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Policy Options to Improve Access to Health Care for the Unemployed Uninsured

David R. Nerenz, PhD,* Barry M. Zajac, MHSA,* Denise P. Repasky,* and Patricia E. Doyle*

The problems of urban health care are discussed from many points of view using many indicators. Those interested in outcomes discuss infant mortality or life expectancy. Those interested in access to care discuss hospital beds, physicians per 100,000 population, or emergency room availability. Those interested in provider finances discuss uncompensated care or Medicaid reimbursement rates. Those interested in the needs of special populations discuss acquired immunodeficiency syndrome prevalence rates or numbers of crack-addicted babies.

While the different indicators provide information on different aspects of urban health care, they may also reflect manifestations of a smaller number of more basic problems. Poverty, for instance, can be linked to all of the urban health care problems listed above. If by some sudden stroke of fortune all residents of urban areas were fully employed, at least reasonably well-off financially, and able to pay for needed health care services, it would be possible to imagine the disappearance of many of the specific problems mentioned.

Urban poverty will not vanish overnight, but the particular kind of poverty that relates to the ability to pay for health care services—lack of insurance—could conceivably be ameliorated by acts of public policy and private sector initiative. Providing access to health insurance would not solve all the problems of urban health care, but those problems having to do with access to and financing of services would almost certainly become less severe.

There has been much recent discussion on ways to reduce the number of the uninsured in this country, and several specific proposals have been put forward (1-8). Many, if not most, of these proposals place major emphasis on expanding employer provision of health insurance, building on our existing situation in which health insurance is primarily private and employer-based.

We focus on options for those who would *not* be directly affected by expansions of employer-based insurance—those who are both unemployed and uninsured through existing public programs. Slightly more than half of the uninsured have no link to an employer, either directly or through a spouse, parent, or guardian (9). This amounts to about 500,000 people in Michigan.

Individuals who are unemployed and not covered by public (such as Veterans Administration or Medicaid) or private health care plans face severe economic barriers to access. Individual insurance policy premiums are beyond the reach of all but a very few in this group, and their unemployment removes them from access to the usual source of group policies. Even if reasonably-priced group insurance were available, unemployment, and the absence of an employer contribution, would still make it extremely difficult for many to afford.

About half of the unemployed uninsured in Michigan live in urban areas (9). Since about 40% of the uninsured live in households with incomes below the poverty level (9), the concentration of uninsured in low-income areas of cities places disproportionate pressure on the health and human service providers and agencies and social systems that serve these areas.

Issues

Several issues need to be examined when comparing policy options for the unemployed uninsured, including the population to be affected, benefit design, administrative mechanisms, costs, and revenue sources and streams. Other issues also have social and political importance, such as the psychological and social impact of the program and its effect on the distribution of power among interest groups and on the ability of policymakers to carry out desired policies, particularly concerning cost control and quality assurance.

What population would be affected by a new program is a basic question. Will it include *all* unemployed uninsured, those with specific health needs, those in certain financial circumstances, or a combination of these two? This question raises some basic issues about the values we have about health care. Is access to health care an individual right? Does society have a responsibility to provide care at least to those who need it? The traditional view is that health care is an individual responsibility and that society will assist those with specific medical and financial need because they are worthy of charity. Is this still a relevant approach?

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What will be the effect of the new program on the unemployed who have private health coverage? Will there be an incentive for some people who are employed to cease working if they can qualify for medical care coverage while unemployed?

Providers are also an affected population, especially if the proposed program changes the structure of the health care system. What are society's or the government's rights and responsibilities with respect to physicians, hospitals, and other health care providers?

The administrative structure of a program will affect both its cost and quality. A program could add or remove layers in the health care bureaucracy. Some programs are merely additional payers of providers. Others may become the only or dominant payer, replacing all others and creating a single, central power.

The source of revenue for the new program is another important issue. There is already money in the health care system for the care of uninsured patients in the form of cost-shifting, allowances for bad debt and charity care, and disproportionate share adjustments. Are these sources tapped? Are new revenues sought from several sources or only from one, such as an existing state tax? Who bears the burden? The rich? The poor? The sick? The well? Employers? Health care providers?

What is the flow of money from the program to the providers? Are providers paid directly based on their overall service to the uninsured or based on the services they provide to individual patients in the program? Is the money channeled through existing payers such as private insurers or does the program pay directly? Are revenues directed to specific providers and are there controls on the amount of services provided, or are patients allowed to choose among all providers, who can determine themselves what services to provide? The flow of money can have an important effect on the cost, viability, and acceptability of the program from the perspectives of both the patients and providers.

A major concern of providers is that they receive adequate payment. Providers will be unlikely to accept rates below their average costs unless they have excess capacity, can get their marginal or incremental costs covered, and have enough other, better-paying patients to cover their fixed costs. Some providers may accept patients at below marginal cost rates if they feel an ethical imperative to do so, which many do, or if they expect to care for some of these patients in any case and would prefer receiving insufficient payment to none. In these cases, the number of patients that providers are willing to accept is probably limited. If the number of patients being offered with below-cost reimbursement is increased without increases in other revenue streams to which costs can be shifted, access to providers may not be acceptable.

Possible Policy Options

There are several possible approaches to providing greater access to care for the unemployed/uninsured. These include: creation of a universal health care plan that would include the unemployed uninsured as well as other groups; redistribution of funds now in the health care system to better reimburse those providing care to the uninsured; expansion of Medicaid or General Assistance-Medical programs to include the unemployed under existing administrative mechanisms; the opportunity to buy into Medicaid, through a combination of personal, previous employer, and public funds; and creation of a separate, publicly-administered program for this group.

We recently conducted an analysis of these options at the *state* level (Michigan) for the Governor's Task Force on Access to Health Care. This group of about 40 members from both the private and public sectors was charged with assessing the nature and extent of access problems and financial barriers to health care, to determine and analyze alternative solutions in the public and private sectors, and to develop policy recommendations for addressing indigent health care issues. A summary of our analysis, tailored to the current situation in the state of Michigan, is as follows.

Option 1: Universal health care plans

The several possible variations of universal health care plans have in common a commitment to providing coverage to *everyone* residing in a geographic area. Some so-called universal plans combine a variety of insurance mechanisms to assure this complete coverage. Truly universal plans, like those in Canada and Great Britain, make a stronger statement about the nature of health insurance. For these plans, coverage is not viewed as an economic good available to those who can afford it or earn it through employment, but rather as an entitlement for all citizens. Health care coverage is primarily a public, rather than private, obligation under these plans, even if some of the economic transactions remain in the private sector.

Universal plans do not *require* the creation of "socialized medicine" in which health care is provided directly by the government. A system in which all citizens are entitled to health insurance vouchers which could be used to purchase insurance from any carrier (including health maintenance organizations) would have the characteristics of a universal plan but leave all transactions other than providing the voucher in the private sector. In Canada, the financing of care is a public operation while the provision of care remains in the private sector.

Under a universal plan, private and public health insurance would be replaced by a single program. Administration would be simplified for providers and most consumers. Providers would have to deal with only one payer, and all patients would have the same benefits (although copayments and deductibles could vary). It is possible that providers would redistribute themselves to better meet the needs of the total population and underserved status would decline or disappear.

Advantages—Administrative simplicity is a main advantage of a universal health plan. It has been argued that much of the difference in total health care costs between the United States and Canada or Great Britain is in administrative costs related to insurance and billing. Canada's experience suggests that we may save at least 6% of health care cost from administrative cost-savings alone. This would amount to more than 0.6% of the gross national product nationally (10). The real saving potential in universal plans, however, is in the direct control of prices and system expansion (11). With only a single payer or purchaser—

called monopsony by economists—the ability to set prices is essentially absolute, although there are obvious practical limitations to this if access to services is to be maintained. In Canada, physician fee schedules are negotiated. They could also be set through a rational method such as relative values. Capital and technological expansion can also be controlled either directly through allocation or indirectly through prices. These account for a large part of health care cost inflation (12,13).

Equity should also be listed as an advantage. Health care would not be rationed on the basis of ability to pay, as is now the case. If rationing needs to occur, as many believe, it would be on some rational basis such as effectiveness or social benefit. If citizens view access to health care as a right for all, regardless of ability to pay, then a universal health insurance system makes that right explicit. It also makes the costs of that care explicit, rather than hidden in the costs of goods and services produced in the state.

Another possible advantage in a publicly funded universal program would be the ability to shift the burden of health care costs from employers to a wider range of funding sources, including excise taxes on items with a demonstrable link to health care costs. In California, for example, a hike in the cigarette tax from 10 to 35 cents per pack is expected not only to raise money for indigent care but perhaps prevent as many as 100,000 young people from starting smoking (14).

Disadvantages—A truly universal health insurance system would require the greatest number of changes, including the discontinuation of existing insurance systems, and would face immense political challenges in implementation. The prospect of a single, monolithic payment mechanism would be threatening to many. Such a major change would require extensive planning and administrative attention during implementation and would probably cause a short-term rise in health care costs as patients needing care were brought into the system and all parties struggled to adjust to new procedures. Potential savings could take some time to be realized.

If the implementation of a universal system in a single state led to a more favorable system of coverage than that available in neighboring states, there could be some in-migration of individuals with serious health needs who would see an opportunity to get better care there. Depending on specific features of the system, physicians and other providers could be adversely affected in terms of either reimbursement or control over practice styles and choose to leave the state.

A possible disadvantage of a universal system, if it were so structured, would be reliance on individuals to enroll, to maintain necessary records, and to participate in processes necessary for provider payment. For most people this is a reasonable expectation, but for individuals who currently receive care as a charity, with no sense of obligation to pay, it is not clear what the incentive would be for enrollment. The enrollment process in Canada is relatively simple and patients are not required to do more than present an identification card when seeking care.

Option 2: Uncompensated care pools

Several specific program options can be discussed under this heading: direct subsidies to hospitals, uncompensated care pools, and all-payer systems. They all have in common a distinctly different approach to providing payment for care for the uninsured. The options described in this section establish an entitlement to *providers* rather than to patients. Their premises are that the health care system already provides needed care to those who cannot pay and that the best way to improve access is to assure the continued financial health of providers through direct payments for otherwise uncompensated care, rather than to improve the coverage of individuals.

Direct subsidies are payments by state and local governments to hospitals (or other providers) to cover the expense of caring for patients who do not pay for their care. The simplest form of direct subsidy would be a lump-sum payment to providers and/or hospitals, the amount determined by using an agreed-upon formula. Other subsidies could come in the form of add-on or pass-through payments for Medicaid, adjusted Medicaid payment rates, or tax credits (if appropriate).

Uncompensated care pools have essentially the same effect as direct subsidies (payment to hospitals with large burdens of uncompensated care), but rely on different mechanisms to achieve that end. Statewide uncompensated care pools involve the raising of funds through mechanisms such as a tax on hospital revenues, a per-bed tax on hospitals, a tax on major payers, or perhaps some direct government contribution. Once these funds are collected, they are distributed to hospitals in proportion to each hospital's burden of uncompensated care. Hospitals with large burdens receive larger shares; hospitals that do little uncompensated care get little from the pool. When revenues are raised from hospitals themselves, the pools serve as a redistribution system for hospital revenues.

In all-payer systems, hospital rates are set at the same level for all private and public payers. The main goal of the all-payer system is to assure that the burden of uncompensated care is fairly or rationally distributed among segments of society rather than being concentrated in those payers to whom hospitals can most easily shift the costs of uncompensated care. A state agency determines allowable hospital rates based on an agreed-upon formula that considers historical costs as well as projections of future cost increases and burdens of uncompensated care. Since Medicare does not allow reimbursement reflecting the costs of uncompensated care, a waiver is required to assure federal participation in the all-payer system.

Direct subsidies, uncompensated care pools, and all-payer systems are primarily directed at hospitals, on the assumption that they have the greatest need and provide the bulk of care for the uninsured, even ambulatory care. These plans, therefore, offer the potential to improve access for those without insurance, even those who would not or could not participate in a program that required enrollment of individual members. They would not have much impact on patients who see private physicians or other nonhospital providers but would offer alternative care as hospitals expand services and also a safety net of sorts if other sources of charity care disappeared.

A state-level mechanism is required to administer either a pool or a rate-setting program. In states where these systems have been set up, a board broadly representative of major interest groups has authority for running the program; the staff

Table 1
Medicaid Income and Asset Limitations in Michigan in 1988

Family Size	Net Annual Income	Asset Limit
1	$5,770	$1,900
2	$7,730	$2,850
3	$9,690	$3,050
4	$11,650	$3,250
	add $1,960 per additional person	add $200 per additional person

needed for administration varies in size depending on the program's scope, scale, and complexity.

The cost of a direct subsidy program depends entirely on governments' willingness and ability to cover the costs of uncompensated care. Subsidies can be made as large or as small as the state or local budgets allow, up to the point where providers are fully reimbursed for the full actual costs of caring for uninsured patients.

Costs of uncompensated care pools and all-payer systems are more difficult to estimate since they are primarily designed as redistribution systems rather than systems for injecting new dollars into the health care economy. Conceivably, one could design an uncompensated care pool or all-payer system with no direct cost to the state other than administration, which could also be financed out of the pool. However, the costs of uncompensated care still in the system would result in higher hospital charges to reflect contributions to an uncompensated care pool or to cover the uncompensated care costs in an all-payer system. There is little evidence to date that uncompensated care pools or all-payer systems add to total health care costs; the willingness of Medicare to participate in the New York and New Jersey plans is contingent on promises that Medicare costs will not be higher in those states than they would be under normal circumstances.

These plans have no explicit benefit design or benefit constraints, since they are ways of paying providers, not insurance plans. Implementation of these plans, however, does create de facto benefit packages by subsidizing some providers and services and not others. The most obvious "benefit constraint" comes when these plans support hospitals and not other providers. Use of the emergency room, hospital-based ambulatory care facilities, and inpatient care is supported; well visits at private physicians' offices, preventive care, prescription drugs, and other nonhospital services are not. Patients who receive care on a charity basis should find it available at institutions participating in the system but may find barriers to care at those who are not.

Advantages—Uncompensated care pools and all-payer systems have had some success in assuring access to care while controlling overall health care costs. Hospitals with large burdens of uncompensated care get some relief, and the risk of hospital closure is lowered.

The plans make explicit the responsibility for care of the medically indigent. Pools establish a mechanism for distributing that risk among hospitals, assuring that hospitals providing little charity care help to support those that do a great deal. All-payer systems create an explicit distribution of costs of uncompensated care among public and private payers. The exact distribution of costs depends on a formula which is set up through the political process.

These plans impose no constraints on patients' abilities to seek care wherever they wish, and they direct resources to those providers who have traditionally provided the greatest amount of care to the indigent. The plans do not ask anything directly of patients in terms of enrollment or participation and do not lead to large administrative structures for establishing eligibility and processing claims. The plans do not typically cause major disruption in existing insurance plans and provider systems—if anything, the plans offer financial stability to existing organizations.

Since these plans have been used for some years in several different states, there is a base of experience to draw on. It would be possible to choose some of the most successful features of plans in states where they have worked well and to avoid problems seen in states (like Florida) where there have been difficulties.

Disadvantages—These plans can conceivably be unwieldy to administer and politically difficult to establish. All parties involved in the care of the indigent must have a sense that the system is fair, since these systems typically involve moving money from those with light burdens to those with heavy burdens of uncompensated care. Participant providers or hospitals must sense that burdens are measured fairly and that the shifting of monies is appropriate.

The plans neither assure coverage nor guarantee access to services and typically do not enhance access to nonhospital providers, since the uninsured remain dependent on the willingness of providers to treat them. They do not promote continuity of care or encourage use of prevention services and primary care. If anything, they encourage use of hospital emergency rooms and inpatient care by supporting those services exclusively.

Option 3: Medicaid expansion program

Medicaid is a complex, state- and federally-funded, state-administered program. States must meet requirements to receive the federal contribution. Within those requirements, states establish their own eligibility criteria, benefit design, reimbursement and payment levels, and administrative and organizational structure. The federal government determines its contribution by calculating state and national per capita income and provides a larger federal contribution to poorer states. Michigan Medicaid operates with about equal funding from the federal and state governments. An option for providing health care coverage to the unemployed uninsured would be to expand the present Medicaid program eligibility to include this population.

Eligibility is limited in Michigan to the following groups:

1. Persons who receive Michigan Aid to Dependent Children (ADC) grants.

2. Persons who receive Supplemental Security Income (SSI) grants.

3. Persons who are in financial need and are either a) under age 21, b) pregnant, c) over age 64, d) blind or disabled, or e) a parent or close relative of a deprived child. (A child is considered deprived when a parent is deceased, continuously absent, disabled, or unemployed.)

Financial need was based on the income and asset limitations in Michigan in 1988 (Table 1). A person could exceed these income and asset limits and still qualify for Medicaid through a "spend-down." If an individual meets the other requirements but has "excess" income or assets, the excess is called the Medicaid spend-down amount. Individuals may become eligible for Medicaid when their medical expenses exceed the spend-down amount.

The Medicaid benefit includes medically necessary services furnished by enrolled providers. Some services are restricted to certain age groups or may require prior approval. A condensed list of the Michigan Medicaid benefits is given in Table 2.

The Medicaid program in Michigan is administered by the Medical Services Administration (MSA) of the Department of Social Services (DSS). The MSA reimburses providers for their services to Medicaid beneficiaries and also performs audits on all claims to ensure the medical care administered was appropriate and sufficient. DSS sets up the eligibility criteria used by the MSA. The MSA and DSS may be capable of increasing their capacity and administering their program to the unemployed uninsured.

Although Medicaid is jointly funded by the state and federal governments, the cost of any additional enrollees would be largely borne by the state. Financing for the additional participants could come from several sources. Some funding could come from the beneficiaries in the form of copayments and deductibles. Other sources could include income taxes, excise taxes, corporate taxes, property taxes, the sales tax, a payroll tax, and/or a health care tax.

Advantages—A major advantage of a Medicaid expansion program is that it is an extension of an existing program and would not involve creating a new financing, administrative, or provider system. The state is experienced at administering the program, and its implementation should be much less work than a new program.

Such a program would provide coverage for virtually all of the unemployed uninsured and perhaps some of the employed uninsured as well. This would eliminate a large portion of the uncompensated care that is presently provided and may relieve other payers of cost-shifting burdens.

The comprehensive nature of the benefit package, if retained, would encourage effective and efficient use of services rather than the acute care use that is common among the uninsured.

Disadvantages—Funds to expand the Medicaid program in some form for the unemployed uninsured would come primarily from the state. Because state budgets are already limited by decreasing federal aid, tax revolts, and balanced budget requirements, this is a major disadvantage.

Another problem is that Medicaid recipients already suffer from problems of access to care because providers are reluctant to accept the low Medicaid reimbursement rates. In order to realize increased access, this problem would need to be addressed, further increasing costs.

The program also may extend welfare and poverty stigmas to this new population, making the program unattractive and interfering with participation.

Table 2
Condensed List of Michigan Medicaid Benefits

Inpatient hospital care	Outpatient hospital care
Prescription drugs	Laboratory & x-ray services
Limited dental & vision services	Psychiatric & long-term care
Medical equipment	Home health care services
Preventive health services	Limited ambulance services
Speech, physical & occupational therapies	Physician, chiropractor & podiatrist services

Option 4: General Assistance-Medical program expansion

The General Assistance (GA) program offers financial help as well as a medical program (GA-Medical) that pays for some health care costs of eligible individuals. To qualify and receive medical benefits a person must meet the following criteria: be financially destitute, which, for a single person, means working less than full-time at $3.35 per hour; have less than $250 in cash, checks, and savings; have no more than one automobile or other vehicle valued at $1,500 or less; not be receiving ADC or SSI; be actively seeking employment; be a US citizen or legal permanent resident alien; and be willing to try to get income from other sources such as other aid programs, insurance claims, or relatives.

GA-Medical pays for doctor visits and for prescribed medicines. Controls on utilization vary by county within Michigan. Many counties require managed care programs or preapproval for GA-Medical use. Hospitalization is not covered by GA but may be covered by separate county hospitalization programs.

Expansion of this program to the unemployed uninsured population not receiving GA could involve the following conditions: eligibility to be based on unemployed uninsured status; this group not eligible for GA cash benefits; present income, such as unemployment insurance, and assets to determine premiums, deductibles, and/or copayments, if any; and beneficiaries to adhere strictly to whatever utilization controls were applied.

Depending on the utilization control mechanism used, existing administrative systems may be usable. Additional capacity as well as mechanisms for marketing the program and receiving premiums may need to be developed.

Existing county programs appear to be able to provide comprehensive coverage at a relatively low cost. However, the low costs of some GA-Medical programs may be the result of restricted reimbursement, which is possible only because the program is small and providers can shift costs to other, better-paying patients. If this is the case, it may not be possible to expand

the program at low cost and to achieve reasonable access for recipients.

Advantages—Because expansion of GA-Medical would be an extension of existing programs, its implementation should be relatively simple. This is a relatively low cost way to provide fairly comprehensive coverage if the experience with existing programs permits reasonable cost estimates for an expanded version.

Disadvantages—Costs of this program would be new and would require the state to repay providers for care at a rate which they are willing to accept. Finding a source for these funds is a problem. The programs also require recipients to follow utilization control procedures. In some county programs this requirement has resulted in providers not getting paid or in recipients not taking advantage of the program.

Option 5: Medicaid buy-in program

The buy-in option is a model in which those not currently insured or eligible for Medicaid would be allowed to receive Medicaid benefits in exchange for a premium. The premium could be paid by the individual, a previous employer, the state, or a combination of these. The amount of the individual's contribution could be based on circumstances such as length of unemployment, amount of unemployment compensation income, number of dependents, and assets. Subsidies would be required to make up the difference for those unable to pay the full premium.

The agency that administers Medicaid would have to develop mechanisms for the determination and collection of premiums along with the capacity to serve a much larger population. Perhaps some of these functions could be performed by another, possibly private, agency.

Advantages—A Medicaid buy-in program could be integrated with the current Medicaid administration. With enough participation, this program would avoid a lot of uncompensated care.

Disadvantages—A problem with this program is determining who would pay the premium. An unemployed person may not be able to contribute much over a sustained period. Such a model seems better suited to benefit the employed uninsured. For the unemployed group, the state would end up having to cover a large portion of the cost or participation would be too low to be useful. Extension of a buy-in program to the unemployed uninsured, with adequate subsidies, would perhaps amount to a Medicaid expansion.

Option 6: A separate public program

Several states have proposed the formation of separate public sponsors for health coverage for the uninsured. In most cases these are part of a system of programs aimed at providing universal health coverage in the state. A public sponsor was part of the Massachusetts Plan for universal coverage that has not been carried out, primarily because of state budget problems. A similar program was proposed by Lewin/ICF for Pennsylvania, as part of a comprehensive program to improve access to health insurance, administered by the state Blue Cross/Blue Shield organization and funded from a public trust. In the state of Washington, the Washington Basic Health Plan, which created a public agency to administer and provide subsidies for a health care program for low income uninsured persons, is being incrementally implemented. Washington provides subsidies of up to 90% of the program premiums to families with incomes up to twice the national poverty level. In each of these cases, the programs are designed to serve both the employed and unemployed uninsured.

Subsidies in Massachusetts were to come from the state's general fund, as they do in Washington. The public sponsor component of the Lewin/ICF proposal would have physicians and hospitals paying annual fees into a trust fund to support the subsidies.

In Washington, the benefit package stresses health maintenance. Certain limitations and exclusions are involved. For example, no major illnesses are covered until one year after enrollment. There is a $5 copayment for most physician services and $25 for emergency room care. The program does not cover dental, vision, mental health care, or prescription drugs. Other states may desire to study the costs and value of other benefit packages.

Advantages—Washington's plan is simple in administration and funding. Premiums and copayments and the fact that it is independent of Medicaid may prevent a welfare-like stigma being attached to the public program. Families with resources greater than 200% of the poverty level are considered able to pay for their own health care or insurance and are not subsidized. The proposed Pennsylvania program, though publicly sponsored, would be privately administered, simplifying the state's role.

Disadvantages—Some employers may perceive the requirement to provide health insurance to their low-wage employees as a disincentive. The need to finance the program from the general fund may be a problem for some states. Fees required from providers could make the state plan unattractive to providers and constitutes a problem if parts of that state are already underserved.

Conclusions

In deciding which of these proposals, or any other proposal, to adopt, states must weigh their interests in the health of the unemployed uninsured and the fiscal condition of providers against necessary additional expenses incurred at a time of increased budgetary pressures. The better a program provides for health care, and the better it pays providers, the more expensive it will be unless some offsetting efficiencies are built in. Programs that cut costs by restricting benefits may not accomplish health-related goals, and programs that underpay providers may create the appearance of efficiency at the price of poor access and quality.

The universal plan provides a mechanism for cost-savings. Savings can be accomplished through reduced administrative costs and through direct cost control via monopsony price-setting. This is a dangerous power, particularly in the hands of politicians. While in the long run funding restrictions may create an incentive for increased efficiency, in the short run they can create either inappropriate use or unacceptable queuing.

Most of the alternatives continue or increase the fragmentation of our health care system and offer no cost-saving mechanism except enhancing access to services that prevent more expensive needs later. Ironically, these alternatives are probably more politically viable than universal plans (15-17).

It is difficult to predict which of the many policy options being debated, if any, will prevail. However, without some initiative to provide for the health care needs of the unemployed uninsured, the problems in urban health care will be difficult to manage.

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