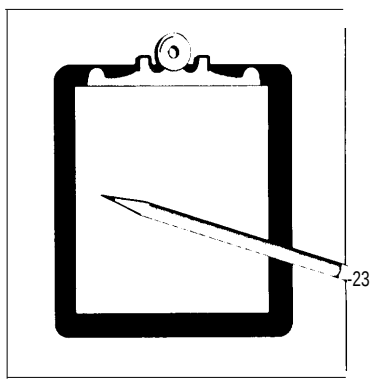
Defining Administrative costs 2

As potential reform of the U.S. health care system has garnered more attention, so too has the perceived complexity of the current system compared with that of other countries (12). Analysts have associated that complexity with the administrative apparatus employed to manage the health care system, making estimates of administrative costs relevant to the debate over health care reform. At issue is whether or not a reformed U.S. system can realize administrative savings that can be used to pay for extended coverage, new benefits, or overall spending reductions.

In the literature, administrative costs often are equated with wasted resources that could be turned to more productive use. Many advocates of single-payer health care systems and analysts who measure health care costs for national accounting purposes (20,31,54,55) believe this is so. Other analysts, with a view towards macroeconomic theory and health care management, focus on administrative expenditures as inputs to the production of health (4,5, 18,38). Seen in this light, administrative expenditures are an investment in people and services that have (often unmeasured) benefits such as making the health care system more equitable, less costly, or more cost-effective. Because such investment tends to be greater and easier to identify in a multipayer system, the notion of administration as an investment is commonly supported by advocates of managed competition or other reform plans that preserve multiple payers (6).



This background paper explores administrative costs in the United States and other countries and conceptual issues such as the one described above. It reviews actual attempts to measure and compare the administrative burdens of different countries' health care systems, and it examines whether international com-

parisons offer any insights into how various approaches to health care reform may alter administrative spending in the United States.

The word "administration" conjures up images of paperwork, clerks, and managers. One political scientist has suggested a more formal definition: those activities that regulate or control the behavior of individuals in an organization, enabling them to implement policy decisions and achieve goals (15). In health care, administration is generally understood to include nonclinical activities, however, this simple definition may not be descriptive enough to allow one to measure administration in the United States and compare it with that in other countries. For example, biomedical research, classroom medical education, and hospital food services are nonclinical but not administrative. The sections that follow review more detailed attempts to define and classify administrative activities in health care and consider their usefulness in trying to measure the magnitude of health care administration.

A TYPOLOGY OF ADMINISTRATIVE COSTS BY FUNCTION

Thorpe (38) classifies administrative activities and their associated costs according to the function they serve and the type of individual or organization performing them. He shares the view that these cost are "inputs" to the production of administrative services that help insure against illness and deliver medical care. In his scheme, total administrative spending equals the sum of 1) "transaction-related" costs, 2) benefits management costs, 3) the costs of marketing and selling of insurance, and 4) the costs of regulation and compliance. Health insurers, hospitals, nursing homes, physicians, employers, and individuals and other consumers are the various actors performing each of these activities (see table 2-1).

Thorpe stresses the fact that administrative costs produce outputs, and that in comparing costs, one must control for the type and level of services produced. In addition, Thorpe points out that in the case of health insurers in the United States, not only does administrative spending vary across insurers, the insurance product itself differs among plans, making straight comparisons of their administrative costs meaningless. Hence, it is fallacious to conclude that the health plan or the country spending the most on administration must be the most wasteful.

Because Thorpe developed his classification to describe the U.S. health care system, its usefulness in comparing administrative costs across countries is limited. In one critique, Hahn sug-

TABLE 2-1: Administrative Costs, by Function and Sector of the U.S. Health Care System

function/ component	Health insurance	Hospitals	Nursing homes	Physicians	Firms	Consumers/ individuals
Transaction - related	Claims processing	Admiting, billing	Admiting, billing	Billing	Tracking employee hires/terminations	Submitting claims
Benefits management	Statistical analysis, quality assurance, plan design	Management information systems	Management information systems	Management Information systems	Internal analyses	Tracking expenses eliglble for reimbursement
Selling and marketing	Underwriting, risk premiums, advertising	Strategic planning, advertising	Strategic planning	Advertising	Flexible benefit programs	Search costs
Regulatory/ compliance	Premium taxes, reserve requirements	Waste management	Discharge planning	Licensing requirements	Filing summary plan descriptions, COBRA obligations[a]	Mandated benefit laws

[a] COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985, which Includes provisions for continuation of coverage when an employee leaves a firm

SOURCE K E Thorpe, " Inside the Black Box of Administrative Costs, *Health Affairs* 11:2 (summer 1992) 41-55

gests two modifications of Thorpe's scheme tomake it applicable to other countries (1 8). He would add a fifth administrative function called "oversight" that includes services associated with calculating and setting global budgets and rate increases, evaluating capital expenditures, and negotiating rates with providers. For example, he points to Canada and Germany as countries in which marketing to attract patients is relatively insignificant since all patients have some coverage. In its place is a bargaining component in which physicians or the associations to which they belong negotiate with the government or insurers for their fees.

Hahn also suggests supplementing Thorpe's scheme with a consideration of the differences in countries' "production functions" for medical services. For example, one country may use clinical staff, such as physicians and nurses, to perform a given administrative function while another country may use clerical staff instead. Furthermore. even if two countries use the same type of staff and technology to perform a given administrative function, the salaries and prices of other inputs to producing that function may differ between the two countries' leading to different levels of total administrative costs. Hence, a true comparison must take account of differences in both input prices and means of carrying out administrative functions.

AN ENUMERATION OF ADMINISTRATIVE ACTIVITIES

Although Thorpe's scheme may be used to conceptualize different types of administrative activi - ties in health care, it is still not detailed enough to serve as a protocol for accurately and comprehensively measuring the amount of administration in a nation's health care system. Recent work by Glaser, commissioned by OTA as part of this project (15) and based. in part on earlier research (1 3,1 4). would be the first step in a bottom-up approach to actually comparing the magnitude of administrative expenditures among nations.

Glaser distinguishes his definitions from attempts to group administrative activities according to their functions (e.g.. transaction-related costs, regulatory compliance, coordination). He argues that while the classifications are useful in aggregating and analyzing administrative data, his definitions are designed to help researchers collect original data at the grass-roots level. Glaser does not measure the outputs of administrative activities—i.e., the extent to which such activities accomplish their goals: attempts only to provide an exhaustive enumeration of the inputs of administration.

Differences in the organization and financing of health care imply that some of the activities identified by Glaser will not exist in every country and that the relative magnitude of other administrative activities will also vary. For each activity identified, Glaser suggests that researchers collect data on the total number of full-time equivalent employees (FTEs) and total expenditures devoted to that activity. However. difficulties in gathering data, discussed later in this background paper, may inhibit researchers' ability to measure and compare the administrative apparatus of health care across national borders.

I Specific Administrative Activities

Table 2-21 lists all of the activities related to heath care that Glaser identities as administrative in nature, primarily classified according to the organizations in which they occur. Unless otherwise noted, none of the substance of the work in these organizations counts as administrative-only the expenditures for activities necessary to support that work. In legislatures and other government agencies responsible for health policy. resources expended in making policy decisions would not be considered administrative. The major exceptions to this generalization are:

- **Ministries and other public agencies that implement health policies** (table 2-2, item 3). To the extent that such agencies are devoted to health, the entire budget can be counted as administrative except for expenditures for direct clinical and public health services and policy-making.
- **Insurers who pay providers** (table 2-2, item 9). All of their activities, except for the value of

TABLE 2-2: Administrative Activities in Health Care by the Type of Organization in Which They Occur

Organization	Administrative activities
1 Public and private organizations that collect vital statistics health-related lifestyles, health care financing data, health personnel, and related Information for private organizations, the public, and policy makers	Management of operations and financing of the agencies, not including actual data collection and processing. Communication between management and oversight or supplying agencies; requests for resources, assignments, guidance. Acquisition, distribution, and storage of resources. Here and elsewhere, only the administration of acquisition, distribution, and storage—not the full payment for the resources themselves. Recruitment, screening, instruction, assignment, supervision, terminations, retirements, promotions, and record-keeping for personnel. Administration of publications and other methods of communicating substantive results to the public and policy makers. Operations of the agency infrastructure: buildings and grounds, cafeteria, security, motor pool, computing, library.
2. Legislatures and other organizations that make health policy—prorated share of total administrative costs devoted to health	Management of legislative affairs. Communications between the legislature and the public; between the legislature and agencies charged with implementing health policy. Operations of organizational infrastructure.
3. Ministries and other public agencies that Implement health policies (Does not Include government agencies to reimburse providers for health care sevices) To the extent agency is devoted to health, entire staffing and budget minus expenditures for direct clinical services, direct public health work, and policy making	Management, internal financial work, clerical work, communications with individuals and organizations outside the agency, acquisition, distribution, and storage of resources, personnel management, administration of publications, infrastructural operations. Resolution of disputes between the agency and providers, between the agency and the public, and among providers and users outside the agency.
4 Organizations that deliver health care (hospitals, nursing homes, community health centers, home health care agencies, etc.). For clinicians within such organizations, Includes prorated share of their time devoted to administrative functions	All costs of "parent" organizations for those health care delivery organizations that belong to private chains or government associations that coordinate and manage them. Organizational management (as distinct from clinical direction), internal financial work, clerical work, communications, regulatory compliance, acquisition, distribution, and storage of resources for the facility and clinical operations, personnel management, infrastructural operations. Calculating bills for patient care, billing payers, collections. Medical records: the work of clinicians, clerks, and central office; transmitting them to patients' outside providers, payers, utilization review monitors, etc. Communication with liability insurers. Litigation of disputes.

(continued)

TABLE 2-2: Administrative Activities in Health Care by the Type of Organization in Which They Occur (Cont'd.)

Organization	Administrative activities
5 Individuals who provide care doctors, dentists, midwives, self-employed home visitors, dispensers of alternate medicine, etc.	Organizational management (as distinct from clinical direction), internal financial work, clerical work communications, regulatory compliance, acquisition distribution and storage of resources for the facility and clinical operations, personnel management, infrastructural operations
	Calculating bills for patient care, billing payers, collections
	Medical records the work of clinicians and office staff, transmitting them to other providers, payers, utilization review monitors, etc.
	Communication with liability Insurers
	Litigation of disputes
6 Associations of providers national, provincial, and local offices	Management, Internal financial work, clerical work
	Communication with payers in negotiation over reimbursement and work rules, communications with regulators, and communications with members explaining reimbursement, regulations, work rules, and clinical Innovations publications and public relations
7 Organizations that supply health care providers with pharmaceuticals, equipment, construction, and other materials	Organizational management, internal financial work, clerical work, personnel management
	Communications with health care providers and others, marketing and public relations
	Negotiating orders, calculating bills, collections
	Record-keeping required by price and quality regulators, communications with regulators
	Communications with insurers, litigation
8 Government agencies that pay all or some providers Such agencies can be national, provincial, local, a special fund that distributes government grants, or two or more of these together	Management of operations, financing, and personnel in the several public agencies that write budgets, process grants, and pay providers Shares attributed to health administration must be prorated, since some of these agencies deal with sectors outside health
	Communications within government--for example, between the Cabinet and the legislature, between the Ministry of Health and the Ministry of Budget--over past costs and future needs
	Management of the flow of money from tax collectors to the payment agencies
	Communications between the payment agencies and the providers Making the payments themselves Collect Ion and audits about costs and performance
	Reports to the Ministry's and the paying agencies superiors in government concerning how the money was spent Reports to the legislature Preparation for special audits
	Work of the auditing agency inl health

(Continued)

TABLE 2-2: Administrative Activities in Health Care by the Type of Organization in Which They Occur

Organization	Administrative activities
9 Insurers who pay some or all providers Payers can be public corporations, mutual aid associations, union-affiliated funds, mutual Insurance companies, or for-profit Insurance companies Nearly everything they do (minus the value of paid claims) constitutes administration.	Organizational management, Internal financial work, clerical work, personnel management Communications with subscribers and their payers, marketing, underwriting, negotiating and writing contracts. Communicating with regulators who set rules for paying providers Negotiating with providers and provider associations over practice and reimbursement rules Receiving, reviewing, and paying claims Utilization review Auditing annual expenditure and utilization review reports submitted by individual providers and provider associations. Communicating with regulatory agencies that review each insurer's financial accounts, Reports to government and to associations of insurers concerning the agency's share of health work and health finance Aggregation of these reports by government and the associations of insurers Publication Administrative activities imposed on outside organizations (such as the subscriber's employer or trade union) in the administration of enrollments and disenrollments, admln-istration of benefits and claims, payment of providers
10. Organizations that conduct research on the organization, management, and financing of the health care system All such work within these organizations may be counted in a county's administrative costs	
11. Organizations that provide education about the organization, operation, and financing of the country's health care system	University and specialty-school training of managers, finance officers, and clerks In-house training Conferences and workshops
12. Organizations that conduct management consulting in the health care sector	

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

claims paid to providers, can be considered administrative.

- **Organizations that provide education, conduct research, or consult on health care management, organization, and financing** (table 2-2, items 10-12). All such work in these organizations can be counted as administrative.

According to Glaser's scheme, specific expenditures in some organizations must be prorated. In the case of government agencies and other organizations that do some work outside the health sector, the value of their administrative expenditures must be prorated by the proportion of their effort devoted to health. For example, in the United States, the Department of Health and Human Services (DHHS) has responsibility for Social Security and other programs that are not directly part of the health care system. One would not attribute the administration of such programs to health care. In the case of individuals who provide direct health care services, one would want to count on] y that portion of their time devoted to administrative functions, and not time spent on clinical activities.

This distinction between clinical and administrative activities suggests at least one ambiguity not addressed by Glaser. He identifies all work by health care providers related to medical record-keeping as administrative in nature, including time spent by clinicians in preparing these records. However, since accurate medical records are part of the way in which physicians and others ensure that they provide appropriate care for patients, one could argue that the preparation of these records (at least the parts related (o patient care) is actually a clinical, not administrative, activity.[4]

Glaser's scheme also draws a distinction between government payment and insurance payment. A line agency of government makes payments to providers from its general budget and tax revenues collected for all purposes, thus making the administrative burden of paying providers a prorated share of all government financial administration. Insurance payment, on the other hand, is made by autonomous public agencies or corporations, nonprofit carriers, for-profit insurance companies, or self-insuring third parties (e.g., employers) from earmarked sources such as subscriber premiums or social security taxes. Using this distinction, Canadian health finance is government payment, while the United States finances private health insurance and Medicare through insurance payment.

As described in chapter 3, Glaser has applied his definitions to the health care systems of four nations, making qualitative estimates of the administrative costs associated with each. However, as mentioned at the outset, the real purpose of his enumeration is to serve as a protocol for a bottom-up measurement of administrative costs. No researcher has yet engaged in this endeavor.

[4] In some instances it may be difficult to distinguish between medical records kept for patient care and those used for truly administrative purposes. For example, providers can record diagnostic information both to facilitate proper patient care and to allow insurance reimbursement.