Appendix B: Comparison of Health Care Administration Found In Four Countries

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Bused on W.A. Glaser, "Administration in Health Care: A Plan for Cross-National Comparison s," contract paper prepared for the Office of Technology Assessment, revised edition, 1993.

TABLE B-1: Health Care Administration in the United S

Health care system	Information and publication	Policymaking	Implementing Agencies of Government	Provider Organizations	Individual Practitioners
Multiple pubilc and private payers. Public programs pay for health care for elderly, disabled, and indigen! citizens; some veterans, active military personnel and their families, Most providers are autonomous, with a growing number of practitioners employed by capitated health in-insurance plans or part of one or more networks of providers associated with a third-party payer that establishes various cost-containment measures (managed care).	Federal government collects vital statistics and morbidity data from state and local governments and publishes them, collects and disseminates data on Medicare program for elderly citizens and Medicaid program for indigent citizens. Other federal agencies and private organizations collect and disseminate data on health care facilities, personnel, practice, organization, financing, and the effectiveness or cost-effectiveness of particular interventions.	Multifaceted and occurs at all levels of government through the executive, legislative, and judicial branches with support from their staffs and agencies, commissions, private-sector foundations, and interest groups. Federal government makes policy for programs in funds and drug and device regulation. State governments with primary responsibility for insurance regulation and licensing of health facilities and personnel, admmistration of Medicaid program within the state, and shared responsibilty with local governments for public health programs,	Government development and updating of regulations to implement legislation and programs (especially at federal level) Administration of public clinics and hospitals at all levels of government.	In addition to usual internal administration, hospitals, nursing homes, and home health agencies require significant administrative personnel and infrastructure to understand reimbursement rules and procedures for multiple payers (including managed care organizations) and bill those payers and/or patients. Hospital administration also includes image and marketing, Iitlgation, regulation and accreditation, and management of admittlng privileges. Some private proivder organizations are part of chains that centralize marketing, supplies, and financial management activities.	Move from billing of patients to direct billing of insurers has increased administrative costs for individual practitioners because of varying reimbursement rules and managed-care procedures. A fee schedule exists for only Medicare, hence, practitioners or their staff often check with Insurers on acceptable charges before doing procedure. Fear of Iiability may add to administrative costs by increasing volume of records kept and need to shop among Iiability insurers. Growth in group practices and group and staff model HMOS alleviates some administrative burdens for associated physicians.

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TABLE B-1 continued: Health Care Administration in the United States[a]

Provider associations	Suppliers	Insurers	Education	Research	Management consulting
Numerous provider associations at national, state, and local levels requiring significant admmistrative support. They lobby for their members interests, interact with the mass media, publish professional journals, operate professional committees, conferences, and workshops, provide members for governmental and other advisory commissions, and collect and publish statistics about their membership.	Drug and device suppliers face administrative costs related to marketing to physicians and other customers, patenting and related activities, licensing by the Food and Drug Admmistration, and lobbying Growing administrative effort devoted to interaction with third-party payers about coverage and reimbursement levels. Medicaid drug reimbursements indirectly regulated through rebate scheme requiring administrative activity by manufacturers.	**Government:** States reimburse providers for services provided under Medicaid with state-by-state variation in rules and benefits and shared Federal and State costs, nonstandardization may raise administrative costs Medicare contracts with private insurers to process claims and reimburse providers within defined geographic areas Existing infrastructure within these private contractors helps minimize Medicare's administrative costs Federal government bears Medicare administrative costs of developing regulations, resolving disputes, and contracting. **Private:** Prviate insurers have slgnificant administrative costs associated with marketing in a highly competitive environment, underwriting and rate negotiation with employers, benefit design, application processing, determination of provider eligibility, claims processing and reimbursement, reserves management, and financial reports Self-insured employers face all of these costs except marketing and application processing. Managed care procedures introduced to contain costs and insure quality raise administrative costs.	Very large number of specialized education programs (degree and continuing education) for hospital and health care admministration	Siginifcant volume of health services and related research done in academia, government, and private sector, all resulting in its own administrative expenses	Significant amount of management consulting and supplementary conferences within health care organizations covering finance, government standards regulations, reimbursement rules, and labor standards

[a] Office of Technology Assessment, 1994. Based on Glaser, W.A., "Administration in Health Care: A Plan for Cross-National Comparisons," contractor paper prepared for the Office of Technology Assessment, revised edition, 1993.

TABLE B-2: Health Care Administration in Canada[a]

Health care system	Information and publication	Policymaking	implementing Agencies of Government	Provider Organizations	Individual Practitioners
Full government funding of health care decentralized to provincial level. Autonomous providers that follow provincial standards for financial accounting. Provider associations represent interests of doctors and hospitals. Little private health insurance	Usual vital statistics. Provincial collection of data from hospitals and other provider organizations about services, utilization, personnel, and spending, aggregated by national health ministry. Provider associations collect and aggregate data about their members for reimbursement negotiations.	Decisions about changes in system made by provincial government (ministries, cabinet, legislature, and ad hoc commissions). National responsibilities for drug licensing and pricing, vital statistic reporting guidelines	Incur large portion of Canada's administrative costs. Provincial ministries (or delegated district councils) scrutinize hospital reports, negotiate total budget with treasury, allocate annual increases among hospitals, distribute grants for construction, inspect hospitals for compliance with safety, personnel, and quality regulations. Some provinces also reimburse for nursing homes and home health care agencies using same procedures as for hospitals. Provincial public corporations negotiate with physician associations for fee schedule and process claims and arbitrate disputes.	Usual organizational management (personnel, physical plant, supplies, inventory, medical records, patient communication, and marketing), Hospitals' prospective budgets, retrospective cost reports, and special requests for grants from provincial ministries for capital Improvements constitute relatively simple form of administration, individual patient billing for amenities. Limited number of teaching hospitals minimize administrative costs associated with residents and research.	Usual expenses of running a medical or dental office with some sharing of offices, especially in urban and rural areas. Practitioners complete fee-for-service forms by mail or Computer and send to public corporation; paid by electronic transfer or periodic lump sums, Billing of patients or Private Insurers for dentistry, extra services, and treatment of foreign patients.

Provider associations	Suppliers	Insurers	Education	Research	Management consulting
Provincial associations with staff to collect and analyze clinical and economic trends, publish professional journals, communicate with/ lobby ministries, legislature, media, members, and provide data to national associations. National associations publish national data and are party to lawsuits over issues affecting professions	Drug and device manufacturers with administrative work to support pateninng, licensing, and pricing regulation by national government	Limited portion of total national administrative expenditures because of small size of private insurance market. Administration includes underwrlting, marketing, application processing, general overhead, claims processing, and reimbursements Employers that offer private insurance to employees may have some administrative expenses.	Admminstration of one or more university health care administration programs in each province, minimal compared to United States, where many Canadian health care managers receive their education.	Health services research limited to university teams supported by provincial governments to perform policy-oriented research on health economics, services, and technologies.	Minimal. Limited to management information system development, computer training, and consulting, Hospitals use management manuals developed by their provincial and national associations.

[a] Off Ice of Technology Assessment, 1994 Based on Glaser, W A , "Administration in Health Care A Plan for Cross-National Comparisons, " contractor paper prepared for the Off Ice of Technology Assessment, revised edition, 1993

TABLE B-3: Health Care Administration in the United Kingdom[a,b]

Health care system	Information and publication	Policymaking	Implementing agencies of government	Provider organizations	Individual practitioners
National Health Service (NHS) owns and manages hospitals employs specialist physicians and contracts with general practitioners Minimal, growing local variatior in administrative procedures as some hospitals become autonomous Reimbursement system provides little administrative information Physician associations play a role in negotiating work rules and other policy Limited private hospitals and private insurance	Government produces vital statistics and data **on NHS services** utiliza. tion, personnel, and spending No data on patient or other private health care spending	Health ministry assimilates analyses and recommendations from NHS, public, other interest groups, and mass media to produce staff reports on budget, legislation, potential reforms Supplemented by work of Royal Commissions and Working Parties Fourteen regional boards supported by staff make recommendations to national government Parliament, Cabinet, and Prime Minister and their staffs also Involved m budget and reforms	Health ministry with staff support competes withln Cabinet for health budget NHS allocates to 200 District Health Authorities (DHAs) for reimbursement of services Newly autonomous hospitals with administrative functions of marketing, pricing, and billing patients and DHAs Family Practice Committees (FPCS), Independent of DHAs, contract with general practitioners and dentists FPCS track fee-for-service for dentistry and Increasing number of medical procedures, capitation payment for all other general practice services Ministry negotiates with unions and professional organzations over employee pay NHS prepares periodic expenditure reports from DHAs and other organizational units	Increasing number of autonomous hospitals leads to increasing administrative expenditures (marketing to patients and general practitioners, development of clinlial emphases setting prices, budget balancing) All nursing homes are private and face these same administrative expenses There are a small number of private hospitals Chains own some private hospitals and nursing homes and perform some of their administration	General practitioners (GPs) and dentists with usual administrative expenses of running an office GPs must track patient enrollment and send fee- for-service bills to FPCs for some services 1980s Innovation of GP "fund-holding for patients provides Increased capitation payments to cover patients' tests, pharmaceuticals, specialist referrals and hospital cares results in increased administrative burden Dentists bill FPCs for all services and must seek approval for all extensive treatments

Provider associations	Suppliers	Insurers	Education	Research	Management consulting
Unions and associations with strong role in negotiating for health professionals Including NHS and hospital administrators, thus requirng their own administrative staffs	Drug and equipment companies require administrative staff to apply patents and licenses to sell theirr products Drug companies also have administrative costs associated with price regulation and NHS formulary approval	Private health insurance limlted to accident, private hospitalization, specialist and other appointments without a wait, and amenities Carriers negotiate rates with prviate hospitals and reimburse patients a fixed rate for each private physician service performed	Litle specialized education in health care admmistration due to relative simplicity and austerity of system Health care administrators tended to be gifted amateurs and accountants Specialized continuing education and workshops have become more common since the 1980s	SIgnificant tradition of re search in uiversties, government, and independent institutes about health care and health economics with particular emphasis on analyses of potential NHS reforms and evaluations after implementation Specialized research has been necessary to learn about usually overlooked pvivate sector	NHS has traditonally relied on own staff and researchers from universities and independent Institutes Rise in autonomous hospitals and DHAs may give new opportunities to Private management consultants in the future

[a] Office of Technology Assessment, 1994. Based on Glaser, W.A., "Administration in Health Care: A Plan for Cross-National Comparisons," contractor paper prepared for the Office of Technology Assessment, revised edition, 1993.

[b] Description applies to England. Wales has almost identical system. Some variations in Scotland and Northern Ireland, which have some greater autonomy.

TABLE B-4: Health Care Administration in Germany[a]

Health care system	Information and publication	Policymaking	Implementing agencies of government	Provider organizations	Individual practitioners
Many insurers (sickness funds) in each province all associated with national organization Hospitals are for-profit, nonprofit, and public Government (at both the national and provincial levels) enacts rules for the system, provides some financing, monitors, and settles disputes Provider associations perform significant functions in negotiating for and paying members	National and provincial ministries collect and publish vital statistics and data on some health facilities and personnel Relevant provincial provider organizations collect data on hospital operations, spending, physicians' and dentists' work, and revenue on annual or quarterly basis indvidual provider data come from claim forms. Provider data are aggregated and published by research centers associated with national provider associations. Provincial sickness fund associations collect and publish data about their members National Ministriles of Health and Labor audit summaries of these data and publish their own reports	Government role in administration of health system relatively small. Reforms of system crafted at national level among political parties and Interest groups within Parliament, Cabinet, and ministries Recent reforms aimed at cost containment and some expansion of benefits. Public health functions administered by provinces within national guidelines developed in Ministry of Health and its secretariat.	Government role in administering and paying for health care limited to provincial teaching hospitals, municipal hospitals, and local public health services Provincial health ministries license and Inspect private hospitals and provide grants to hospitals for capital improvements Ministry staff evaluate need for such grants. Public health services supported from general revenue	Hospitals are mainly private nonprofit and for-profit, but public, municipal hospitals also operate autonomously, German hospitals have relatively few staff, including for admministrative purposes Administrative activtis include usual i internal administration, preparation of annual prospective budget, and budget negotiations with committee of local sickness funds Negotiations have been tradditionally quick and simple, but have become more stringent in the 1990s	German physicians use their offices to perform many ambulatory procedures performed m hospital and outpatient clinics in other countries, thus requiring additional adminirstration to acquire equipment and supplies Physiclans and dentists send out fee-for-service bills Physiclans who work in private clnics have hospital privileges and rely on the clinic to bill payers for them.

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TABLE B-4 continued: Health Care Administration in Germany[a]

Provider associations	Suppliers	Insurers	Education	Research	Management consulting
All office physicians belong to provincial *Kassenartzliche Ver einigung* (KV) that negotiates with provincial committee of sickness funds for a lump sum and then pays all claims Physiclans do not bill patients for any additional payments Provincial KVS with significant administrative apparatus to negotiate with funds, track members' utilization, process and pay claims, and reduce fees if necessary to avoid deficits. National association of KVS negotiates with national associations of sickness funds over work rules, reimbursable procedures, fee schedules, and approximate payment levels Provincial arbitration committees settle disputes and deadlocked negotiations. Provincial hospital associations perform parallel functions for their members	Administrative work for manufacturers for patents, marketing licenses, and recently Introduced drug price regulation	Sickness funds enroll members, calculate and collect premiums and social security pension contributions, negotiate with hospitals and KVS, scrutinize KV statistical reports, communicate with and pay proincial association of KVS and hospitals, cooperate with national and provincial financial audits Marketing Will likely increase due to recent reform increasing citizens' choices in fund enrollment National associations of sickness funds have relatively large administrative burden strategic planning, lobbying for reforms, negotiating at the national level, organization of health insurance in former East Germany, preparing reports, and publishing journals for members and the public Private health Insurance provides primary coverage for 10 percent of population and has administrative functions parallel to sickness funds. Private insurers also have administrative costs associated with policies for long-term care and other extra benefits Employers' admministratvee work limited to payroll deductions and payments to sickness funds	Educational programs for health care managers traditionally limited to general business and financial management courses Some new curricula in medical schools and in-house training by some sickness funds	Significant tradition of health services research in universities and private Institutes in Germany, often commissioned by government ministries	Significant number of management conferences and workshops Some consulting is done for new cost accounting methods or Introduction of computing technologies in hospitals, but it is Iimlted since all players work within a single set of national accounting standards' and necessary training is usually done by national ministries or the contract consultants

[a]Office of Technology Assessment, 1994Based on Glaser, W A "Administrationin Health Care A Plan for Cross-NationalComparisons," contractor paper prepared for the Off Ice ofTechnology Assessment, revised edition, 1993