of course the impact on children is very real as well. Close to 80 percent of pediatric AIDS cases in the city, and there have now been more than 1000, are related to the problem of substance abuse as well. And again, with respect to issues of AIDS and women, we don't know enough about manifestations of the disease in women, particular treatment strategies in women, we've not done adequate research involving issues of women and AIDS, but it's an area of intense interest now. It certainly has to be high on the agenda and it is an area where we will be gaining considerably more new information in the years to come.

I think one of the things that all of these different health problems tells us that while there is a very pressing medical need that we have to address, that we have to treat, that we have to try to prevent, that the problem occurs within the context of a broader array of social and economic concerns. And that as medical providers we'll fail to effectively treat and cure the medical problem if we don't attempt to address some of those broader issues that influence and threaten to undermine our medical interventions. And we really have to re-think how we provide services, what those services should be, how they most appropriately should be provided. When we talk about healthcare reform it's not just who pays the bills; it's a lot bigger question than that. And not all important health activities occur in the doctor's office or in a hospital setting. Many important health activities, particularly activities aimed at prevention and health promotion, occur in communities, occur in families, and occur at the individual level. So I think we need to be a lot broader in how we think about health, how we think about healthcare reform.

And I just want to mention briefly a topic that I think is going to be under much discussion that certainly raised some attention in a recent journal that came out, *The American Journal of Public Health*, calling for a social model of health as opposed to a medical model for health, which you can imagine sends shivers down some physician's spines. It really is very important and it's key, I think, to the issue of effective

women's healthcare because the social model really allows you to put women's core health needs at the center of your analysis and then to focus attention on the diversity of a woman's health needs and social needs over the course of the entire life cycle.

I think we also have to begin to acknowledge the cultural realities that affect women and their ability to use the healthcare system and their desire to use the healthcare system. For example, women are generally the caretakers of their families, putting the needs of their children and their families first, and we need to find better ways to help women support them so that they can continue in those roles if they chose to but also get the healthcare they need, or to challenge those roles when [they] in fact interfere with their ability to achieve what they need in terms of their own lives and their own health. And I think self-empowerment is an important part of that. Women need to be helped as consumers of healthcare. They need to challenge some of the cultural and bureaucratic barriers that are before them. We have an obligation as medical professionals to provide user-friendly services, accessible services, services that also have other components that reflect the realities of women's lives, such as day-care, other services that reflect the realities of all of our lives, such as healthcare workers who can speak in the language of the individuals seeking care, etc. And we certainly need to sensitize medical professionals so they're less hierarchical in their treatment of patients and they really can understand and appreciate the needs of patients, to get the full information that they need, to really understand their medical problem and the treatments that are being advised so that physicians and their patients can become partners in treatment.

So let me just finish up by saying that I really do think that this is a special moment in time in terms of what's going on in the realm of healthcare reform and the changing perceptions about women's health. And we really need not to be complacent. We need to take up the challenge. We need to work together from our various perspectives and professional identities, but for the common cause which is improving healthcare for women. Thank you.

Prof. Terry Rogers, Barnard College: Evelyn Longchamp ~~on my immediate~~ left is a nurse, a president of the Senior Management Consultant of the Office of Women's Health in New York City at the Health and Hospitals Corporation. She's also on the faculty of the Division of Nursing at New York University and has been particularly active in the Haitian community. *** In 1990 the Greater New York March of Dimes awarded her the Maternal Child Health Nurse of the Year.

Evelyn Longchamp, Office of Women's Health, New York Health and Hospitals Corporation: Thank you for the introduction and I'm really happy to be here on this illustrious campus and in such good company. And it was very good, the planners of the conference gave me carte blanche and said, "Okay, what do you want to speak

about?" This was the first time that I was invited to a conference where I could chose my topic. And I chose a topic that's very close to my heart also. It's the access to care for poor pregnant women. And I wanted to look at the impact of a special program that was created in 1985 by New York State called the Prenatal Care Assistance Program, PCAP, and how in the past 6 years it seemed to have impacted favorably on the outcomes of the births in the city. And I'll give you a little background in terms of what the story was before PCAP came along or midway PCAP.

I'll take the year 1988. In 1988 132,226 babies were born in New York City, there were 26 maternal deaths, and 1770 of those infants that were born died before their first birthday. Now the disparity in infant mortality -- infant mortality is the rate of babies that die before they reach their first birthday in a given year and it's calculated per 1000. So let's say that 1770 is about 13.4 per 1000 ***. And it's high for an industrialized nation or for a city as exorbitant as New York City. But what was even worse was that the disparity in infant mortality has persisted between racial and ethnic subgroups. And I'll give you an example: When we say 13.4 for New York City, in Harlem it was 27 per 1000, while, let's say, in *** Bay it was 2 per 1000. So this is when you get those large disparity and you combine them, then we are screaming about 13.4, but really in Harlem, and Fort Green, and Bronxville, and Bedford Stuyvesant, you know, it's like in the double digits, near the 20s and in Harlem, of course, 27. And 27 per 1000 is what you find in the developing world.

Black newborns also are twice as likely to be born at a low birth weight, meaning under 5 pounds. And that makes them more likely to die before their first birthday. And the percentage of women receiving late or no prenatal care was fairly high also in New York State; it was 20 per 1000 women. And what it means is that if there are complications that occur in the pregnancy they are not caught on time. So that by the time medical or other intervention, you know, could have taken place to make the birth outcome better, the woman just goes to the hospital and delivers and there's a complication and the baby is at low birth weight and it stays in the NIC for 6 weeks and one day dies of pneumonia.

So studies have indicated that many women do not seek prenatal care and, as Dr. Hamberg was saying, until late or not at all in the pregnancy. And the most commonly cited barrier for not seeking early prenatal care is lack of sufficient funds or sufficient health coverage. And that, as I was saying before, is the cause of the low birth weight. So in 1985 with the help of advocacy groups and other providers, New York State created what they called the Prenatal Care Assistance Program.

Now I want to go a little bit over the barriers that prevent women from seeking prenatal care. And Dr. Hamberg before was talking about the poverty and lack of healthcare coverage and she talked about the feminization of poverty and we have a

good example here in New York City. For instance, according to a report by the Committee Services Society in 1985 25 percent of New York City residents were living below the federal poverty level. And 4 out of 10 children under 12 lived in families within the poverty level. And 40 percent of these families were headed by females and 62 percent of the female-headed households were below the federal poverty level. So it keeps going down. And approximately 45 percent of the births to women were women who qualified for Medicaid and had no health insurance.

The other barrier was limited system capacity. What was happening [was that] at the American College of Obstetrics and Gynecology [they] did a study whereby they found that because of the malpractice issues that in the 1980s obstetricians started abandoning the field more or less. They had numbers like 21 percent of the obstetricians had changed their practise; they only practised gynecology, no longer obstetrics. Thirteen percent had decreased the number of deliveries that they were doing and another 12 percent no longer practised obstetrics at all. So that was changing and *** thought of those doctors and also nursing shortages in the public hospitals where poor women usually would go for care, you had a very long wait. Even if she presented herself for prenatal care, she had a long wait, over a month to wait, for an appointment. So that case for ***

And as *** was saying, you have the barrier of language and culture. As you know, New York City [is] racially and ethnically diverse and in 1980 47 percent of the population was Black, Hispanic, or Asian. And then 6 out of 10 of the births in the city were to African American, Asian, and Hispanic women. So this diversity created some problems in accessing service because of language and culture, and among the undocumented, the few who are being deported. So again, you have women who did not seek prenatal care.

The other barrier was substance abuse. And in `88 the maternal substance abuse in New York City was 30 per 1000 ***, which was significantly higher than the national rate which was 11 per 1000 ***, but again in certain pockets in the city it was way out. I mean, off the chart. In Harlem it was 107 mothers using drugs per 1000 *** and most of the increase in the substance abuse rate was represented by Cocaine, crack, and several drugs, poly-drug use by the moms.

The other aspect was birth to teenagers. In New York City they represent about 10 percent of the births for a given year, but in some pockets, again, it's much higher. For instance, in Central Harlem the rate is 16 percent of the births are to teenagers, meaning children under 19, and in the South Bronx it's 5 in every 20 births, you know, is to teens.

And the last barrier is homelessness. How do you seek prenatal care if you don't even have an address? And that means you have so many other problems that the baby is not your first priority, you just present to the hospital when you are ready to deliver. And in 1987 Dr. Schefkin and other researchers did a study whereby the homeless women average between 0 to 3 visits in terms of monitoring their prenatal care, and their infant mortality rate was much higher in the scale. It was about 25 per 1000.

So the Prenatal Assistance Program, PCAP, was established in `85 primarily to provide women, those who were working but didn't have health insurance or did have health insurance but the health insurance didn't cover prenatal care, preventive care, it was designed and implemented for them. In 1990 PCAP was combined with Medicaid whereby a woman who presented herself for prenatal care, the provider streamlined an application and did a financial kind of analysis whereby she was presumptively eligible for this service. And they covered up to 185 percent of the poverty level. And in our dollar terms it means that a family that was [making] $1783 per month for three could be eligible for this kind of service, mother, father, and the baby. So studies have shown that it's more cost effective to provide clinical care, which costs about $2000 per delivery than to pay $500,000 for an infant who stays in the Emergency Care Unit, not to mention the lifetime costs and social costs for those premature babies.

Now this coverage was only good for the pregnancy or to the mother's 6-week post partem, after that she could reapply for Medicaid. Now this Prenatal Care Assistance Program applied very stringent standards to the providers who contracted with the state for this to enhance the reimbursement for Medicaid. For instance, it was quite enhanced, the first visit, facilities received three times what they would have received for a regular Medicaid visit and the next visit *** in terms of dollar amount. So we had quite a few providers providing this PCAP prenatal care. And I'm going to make Dr. Hamberg's heart not feel so great; I'm going to tell you what the women would receive under PCAP. They had prenatal care assessment, labor and delivery services, in-patient care in case they became sick, specialty physician and clinic services necessary to insure a healthy delivery and recovery, laboratory services -- all those things are covered -- health education -- Dr. Hamberg doesn't get health education -- mental health, substance abuse and alcoholism service, including screening and counselling, dental health -- she has to go to the dentist herself and pay *** -- transportation if they can't transport themselves, post-partem services, including family planning, emergency room services, home care, and pharmaceuticals. So, I mean, Judy is one of the advocates who was working with us since 1985 and it is the best in all types of worlds. So in conjunction with the advocacy group, providers, the New York City Department of Health, [and] the Women's Health Line, the service was promoted and women were recruited and appointments were made for them, and you know, a lot of women used the service.

And what we have seen in the past 5 years and those of us that are a little tunnel

visioned, attributed to PCAP was a reduction in the infant mortality rate. For instance, in 1988 it was 13.3. per 1000, in 1989 it went down to 11.6, in 1990 to 11.4, and so that's how far we are here, 11.4. So that's quite a change from 13.3, it's almost three percentage points. And the national average now is 8.9 per 1000.

Also the state did an analysis of the impact of the Prenatal Care Assistance Program and what they found was that particularly in New York City significantly more Black PCAP mothers carry their babies to term than did Black mothers that didn't have PCAP. And the impact of PCAP in reducing the rate of premature and low birth weight was *** particularly among those groups, people who didn't report for prenatal care early but because of PCAP they were, more or less, captured, and people that were usually at high risk which was the Blacks and the Hispanics, they seemed to be having fewer low birth weight babies, and that's affecting the infant mortality rate. And one recommendation is that enrolling the mothers early in PCAP and encouraging them to return for more visits would further enhance the PCAP beneficial effect on the mother and child.

Now, this is wonderful news. You know, why I'm talking to you about it is now with [the] advent of managed care most Medicaid clients will be enrolled in some kind of an HMO and the standards are not going to be as stringent as what we had in PCAP. So we in the advocacy groups are really working hard so that the PCAP program can be exacted from the managed care as they are doing for HIV and mental health. So those of you that are in planning, we'll be calling on you to go to Governor Cuomo, or whatever, because we feel that why lose this program that seems to work. Why send a woman to a medical mill or for managed care, you know? Why don't we let them continue to get the benefit of PCAP? Of course, PCAP is not a panacea and, as Dr. Hamberg was saying, we have to look at what is happening in terms of poverty. It doesn't cure poverty. It doesn't cure homelessness. It doesn't cure substance abuse and the violence that seems to plague our community. Those are things that we will have to work on concurrently in order to really have this true lowering of our infant mortality rate.

I have a chart that can show you, since we are such a small group. The black column is the patients we enrolled in Medicaid and the other one is the infant mortality. When you have fewer Medicaid you had a high infant mortality. And as PCAP increased and more women were going through it and now you have a higher number of women in Medicaid and a lower infant mortality. So if you can advocate for PCAP ***.

Q: Can I just ask this question? You talked about the rate coming down to ***. That's because the rate in places like Harlem has come down significantly?

Longchamp: Not very significantly. But Bedford Stuyvesant is coming down, Bronxville is coming down because I don't think we are doing enough in terms of drug policing in Central Harlem and Fort Green, and the violence and all those concomitant ***. No, it's not as much as we would like to see, but it's very, very slow, very, very slow, but it's changing. Bedford Stuyvesant is not...

Q: Harlem went down.

Longchamp: Yea, it went down from 27 to 24.

Q: ***

Longchamp: So if you have a chance you can ***. So that was the rate between 1986 and 1990 and this is the `91. So you can see it is changing, but not as rapidly for Harlem and some pockets *** Harlem, Fort Green, *** the South Bronx, where we usually hear the problems of drug abuse. And now we have the other concomitant which is HIV disease. So...

Q: Are there ways of intensifying the work that can be done in the places where infant mortality is higher? I mean, if the drug abuse seems to be the piece that's sort of keeping things from happening more, how do you focus, what are strategies to focus on?

Longchamp: Well, it would be to attract these women into special care because there is special care. For instance, we have a wonderful clinic that's run by Lincoln Hospital in the South Bronx where they use acupuncture to help women to keep away from drugs. This seems to work, but as Dr. Smith was saying, you get them, they go under acupuncture, they stop using, but they live in a society where, you know, the drug is like having a glass of wine, things like that. When he explains it, it sends shivers through you. So their partner is a drug user, so that's part of their lives. They go back to it again, and again, and again. And that there are support services... So it's a very, very slow process.

?: And substance abuse treatment services in general in New York City are very hard to come by. There is an estimated 550,000 substance abusers in this city and around 44,000 treatment slots available. And for pregnant women that's the group that it's hardest to find a treatment slot. Adolescents is another group that's very, very hard to identify a treatment slot because most of these programs do not want to take on those particular kinds of clients. So that even for a woman who's truly motivated the combination of inadequate access to substance abuse treatment services and then living

in a community where it's just so prevalent, it's a very hard problem to overcome.

Elyce Rackmall, Maternal/Child Health Advocate: And I think that's just like in other areas. Substance abuse treatment programs have very limited experience with women in terms of the model that they employ, the types of services they have to offer. And the thing about substance abuse treatment with women is it's very labor intensive. You really need a lot of staff for a small group of women and most programs are not willing to do the outlay for the types of resources that are needed because when you're talking about women, you're usually talking about children, you're usually talking about providing a living setting for a family.

Rogers: That was Elyce Rackmall, who I was going to say is a social worker right here in the neighborhood. And is in charge of the comprehensive Sickle Cell Center at St. Luke's/Roosevelt Hospital and done an enormous range of case work services to families and with children diagnosed as having sickle cell, counselling to families as well as to adolescents, and a variety of community outreach. Prior to that she also worked very much in the Ob/Gyn counselling service, foster care, and the like. We're delighted to have you speak up sort of informally and please, go ahead.

Rackmall: Well, I'm going to be a little more controversial and I guess that's what falls to social workers. That's our calling in life.

From it's inception the feminist movement of the late `60s, `70s, and `80s has placed much emphasis on the question of women's health issues, particularly reproductive health. Women have struggled long and hard for abortion rights and other reproductive choices. We've had our successes and we've had our failures. While there has been much talk about making our health agenda as inclusive as possible, there has been limited success in concretely taking up the everyday survival issues of our society's poorest women and children. Unfortunately, questions of accessibility, cultural sensitivity, language barriers, and funding for public health programs have all too often been placed on the back burner of the feminist agenda.

In New York City the stark difference between services available to middle income, privately insured women and children and the unemployed and the employed poor is overwhelming. From the New York City fiscal crisis of 1975 until the present we've witnessed an almost unrelenting assault on programs and services designed to be a safety net for New York city's poorest women and children. Years of funding cuts resulting in deteriorating physical plans, depressed wages for health workers in the public sector, making recruitment difficult, and the slow and steady chipping away at services have weakened New York City's once glorious public health system. I think, the people here with me agree.

Just a few glaring examples: In the 1991 budget cuts the New York City Department of Health was going to drastically cut the school health program, which provided school-based clinics that give physicals and immunizations for new students and health maintenance for students who have no medical coverage and no means of paying private physicians or clinic fees. It was only after a pro-tactic court battle by the doctor's council, the union of the physicians', in conjunction with a struggle by parents and community health advocates, that this issue was resolved.

Then we have the pap smear scandal. There was a backlog of dozens of pap smears done at Department of Health facilities because they were unable to process them in a timely fashion. Thousands of pap smears sat around untested for more than a year, giving women a false sense of security. Many cases of pre-cancerous conditions and infections went undetected and untreated. And this included even a few cases of probable cancer. Most recently a memo from the Health and Hospital Corporation, Women's Health Office, was released. It stated that women using the Health and Hospitals Corporation's 11 hospitals and 6 clinics must often wait months for potentially life saving examinations and treatments. A pregnant woman's average wait for her first clinic appointment could be anywhere from three weeks to as long as months. The normal wait for a gynecological exam is 39 working days, but in some hospitals it can be up to 6 months. Women with positive pap smears had to wait for more than 4 months for a culposcopy. To get a family planning appointment one might have to wait anywhere from 7 weeks to 6 months. I think you can only imagine the urgency that the Women's Health office must have felt in preparing the report and continuing their fight for adequate funding to provide accessible and high quality services to women that are dependent upon their clinics and have no other place to go.

While the Health and Hospitals Corporation has taken measures which hopefully will begin to address some of these problems, we do need to wonder how long these conditions have been going on. And what type of methods does it give to the patients using these clinics? How do you go for early prenatal care when it's so difficult to get an appointment? How can you learn about family planning and make informed choices if getting an appointment is a very difficult task? Imagine waking up with a gynecological problem and worrying about whether it was serious enough to go to the emergency room or should you wait a few months until you can get an appointment? It's no small wonder that hospital emergency rooms are crowded with women needing gynecological evaluation, who really don't need to be treated in an emergency room.

What I really would like to talk about now is a tug-of-war for healthcare for women and children that's taking place just a few blocks away from us. Most of you know St. Luke's Hospital which has been located in Morningside Heights since 1893 and Women's Hospital which was founded in 1906. These facilities merged in 1952 and since then have become a major provider of PCAP to African American and Latina women and children from Manhattan Valley, Morningside Heights, West and Central

Harlem, and Washington Heights. In 1979 St. Luke's merged with Roosevelt Hospital and the new facility embarked upon an ambitious long-ranged plan. Their goal was to cultivate a more upscale clientele at the midtown site. The community's first warning was the announcement of a much-needed modernization and construction program. The earliest proposal indicated a loss of over 300 beds at St. Luke's and the transfer of all of the hospital's in-patient, pediatric, obstetric, and neonatal services to the Roosevelt site. Now, keep in mind some of the statistics that we were all hearing before.

Initially the above proposal was not taken seriously. It seemed almost unthinkable that a hospital receiving public funds would move services away from a densely populated community of high medical and social need with few private physicians, to one significantly less populated, whose residents have more resources, greater options for obtaining medical care, and enjoy a much higher health status.

In 1982 the hospital's own community advisory board began to take up a report to address the impact that the hospital's various proposals would have around the community served by St. Luke's. At that time the hospital was toying with three distinct proposals: One was to continue medical, surgical, and psychiatric services at St. Luke's, but move all maternity, pediatric, and specialty services to Roosevelt and consolidate detox up at St. Luke's. So that's taking away all services for women and children from the neighborhood. The second was to continue low risk maternity and general medical surgery and specialty services at the two sites and to consolidate pediatrics, high risk maternity, and prenatal and pediatric services at the Roosevelt site, but still consolidate detox up at St. Luke's. So that's to leave a little low risk maternity, but no pediatric services uptown. The third proposal was to take all medical, surgical, maternity, pediatric, and all specialty services downtown to Roosevelt and only have psychiatry, ambulatory surgery, and only those services necessary to maintain an ER up here. Keeping in mind all of the things we talked about.

The hospital's own community board found the three plans lacking. The board felt that routine, high volume, ambulatory, and in-patient pediatrics, obstetrics and gynecology and internal medicine services should be located in closs proximity to the target population. Their studies showed that Northern Manhattan had a higher percentage of high risk mothers and infants, a markedly higher birth rate, and volume and proportion of children in the community near St. Luke's. They also show how the St. Luke's site draws more patients from the area, versus Roosevelt whose patient's came from a very diverse community and therefore travel time would be increased by at least 30 minutes.

Therefore, based on the demographic health statistics and the patient origin data they recommended the consolidation of high and low risk maternity, high risk perinatal, and

in-patient pediatrics at the St. Luke's site. Makes sense, right? Remember, this was even before the advent of crack -- this is 1982 -- the AIDS epidemic, homelessness, increased rates of T.B., congenital syphilis, delayed immunization, unemployment, and the uninsured. Nor did it take into account plans for the redevelopment of West Harlem that would bring thousands of new young families into the area. This September there's massive redevelopment in the Bradhurst area that will be bringing thousands of new young families into the area.

Because of the hospital's control over the community board this report was never publicly issued. Almost immediately the plan met opposition from local residents. They decried the closing of 7 hospitals in Harlem during the past 20 years. However, in 1986 the hospital got preliminary approval from the New York State Department of Health for the rebuilding process. No final determination was made about the obstetric and pediatric services. In 1986 community and church leaders began a vigorous petition and letter writing campaign. By 1989 they formed a coalition to save St. Luke's and held prayer vigils, demonstrations, and even a hunger strike by some local ministers. With few exceptions city, state, and congressional representatives from the Upper West Side and Harlem have sided with the community and have criticized the hospital's efforts to basically run away from Harlem. Following a 1989 study by a West Harlem coalition the New York State Department of health commissioned the New York City Heath System's Agency to review the need for obstetric and neonatal services in the St. Luke's area. To no surprise to any of us, they found that the number of high risk births to Harlem women had sky-rocketed and that 89 percent of the high risk births and 77 percent of all births to women of Central Harlem were either Medicaid reimbursed or uninsured. Their research also revealed that while privately insured women often traveled to hospitals outside their neighborhoods, only 17 percent of the Medicaid and uninsured women did so. Since Harlem, Columbia Presbyterian, and Metropolitan Hospitals, all located in Upper Manhattan, were already extremely over-crowed, they wouldn't be able to assume added numbers of high risk patients.

In 1990 the New York State Department of Health ordered the hospital to keep 22 obstetric beds and 14 neonatal intensive care beds at the St. Luke's site, but no allocation of money has been made for either of these services. The hospital didn't change its construction plans to follow the state order and didn't submit any serious plans as to how they were going to do so. Meanwhile the hospital has continued to allow the physical slant of both the obstetric and pediatric services to deteriorate. Chronic understaffing has resulted in over-crowding and a reduced level of services and attention. Many St. Luke's officials have revealed their disdain for the Harlem community by stating that you just can't get doctors and nurses to come up to St. Luke's. Now, we know that Columbia University and Barnard doesn't have a problem getting faculty or students and we're all located in very close proximity to each other. Others have said that they hope that when they move to Roosevelt they'll be able to communicate better with their patients.

Finally, in 1991 the NAACP Legal Defense Fund and the Puerto Rican Legal Defense Fund on behalf of the Coalition to Save St. Luke's filed a complaint with the federal government, saying that the hospital was discriminating against African Americans and Latinos and women and children who are on Medicaid by cutting services at the Morningside Heights facility. Hospital administration has done everything possible to entice patients to come to the beautiful new building opening up at the downtown site. They've beefed-up staffing and promised that there will be a higher level of medical attention there. At the same time, the hospital has said that it will keep a 22 bed OB and a 14 bed neonatal intensive care unit for two years and then evaluate its feasibility and need at the St. Luke's site. I think everything we know about health statistics of Upper Manhattan show that there's certainly a tremendous need.

At present, the hospital has begun to move the majority of obstetric services downtown. Starting on April 12th women receiving prenatal care at the MIC Center on 126th Street and Old Broadway, at the Ryan Clinic, or with private doctors must deliver at Roosevelt. All high risk prenatal patients must also be followed there. All of this is ostensibly because all doctors with expertise in high risk delivery are now only working downtown. Low risk obstetric patients from the St. Luke's clinic are being given the choice of where to deliver. But the cards are stacked. The Roosevelt facility is brand new, it's beautiful, well-equipped, and well-staffed. The St. Luke's floor has yet to be renovated and it continues to be under-staffed.

Even so, a recently released study of 95 women living in the St. Luke's Ketchmen area done by Luis Gomez, a Mount Sinai medical student, shows that if services were not available at St. Luke's only 4 percent of the women studied would go to Roosevelt and 96 percent would seek maternity studies at other Northern Manhattan hospitals. In June the entire pediatric floor in-patient service is scheduled to move downtown. What impact will this have on the women and children in Harlem? The sheer distance of the downtown site will result in the added burden of travel time and financial resources. Family members will have a much harder time visiting their children on the new pediatric unit. High risk prenatal patients in advanced pregnancy, unable to travel long distances by train or bus, might not have the financial resources to get to their clinic appointments. Many women and children will probably begin showing up at the already over-burdened Harlem, Metropolitan, and Columbia Presbyterian Hospitals. One really has to wonder if this plan was deliberately set up to limit the access of St. Luke's traditional obstetric and pediatric patients. Remember, you need to place services near your target population and when you move services from your target population, you have a new target. In a time when city hospitals and clinics are extremely overwhelmed -- think of some of the statistics from before -- St. Luke's flight from Upper Manhattan will surely impact on the area's already abysmal health statistics.

Rogers: As you can see the problems are there.

I'll tell you a small little anecdote that happened to me the other day in class. I teach a course, it's a large course, the Sociology of Medicine. It has students from Barnard, it also has students who are older at the School of General Studies across the street -- the men's college, not the coed college. Anyway, we were talking about HIV in the classroom and when I started it I said, "Has anyone had an experience of working with people ***?" When I can I like to see where students are. So one or two said, one of them had been a home care visitor, another said he had worked at St. Luke's, and a woman sitting in the front row, an older student, said she had them out in strollers. And I said, having raised children, "Strollers?" She said, "No, the women in my project, 5 of us, got together, bought some condoms, and distributed them to Strollers," as she termed them and there are meetings just later this week. I've heard them referred to as "commercial sex workers." *** They had by themselves strategized and offered a way to begin to make a connection right there in their project with women on the street. So that myself and all the younger students ***. So there is a lot to be done in all sorts of ways. Now that's my anecdote. Sit down, if you will. And a...

Q: I'll start out with Dr. Hamberg. The question's about research, women in research, not only from the point of view of studies that have been done on them, but women actually working in research. I became very aware of this working at Longfellow University where they had a long history of not promoting the women ***. I think we've had one tenured professor who was a woman to behold. She had been there since 1904. They're able to get past some of the restrictions because they have enough ***. What I find stunning though, and I don't know if this is also true with women my age, is so many women who are actually in research are so blind about the discrimination, that they themselves are not feminists, or even if they aren't feminists it doesn't apply to either their research or to their position as women in research. Do you have any comments on that?

Hamberg: Well, I think you've identified a very real problem which is the sort of, "If I can make it, what are they complaining about...?" On the other hand I think that if you really sit down with most of those women they've adapted to their situation and correspondingly adopted behaviors. But it's not easy. They feel vulnerable, they feel that they're loners, and sooner or later, I think, they would welcome the opportunity to take a different approach and to speak out. The woman surgeon, Francis Conway, I think her name is, at Stanford, where she for many, many years just put up with this stuff from these surgeons who are just renown for their chauvinism. And at a certain point she just couldn't take it anymore. And at that point it was worth risking her job security and, at least she thought, her professional integrity. She was really worried that the male cabal would not only oust her, but would also discredit her. But I think the time was right and I think instead it was a very powerful message for a lot of us. But it's really a problem and the farther you go, the fewer and far between are the women that you can sort of form the bonds with, and the fewer and far between are the

men who are enlightened enough to want to support women also.

There's another dangerous trend, I think, I mean, it's positive and negative, but there are more and more women in medical school, which is positive on one hand. But what it also reflects is that medicine as a field is devalued and that it no longer is attracting the creme de la creme. Many of the men that would have been occupying those slots in the past are now, you know, going into law school, business school, whatever. So on the one hand I do think it's a very positive thing. If you get more women in medical school and more women in the medical profession it's going to help change the shape of that profession in a positive and profound way, but I think one can't be naive about what's going on also. The same thing is true in public health. There are quite a lot of very outstanding women in public health, but, and there are opportunities, not as many as there should be for women to be at high levels in the public health field, but public health is again a devalued component of the overall medical establishment and it's considered the sort of squishier part of medicine. And so, you know, on the one hand you have to sort of take the positives and recognize them for what they are, but you also, I think, have to continue to recognize that...I don't know the opposite of "For every cloud there's a silver lining," or "For every silver lining there's a cloud." And I think the medical establishment is only one sector of our society where these problems are occurring. I think it's probably more brutally obvious in the business world.

Rogers: One small comment: A study done at a large computer firm by a sociologist indicated that women who were promoted in contrast to men who were promoted from mid to upper level positions, the women, those who were promoted, tended to be sponsored by someone a skip ahead of them in rank, where men tend to have been mentored by, watched over by, someone in the immediate rank above them. For whatever it's worth, it took that extra connecting, length. And a counter to what you said about medical school enrollment, it still is at this time even more competitive for admission and there is a feeling about the best and the brightest. I don't know any data so strongly, but one silver lining in that otherwise very real cloud is that at "elite" medical schools the proportion of women is higher. Some cynic could enter the room and say, "That's because...," but I think not. I think that that is a sign. So uptown it's 40 percent and the overall average is closer to 30, but feminizing a profession and it still is segmented very much so. It's an ongoing problem.

Q: I'm actually *** you know we see very strongly that women tended toward pediatrics in our program and I'm thinking of 50-50 to an incoming class of 20 women and one man. Which is very good, you know, we really run our own department and feel like it's kind of our place. But *** the medical department which is much more male often has access to the new computers to the new money and power...

Hamberg: And when they get out they'll make higher salaries, too.

Q: Exactly, exactly, and we're kind of shuffled over and so it's now, "Well, children's needs are not primarily our interest ***." And you know because we were becoming more and more women we see that we have to try harder to get equal resources from some of the other surgeons ***.

Q: The flip side in nursing now is that it's a real up and coming career and there are a lot of opportunities, we're seeing more and more men coming in. And I hear that the Columbia Nursing School is 50 percent men. And it's ironic that when men go into nursing they tend to go into administration and critical care, they get promoted faster, and make bigger salaries than women ***. There's something to be said about feminizing the system and not letting men, you know, ***

Q: The three speakers were very eloquent on problems and issues of women and women of color *** and they're very, very serious problems. I just wonder if putting some of it together we could talk about what it is that we could do and what kinds of resources ***. For example, here there are not necessarily *** in the issue of the struggle to changing some of what we know are very serious problems and issues both in New York City and the country.

Hamberg: Well, we probably all have slightly different perspectives or see a different set of priorities. But from my perspective trying to manage a public health agency in the midst of fiscal crisis, one of the things that has been a surprise and a disappointment to me, to be honest, has been that the public at large and the sort of constituency base for the most part doesn't see this as a priority. You know, I have really been educated not in a positive way that to many -- many is the public at large -- and particularly to many of the voters that the politicians listen to, there are other things that are far more pressing and one can have some sympathy, you know, keeping libraries open and swimming pools open during the summer. You know, they're important things for communities and they're important things in the lives of children in particular. But yet, how can you be out there protesting because [that] the library is going to not be open on Saturday when the entire immunization program of the Department of Health is going to be eliminated? So I could certainly see a very important role for anyone in this room, regardless of what their background, profession, whatever is in terms of just helping to keep these issues on the front burner, helping to make it clear that public health is public safety, that it's as important to have a community based clinic as it is to have a cop on the beat. You know, these priorities that get set by political agendas tend to focus on, you know, what are the sort of short-term immediate benefits to the voting population, but I think healthcare is such a fundamental need that it ought to be as much of a sacred cow as anything in a city, state, or federal budget. That would be what I say: That advocacy to keep these issues on the front burner coming from many voices and many perspectives and many power bases is absolutely essential.

Rackmall: I couldn't agree more. I think that one of the things we see in terms of public healthcare or community based clinics is basically they serve a certain sector of our population. It's kind of the difference between Social Security and Medicaid. They can cut Medicaid because the people that are concerned about the Medicaid levels are people that are powerless in our society. They cannot do the same to Social Security because it's universal. And I think that's a lot of what we see when we talk about the public healthcare system in New York City. It's basically seen as ,"Well, that doesn't really concern me. That only concerns the people that go to those clinics, or the people that need those services." And I think we're seeing the same thing happen now with our educational system. There are so many voting middle class people that no longer have children in public schools. So they're kind of falling into the same kind of disrepair and lack of support and lack of will. And I think that what you're saying may be the critical question. We really have to let people know across the city that what goes on in the public healthcare sector, what goes on in terms of clinic services and hospital services, that essentially serve poor people, they're really in the interest of the whole society. And I think until that message gets out we have a very small constituency and we really haven't reached the constituency that has power in our city.

Longchamp: Well, in my case I see that we have to keep educating and re-educating legislatures or the people that have the purse string for them to understand that preventive health and health education in the long run will save them money because for every dollar you invest, in terms of clinical care, you save $2.50 in future care for a bad baby or things of that sort. And that goes around in terms of HIV, drug abuse, and...but education and prevention is the key more or less to the health of the city.

Q: *** in public schools in terms of making younger adolescents, teaching them the importance of prenatal care ***?

Longchamp: Well, you know, this is a very risky issue. But they have a program -- I think it's called Seek, Judy? -- whereby the children can go into high school, but there is a health educator...she cannot go and present in the class but she's there or he's there, she has a room and then the children can come to her for individual counseling and knowledge and distribution of whatever and referral. But it would be better if it was accepted that there is, in hygiene class or whatever, that it could be promulgated, this is what is needed. You would reach many more children, but they do have those health educators that are available. But some children are not going to make the service have anything to do with themselves until they are already in a problem.

Hamberg: It's really a lost opportunity I think that we have failed badly to integrate health education and risk reducing education into just routine health science teaching in the schools. I mean, something like the chance of an HIV education curriculum, which

did include the condom distribution program, got everybody's attention and got people all agitated and ultimately it more or less derailed because it was a new thing focused on one controversial issue. But the truth its that these kids are at risk for HIV, but they're also at risk for sexually transmitted diseases at an extraordinary rate. Something like one in 4 teenagers gets a sexually transmitted disease and those diseases not only have immediate consequences, but they have life long consequences in terms of infertility and chronic pelvic inflammatory disease, etc., increasing risk for HIV as well, and also unintended pregnancy. So that it's important that these messages reach adolescents and early adolescents very early on and not just because of one disease process, but to understand you know the whole impact of, to understand their own bodies, to understand their own sexuality, to understand their risks and how to reduce risks. And even more broadly than that it is clear that many of the health problems that are before us are linked to behaviors, and whether it's unsafe sex, or risky driving, or smoking, or substance use, drinking, all those behaviors are behaviors that really start to get developed during the adolescent years. Through better education and I think a more open education system, you know, [we could] really help shape those behaviors early on so we wouldn't be spending so much time on the back end trying to cope with the consequences of those risky behaviors. We could actually do some primary prevention in the first place.

Q: *** adolescents trying to access healthcare or even doing things like role-playing in classrooms where teenaged girls can learn to say no to having a baby, or you know, whoever *** teenaged girls, you know, their kind of view of themselves. Even though *** American schools *** even though there's a large predominance in American schools and their English is very good ***, they still have sort of a mentality where they can't say no to their boyfriends *** and they don't realize that they should get prenatal care. *** basic things that you would think every American citizen might know, they're just not aware of. And I'm just wondering if *** schools where they are.

Hamberg: There's a whole movement that I don't know how developed it is in the New York City schools, but what they call "life skills training," which is really a very powerful intervention because it's not focused on the disease, but it's focused on helping people take control of their lives, helping people understand that they can make a difference, also looking at the broader issues of giving people skills that are meaningful and will help them progress in the world and believe that there's some point in even caring about taking care of themselves and others. But it's a whole way of thinking about self-esteem and efficacy and those kinds of buzz words. But you know, they're a real phenomenon. And I think in some of the studies of adolescent pregnancy reeducation, for example, it's the life skills that make much more difference than the actual information about how to use contraceptives because it is the ability...I mean, Nancy Reagan may have had it partially right when she [came up with] "Just say no."

Q: That issue of adolescents I think it also goes back to what you were initially saying about how we need a more social view of how to deal with medicine. You know, it's the old, "You can give them a fish, but teach them how to fish"...*** it's as effective as it's going to be. They did a study at Radcliff of teenage girls that had already had one child and the biggest factor that made them stop having children and wait and use birth control effectively was union membership. They had jobs that they liked, they were being supported by a union that was much more effective on how they maintained their lifestyle than any amount of health information they had from the beginning.

Q: I have a question, I just want to know want know ***. Maybe you can help me. We mentioned managed care as something that was sort of *** that society ** accept the managed care approach. And is managed care involved in this whole business of the Roosevelt St. Luke's... I guess I'm confused because I thought there was a connection. It sound like the state *** some sort of big management segregation of... No? Okay.

Rackmall: The issue there is the fact that all hospitals are in tremendous financial difficulties supposedly at this point in time. And when you treat a poor, Medicaid, or uninsured population base you don't get the same reimbursement rate and you get people with more medical and social problems which from a very cost point of view is more costly to treat. Therefore, if you have the option of moving your locus of operation from a community of very high medical and social needs, which is a costly community, to a community that has less medical and social needs, chances are you'll make more money.

Q: That sounds like managed care.

Longchamp: Managed clientele.

Rackmall: It's an underlying principle that's played out in various ways.

Q: So that managed care that Health and Hospitals Corporation is talking about is that what you're talking about?

Longchamp: No, the managed care is what's going to come down the pipe for the recipient of Medicaid. They'll have a primary care provider who will act more or less as your gatekeeper as to what are the services they are going to receive instead of going to the emergency...

Q: And this incorporates the PCAP ***?

Longchamp: No, in theory it could.

Rackmall: PCAP really has high standards for prenatal care, higher than most people get at a private doctor.

Q: Is it possible for Medicaid ***?

Longchamp: No, a person who is on Medicaid becomes a PCAP customer right away. Either if you have Medicaid, or you don't have Medicaid, or [are] poor, or at 185 percent of the poverty level, you get the same type of care. That's what is good about it and the hospitals get reimbursed at a much higher level, too, I mean, the facilities that provide PCAP. It was very well thought about and it kept changing as it went along. The advocacy group, when they didn't have coverage for the delivery, we said, "But you need to unscrew the delivery in there. And you need not to ask to be documented, for any kind of papers." And they would then cooperate around those things. The state was listening, like it was a real partnership. It's our baby and now we're afraid that it's going to go away and it really works.

Q: I was very moved by your *** point that looking at the coverage brought *** and maybe we could speak to the needs of the powerful institutions -- that's the phrase that I wrote down -- because I think that's what we're talking about. Because these managed care companies, no one's looking into the high pay of those executives making big decisions on the telephone to low level people. And I really empathize and if there's anything I can do to help your situation I would be very happy to... write to somebody. I'm in the process of doing that about this coalition I mentioned and what's overwhelming is the fact that when I contacted the Women's Political Services in Albany I got all of these very wonderful answers supporting the managed care company. And I was absolutely -- this just happened yesterday, so it's very fresh in my mind -- that I have to start somewhere to answer ***. The managed care company was approached. I complained. The managed care company was approached and all of their answers were spouted out in a letter. This is a powerful institution and when you get up against that it's really very overwhelming. So...

Q: How were they approached?

Q: They were approached about a problem *** coverage and they contacted the managed care company and got all of their answers to refute mine. They didn't refute the main person.

?: A state agency?

Q: First the state insurance commissioner who told me that managed care companies do not come under the egis of the laws, *** laws of the state, so that he suggested that I go to *** service *** Mr. DuBois and I wrote and sent all of my materials to him and I got a lower level person writing back to me that they had contacted the managed care company about my case and about the cases I had brought up and they answered point by point from their perspective that no ***. So now it remains to me to go back and answer those points. My point is that this powerful institution struck me a bold stroke, that when small persons speak up to them it is almost overwhelming. And I applaud all of your efforts, I just feel for you. But I would like to say that ***

Q: What has to happen for the PCAP programs to be preserved? Are you putting together some sort of outreach project? ***

Longchamp: No, we have an organization called the Prenatal care Steering Committee which has been acting as, and it's a consortium of different advocacy groups and institutions. And we've been coming together since 1985 and the state had been working very closely with us with all those changes and things of that sort. But let's say the person at the state, we invited her to our meeting and presented all of what we see will be happening and the different standards. It was even, even the idea of a person going to an HMO, to that type of an office, they feel extremely intimidated because it's a different kind of a setting than they were used to and the material that they are given is not written in a language that they can understand.

Q: What has to happen to exempt the PCAP programs?

?: One of the problems and issues *** is such a small primary care infrastructure, primary care base that the state is and the city also *** the mayor's office *** mentioned as well, are trying so hard to get more primary care available that they're treading lightly and with some kid gloves with some of these providers, some of the HMO and other managed care providers. And there's been a very strong effort by the Prenatal Care *** Committee and by the state Prenatal Advisory Committee to insist that at a minimum that the same standards that have been present for PCAP will be in the HMO contract or in managed care. But again, because there's this tip-toeing around the tulips to make sure that the providers are there, there's a tremendous reluctance by the state and the city to push these standards. So that the options are to push for exemption for pregnancy, *** pregnancy, that you can go to another prenatal care provider *** or that the whole package of services be carved out of the HMO range and a woman be given an option to go wherever she wants to or any alternative or combined that the standards have to be adopted within the *** or managed care

contract. Managed care is about providing medical care and the kinds of healthcare that Peggy and Evelyn were talking about. So that the wider concept of a packaged *** which is really what's needed is really not in there ***

Q: I just want to ask how we make preventive care and primary care sexy? Because it isn't. I mean high tech and sexy. Doing heart transplants, liver transplants is sexy.

Rackmall: It's also financially lucrative.

Q: But if you took the... Did anyone ever see the documentary in the `70s called *Your Money or Your Life*? Has anything changed? There they showed you so completely what the monies would be for keeping hypertension clinics open versus one heart transplant. How can *** change ***? I mean, I remember back in the `70s hearing somebody say they went to Israel and Israel at that point, I don't know if it was all of Israel or just some sections that said we're going to spend all our money on prenatal care. We are not having intensive care units for high risk ***. Are we ready as a society to do something like that?

Rogers: No, Oregon is the state probably that's put it's neck out farther in that direction. I think, and I don't have much favorable to say about managed care, *** snake oil if I see it in the distance, but it will put your interest in prevention more into center place to some considerable extent. But on a very minimal level and that's the sorrow of the PCAP and the demonstration programs which we have had and get gobbled up by the bureaucracies so very often. That's sort of a gloomy note because my voice [went] down.

Anyway, it's about time. You've been a wonderful audience. It's a pleasure and I thank you for joining me and our panel.