BOOK REVIEW

Improving Health Care of the Poor: The New York City Experience. BY ELI GINZBERG, HOWARD BERLINER, AND MIRIAM OSTOW. New Brunswick, NJ: Transaction Publishers, 1997. 130 pages.

Why read a book about the atypical experience of New York City? First, because the authors challenge both the present dominance of the "market model" for health care reform, and the previous "pluralistic model" that achieved its most developed expression in New York City. Second, because it is a quick read—the authors cram a lot of information into 130 pages. And third, because everyone should read a book by a sage—Eli Ginzberg is now 88 years old and remains as sharp as a tack.

No doubt, New York City is unique. It is home to 3.7 million people who are Medicaid-eligible, uninsured, or underinsured, which is almost half of its total population. Over the last three decades, while its population has shrunk by 6%, New York City's expenditures on health care have more than doubled from \$20 to \$44 billion. Its Medicaid program spends more than twice the amount per capita as California's, yet its reimbursement to physicians for office visits is only \$13. Its municipal hospital system is the largest in the United States, with 11 acute care hospitals, but despite \$500 million paid each year to six of the seven academic health centers for physician services at municipal hospitals, there is still a huge gulf between New York City's public and the private hospitals.

This book sets out to explore the impact of Medicare and Medicaid on the poor of New York City over the 30 years since they were established. Although the overall assessment is mixed, one conclusion is clear. The elderly poor have been able to join

the mainstream delivery system. Medicare is identified as the primary reason for this success. But, the nonelderly poor have not fared so well. Although they have gained broader access to both public and private hospitals and clinics, even nursing homes, they still receive care predominantly in a separate and unequal system. Explanations for the persistence of the two-class system range from the arms-length status between public and private hospitals, to market forces that result in inner-city neighborhoods with less than one private practitioner per 10,000 residents as compared with one per 500 in affluent neighborhoods. The authors conclude that "the single most important insight to be extracted from our historical analysis is the fact that there was no agency in the public or voluntary sector with responsibility for monitoring the dollars that were flowing into New York City to improve the health of the entire citizenry."

If Medicare worked for the elderly poor, why shouldn't it be the platform for addressing the problems of the nonelderly poor? Why do the authors shy away from a prescription of Medicare for all? A system of single-payer financing, like Medicare, may not be all that is required to bring the poor into the mainstream health delivery system, but it is an essential first step.

One of the institutional barriers to one-class care is the voluntary hospital system itself. I was disappointed that the authors' analysis did not point out the enormous power of the hospital industry over the New York State legislature. As a consequence, hospital-based clinics are reimbursed by Medicaid at over \$100 per visit compared to \$13 per visit in private offices. In addition, although considerable attention is devoted to the public hospital system, the authors do not highlight the exclusion of the public hospitals by the academic health centers from highly profitable procedures such as coronary artery bypass surgery, while private hospitals still shun the uninsured. Although the authors don't say it, one gets the impression that the major reason public hospitals exist is because the private sector finds it useful to have a place to dump the uninsured.

Despite these shortcomings, *Improving Health Care of the Poor* is worth reading. It corroborates the need for single-payer national health insurance, while illustrating many of the local factors that constrain change.—**OLIVER FEIN, MD**, Weill Medical College of Cornell University, New York, NY.

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