

reason to believe that one or all of them are important preconditions for aggressive primary health care programs and reductions in infant mortality. The reader is left to determine whether issues such as historical legacies, bureaucratic capacity, stewardship, democracy, and international reputation are necessary and perhaps sufficient preconditions for the launching of successful programs.

Despite these shortcomings, McGuire's book provides a seminal contribution to the burgeoning field of political science theory applied to public health. McGuire does a commendable job of carefully blending rigorous statistical analyses with in-depth qualitative evidence. Given the dearth of studies conducting this kind of methodological approach, this book is a must-read for any political scientist working on comparative public health policy.

Eduardo J. Gómez, Rutgers University

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Review

Michael K. Gusmano, Victor G. Rodwin, and Daniel Weisz. *Health Care in World Cities: New York, Paris, and London*. Baltimore: Johns Hopkins University Press, 2010. 200 pp. \$50.00 cloth.

Gusmano, Rodwin, and Weisz provide a subtle and sophisticated account of some significant variation in health care services in New York City, London, and Paris, in terms of levels of funding, varied institutional structures, and varied opportunities for access to differing types of health care services. This account, of course, takes place—with respect to the United States and New York City—prior to the 2010 national health care reforms. These municipal health care delivery systems abroad are in Paris within France's national health insurance infrastructure and in London within the United Kingdom's National Health Service (NHS).

This review will note some of the authors' significant findings. But first it is useful to acknowledge the institutional differences that the authors review in this interesting slim volume. They describe the U.S. system as “a

complex patchwork of public and private insurance with large gaps in coverage” (21). Thanks to the recently passed Patient Protection and Affordable Care Act, the figure of 47 million people in the United States with no health insurance cited in this book is in the process of being reduced, ultimately to about 15 million. However, even within a newly enacted regulatory framework, the U.S. health care system remains “a complex patchwork of public and private [health] insurance.” The main characteristic of the United Kingdom’s NHS system, according to this account, is its reliance on a public budget to allocate government resources in the health care sector. The French system is more complicated. Its national health insurance covers the entire population that legally resides in France and meets basic residency requirements. Various coinsurance policies cover most of the population’s out-of-pocket expenses. Also, patients with debilitating or chronic conditions are exempt from coinsurance payments. Of personal health expenditures in France, national health insurance covers 79 percent, private insurance covers 8 percent, and out-of-pocket expenditures make up 13 percent.

The French national health insurance system is administered by three major funds and eighteen smaller funds for specific occupations and dependents. These funds operate as quasi-public organizations that are supervised by the ministry overseeing France’s social security. For the United Kingdom, 75 percent of NHS funding goes to three hundred local primary care trusts (PCTs) that are capitated payers responsible for purchasing a continuum of health services for their geographic area. The authors carefully review the institutional and payment structures of these diverse institutional systems, but their main concern is how these cities provide access to health care for their urban populations.

The book contains some interesting institutional observations and institutional details. For example, the New York City Health and Hospital Corporation operates the city’s sixty-five acute “short-stay” hospitals and is responsible for 20 percent of total admissions to acute care beds in New York City. In the thirty-three boroughs of Greater London, NHS London is managed by the Strategic Health Authority, which not only oversees NHS hospitals in this area but also oversees the delivery of primary care, within three PCTs.

Despite significant progress in criteria such as life expectancy at birth and declines in infant mortality, London experiences significant health inequalities by ethnicity, social class, and neighborhoods. While significant improvements in access to primary care have been made in Inner

London's most deprived boroughs, some PCTs are still having difficulty providing non-English-speaking patients with access to primary care and achieving the goal of patients' seeing a general practitioner within forty-eight hours. An exhaustive account of the difficulties poor Londoners face in accessing prevention and early intervention services is presented in *Healthcare for London: A Framework for Action* (known as the Darzi Report; NHS London 2007).

In Paris, the structure of primary care service is more like New York's than London's. Primary care is largely office-based fee-for-service care. About 50 percent of physicians do not accept national health insurance reimbursement as payment in full. For some subspecializations, 80 percent do not accept such reimbursement as payment in full. Medigap-type supplementary policies often cover part of this gap. If high coinsurance is a barrier to access, patients may choose sector 1 physicians—those who accept national health insurance rates as payment in full. If coinsurance payments present a barrier to access, patients may consult physicians at fifty health centers located in every arrondissement in the city of Paris; these centers constitute a safety net for primary care. In all three cities, special efforts are being made to target health and social service resources in the poorest areas.

In its review of significant health indicators, the authors examine Paris—a city of 2 million in its “urban core,” with a peripheral freeway around its twenty arrondissements. In New York City, the authors examine Manhattan and its 1.5 million residents; and for London, they look at the fourteen boroughs known as Inner London, with a population of 2.7 million. The three dependent variables examined are avoidable mortality, avoidable hospital conditions, and access to specialty care for the treatment of heart disease.

Gusmano, Rodwin, and Weisz examine “avoidable deaths”—selected causes of mortality linked to health system performance. That is, they assume that health care should be able to prevent premature deaths from diseases amenable to a combination of different interventions, such as immunization or screening and early detection, as well as “tertiary” prevention, such as the utilization of aspirins, statins, and antihypertensive pharmacology for patients diagnosed with ischemic heart disease.

Utilizing the criteria, a 1998 study indicated that France had a standardized rate of avoidable mortality of 75 per 100,000, as compared to a U.K. rate of 134 per 100,000. The U.S. and U.K. rates were almost identical. Indeed, the health of Inner London residents, measured by total

mortality and avoidable mortality, was worse than the health of Manhattan residents. However, those living in the poorest areas of Manhattan had a significantly higher percentage of avoidable deaths than people living in the rest of Manhattan. While Paris had the lowest rate of avoidable deaths, it still experienced a 16 percent decline in avoidable deaths in the two periods examined in this study. The authors attribute much of this description of health care inequalities to the variability of access to primary care services.

Access to primary care physicians is another factor that affects findings with regard to avoidable hospital conditions (AHCs). The authors examine 2002 data with respect to the management of four chronic diseases—cancer, cardiovascular disease, diabetes, and chronic lung conditions. Despite some criticisms of the coordination of primary care and related services in France, the authors found that the AHCs were lower in Paris than in Manhattan and Inner London, as were the disparities between different neighborhoods in Paris. Their findings indicated that for persons eighteen or older, age-adjusted rates for AHCs in Manhattan were 50 percent higher than in Paris and 40 percent higher than in Inner London. The authors maintain that the differences in these rates can be attributed to differences in access to care and are not merely a reflection of population health status or the operation of acute care hospitals.

With regard to “revascularization” operations for individuals between the ages of forty-five and seventy-five, in Manhattan the odds of revascularization were found to be 62 percent lower for persons without health insurance than for those with health insurance. In Paris, the odds of revascularization were 21 percent lower for residents in the lowest-income arrondissements as compared to those in the highest-income arrondissements. A resident of one of Inner London’s most deprived boroughs was 53 percent less likely to receive a revascularization procedure than a resident of the least deprived borough. These latter disparities were comparable to those of Manhattan residents. The authors conclude that while the three cities examined all have extraordinary health resources, they all face significant health care inequalities. As of the book’s publication date, the lack of national health insurance placed additional burdens on New York City’s poorest residents. With the gradual implementation of national health insurance in the United States, perhaps that burden will shrink considerably. The authors’ study provides salient evidence that even after the adoption of a national insurance or national health service program, significant organizational and delivery-of-care efforts must be made to

achieve equality of access and outcome for the poorer residents of these major cities.

Howard A. Palley, University of Maryland

Reference

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