

## SPECIAL ARTICLE

# Costs of Health Care Administration in the United States and Canada

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## ABSTRACT

**BACKGROUND**

A decade ago, the administrative costs of health care in the United States greatly exceeded those in Canada. We investigated whether the ascendancy of computerization, managed care, and the adoption of more businesslike approaches to health care have decreased administrative costs.

**METHODS**

For the United States and Canada, we calculated the administrative costs of health insurers, employers' health benefit programs, hospitals, practitioners' offices, nursing homes, and home care agencies in 1999. We analyzed published data, surveys of physicians, employment data, and detailed cost reports filed by hospitals, nursing homes, and home care agencies. In calculating the administrative share of health care spending, we excluded retail pharmacy sales and a few other categories for which data on administrative costs were unavailable. We used census surveys to explore trends over time in administrative employment in health care settings. Costs are reported in U.S. dollars.

**RESULTS**

In 1999, health administration costs totaled at least \$294.3 billion in the United States, or \$1,059 per capita, as compared with \$307 per capita in Canada. After exclusions, administration accounted for 31.0 percent of health care expenditures in the United States and 16.7 percent of health care expenditures in Canada. Canada's national health insurance program had overhead of 1.3 percent; the overhead among Canada's private insurers was higher than that in the United States (13.2 percent vs. 11.7 percent). Providers' administrative costs were far lower in Canada.

Between 1969 and 1999, the share of the U.S. health care labor force accounted for by administrative workers grew from 18.2 percent to 27.3 percent. In Canada, it grew from 16.0 percent in 1971 to 19.1 percent in 1996. (Both nations' figures exclude insurance-industry personnel.)

**CONCLUSIONS**

The gap between U.S. and Canadian spending on health care administration has grown to \$752 per capita. A large sum might be saved in the United States if administrative costs could be trimmed by implementing a Canadian-style health care system.

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**I**N 1991, WE REPORTED THAT PEOPLE IN the United States spent about \$450 per capita on health care administration in 1987, whereas Canadians spent one third as much.<sup>1</sup> Subsequent studies reached similar conclusions, but all relied on data from 1991 or before.<sup>2,3</sup> In the interim, organizational and technological changes have revolutionized health care administration. The ascendancy of managed care and competition has forced providers to adopt more businesslike approaches. Mergers between hospitals and between health maintenance organizations (HMOs) have centralized “back office” tasks. E-mail has displaced regular mail, and the Internet allows insurers to offer on-line verification of applicants’ eligibility, utilization review, and payment approval.<sup>4</sup> By 1999, nearly two thirds of U.S. health insurance claims were filed electronically, including 84 percent of Medicare claims.<sup>5</sup>

Canada’s national health insurance system has also been subject to technological change and turmoil — strident debate over cost controls, the availability of medical technology, hospital closures, and the appropriate role of investor-owned providers. But its organizational structure has changed little. We evaluated whether the adoption of a more businesslike attitude, the proliferation of HMOs, and the automation of billing and clerical tasks have trimmed administrative costs in the United States and whether Canada’s administrative parsimony has persisted in the years since our earlier study.

## METHODS

To estimate administrative costs, we sought data on insurance overhead, employers’ costs to manage benefits, and the administrative costs of hospitals, practitioners’ offices, nursing homes, and home care. Our estimates use 1999 figures, the most recent comprehensive data. We used gross-domestic-product purchasing-power parities<sup>6</sup> to convert Canadian dollars to U.S. dollars, and we used SAS software for data analyses.<sup>7</sup>

### INSURANCE OVERHEAD

We obtained figures for insurance overhead and the administration of government programs from the Centers for Medicare and Medicaid Services<sup>8</sup> and the Canadian Institute for Health Information.<sup>9</sup>

### EMPLOYERS’ COSTS TO MANAGE HEALTH CARE BENEFITS

For the United States, we used a published estimate of employers’ spending for health care benefits

consultants and internal administration related to health care benefits in 1996.<sup>10,11</sup> We used this figure to estimate 1999 costs on the basis of the growth in health care spending among employers in the private sector.<sup>12</sup> No comparable figures are available for Canada. We assumed that employers’ internal administrative costs plus the costs of consultants (as a share of employers’ health care spending<sup>13</sup>) are the same in Canada as in the United States.

### HOSPITAL ADMINISTRATION

For the United States, we calculated the administrative share of hospital costs by analyzing data from fiscal year 1999 cost reports that 5220 hospitals had submitted to Medicare by September 30, 2001, using previously described methods.<sup>14,15</sup> For Canada, we and colleagues at the Canadian Institute for Health Information analyzed cost data for fiscal year 1999 (April 1, 1999, through March 31, 2000) for all Canadian hospitals except those in Quebec (which use a separate cost-reporting system), using methods similar to the ones we used to calculate costs in the United States. When questions arose about the comparability of expense categories, we obtained detailed descriptions of the Canadian categories from Canadian officials and consulted U.S. Medicare auditors to ascertain where such costs would be entered on Medicare cost reports. For both countries, we multiplied the percentage spent on administrative costs by total hospital spending.<sup>8,9</sup>

### ADMINISTRATIVE COSTS OF PRACTITIONERS

We calculated the administrative costs of U.S. physicians by adding the value of the physicians’ own time devoted to administration to estimates of the share of several categories of office expenses that are attributable to administrative work. We determined the proportion of physicians’ work hours devoted to billing and administration from a national survey<sup>16</sup> and multiplied this proportion by physicians’ net income before taxes.<sup>8,17</sup> We calculated the costs of administrative work by nurses and other clinical employees in doctors’ offices by assuming that they spent the same proportion of their time on administration as did physicians. We calculated the value of this time on the basis of total physicians’ revenues<sup>8</sup> and survey data on doctors’ payroll costs from the American Medical Association.<sup>17</sup> We attributed all of physicians’ expenses for clerical staff to administration.<sup>17</sup> Although administrative and clerical workers accounted for 43.8 percent of the work force in physicians’ offices (unpublished data), we attributed only one third of office rent and

other expenses (excluding medical machinery and supplies)<sup>17</sup> to administration and billing. Accounting, legal fees (excluding the cost of malpractice insurance), the costs of outside billing services, and other such costs are subsumed in “other professional expenses,”<sup>17</sup> half of which we attributed to administration.

To estimate the administrative expenses of dentists (and other nonphysician practitioners), we analyzed data on administrative and clerical employment in practitioners’ offices from the March 2000 Current Population Survey using previously described methods.<sup>18</sup> Administrative and clerical employees’ share of office wages was 43 percent lower in the case of dentists’ offices and 14 percent lower in the case of other nonphysician practitioners’ offices than those of physicians’ offices. We assumed that the administrative share of the income of dentists and other nonphysician practitioners mirrored these differences.

To calculate administrative costs in Canada, we obtained figures from a Canadian Medical Association survey on the proportion of physicians’ time devoted to administration and practice management<sup>19</sup> and multiplied this proportion by physicians’ net income before taxes.<sup>9,20</sup> To calculate the cost of nonphysician staff time, we used figures from Canadian Medical Association surveys of physicians’ expenditures for office staff,<sup>20,21</sup> which did not distinguish between clinical and administrative staff. We analyzed special 1996 Canadian Census tabulations to determine administrative and clinical workers’ shares of total wages in doctors’ offices.<sup>18</sup> We attributed all of the administrative workers’ share to administration and assumed that nonphysician clinical personnel spend the same proportion of their time on administration as did physicians.

To calculate the costs of office rent and similar expenses, we attributed one third of physicians’ office rent, lease, mortgage, and equipment costs<sup>20,21</sup> to administration and billing. We attributed half of other professional expenses<sup>20,21</sup> to administration. To calculate the administrative expenses of nonphysician office-based practitioners in Canada, we used the same procedure that we used for the U.S. data and based the analysis on 1996 Canadian Census data.

#### **NURSING HOME ADMINISTRATION**

No published nationwide data on the administrative costs of U.S. nursing homes are available for 1999, and only Medicare-certified facilities (which

are not representative of all nursing homes) file Medicare cost reports. However, California collects cost data from all licensed homes. Therefore, we analyzed 1999 data on 1241 California nursing homes,<sup>22</sup> grouping expenditures into three broad categories: administrative, clinical, and mixed administrative and clinical. We used methods similar to those employed in our hospital analysis<sup>14,15</sup> to allocate expenses from the “mixed” category to the clinical and administrative categories. To generate a national estimate, we multiplied the administrative share of expenditures by total nursing home spending.<sup>8</sup>

For Canada, we and colleagues at the Canadian Institute for Health Information analyzed data for fiscal year 1998 (April 1, 1998, through March 31, 1999) on administrative costs for homes for the aged (excluding Quebec) from Statistics Canada’s Residential Care Facilities Survey, using methods similar to those we used for the U.S. data. We multiplied the share spent for administration by total nursing home expenditures in Canada.<sup>9</sup>

#### **ADMINISTRATIVE COSTS OF HOME CARE AGENCIES**

We analyzed data from fiscal year 1999 cost reports that 6633 home health care agencies submitted to Medicare. We excluded agencies reporting implausible administrative costs that were below 0 percent or above 100 percent and then calculated the proportion of expenses classified as “administrative and general.”

For Canada, we obtained data on administrative costs in Ontario; the categories used appeared similar to those used in the U.S. data.<sup>23</sup> We totaled the administrative costs of Community Care Access Centres,<sup>24</sup> which contract with home care providers; home care providers (White G, Ontario Association of Community Care Access Centres: personal communication); and provincial government oversight of home care. We multiplied the proportion spent for administration by total home care spending throughout Canada.<sup>25</sup>

#### **TOTAL COSTS OF HEALTH CARE ADMINISTRATION**

To calculate total spending on health care administration, we totaled the administrative costs of all the categories detailed above. In analyzing the administrative share of health care spending, we excluded from both the numerator and the denominator expenditure categories for which data on administrative costs were unavailable: retail pharmacy sales,

medical equipment and supplies, public health, construction, research, and “other,” a heterogeneous category that includes ambulances and in-plant services. These excluded categories accounted for \$261.2 billion, 21.6 percent of U.S. health care expenditures, and \$21.0 billion, 27.6 percent of Canadian health care expenditures.

**TRENDS SINCE 1969**

The analysis for 1999 relied on several sources of data that were not available for earlier years. To assess trends over time, using previously described methods,<sup>18</sup> we analyzed U.S. Census data on employment in health care settings from the March Current Population Survey for every fifth year since 1969 and the Canadian Census for 1971, 1986, and 1996.

**RESULTS**

**INSURANCE OVERHEAD**

In 1999 U.S. private insurers retained \$46.9 billion of the \$401.2 billion they collected in premiums. Their average overhead (11.7 percent) exceeded that of Medicare (3.6 percent) and Medicaid (6.8 percent). Overall, public and private insurance overhead totaled \$72.0 billion — 5.9 percent of the total health care expenditures in the United States, or \$259 per capita (Table 1).

The overhead costs of Canada’s provincial insurance plans totaled \$311 million (1.3 percent) of the \$23.5 billion they spent for physicians and hospital services. An additional \$17 million was spent to administer federal government health plans. The overhead of Canadian private insurers averaged 13.2 percent of the \$8.4 billion spent for private coverage. Overall, insurance overhead accounted for 1.9 percent of Canadian health care spending, or \$47 per capita (Table 1).

**EMPLOYERS’ COSTS TO MANAGE HEALTH BENEFITS**

U.S. employers spent \$12.2 billion on internal administrative costs related to health care benefits and \$3.7 billion on health care benefits consultants — a total of \$15.9 billion, or \$57 per capita (Table 1). Canadian employers spent \$3.6 billion for private health insurance and \$252 million to manage health benefits, or \$8 per capita.

**HOSPITAL ADMINISTRATION**

The average U.S. hospital devoted 24.3 percent of spending to administration. Hospital administra-

tion consumed \$87.6 billion, or \$315 per capita (Table 1). In Canada, hospital administration cost \$3.1 billion — 12.9 percent of hospital spending, or \$103 per capita.

**NURSING HOME ADMINISTRATION**

California nursing homes devoted 19.2 percent of revenues to administration in 1999. Nationwide, U.S. nursing homes spent \$17.3 billion on administration, or \$62 per capita (Table 1). Administration accounted for 12.2 percent (\$882 million) of Canadian nursing home expenditures, or \$29 per capita.

**ADMINISTRATIVE COSTS OF PRACTITIONERS**

In the United States, administrative tasks consumed 13.5 percent of physicians’ time, valued at \$15.5 billion. Physicians spent 8.3 percent of their gross income on clinical employees; the administrative portion (13.5 percent) of compensation of these employees was \$3.0 billion. Physicians’ costs for clerical staff averaged 12.3 percent of physicians’ gross income, or \$33.1 billion. The one third of physicians’ office rent and expenses attributable to administration represented 4.6 percent of physicians’ gross income, or \$12.4 billion. Finally, the half of “other professional expenses” (a category that includes accounting and legal fees) attributable to administration accounted for 3.2 percent of physicians’ income, or \$8.6 billion. In total, physicians’ administrative work and costs amounted to \$72.6 billion — \$261 per capita, or 26.9 percent of physicians’ gross income.

The administrative costs of dentists and of other nonphysician practitioners totaled \$8.6 billion and \$8.8 billion, respectively. Overall, U.S. practitioners’

**Table 1. Costs of Health Care Administration in the United States and Canada, 1999.**

Cost Category	Spending per Capita (U.S. \$)	
	United States	Canada
Insurance overhead	259	47
Employers’ costs to manage health benefits	57	8
Hospital administration	315	103
Nursing home administration	62	29
Administrative costs of practitioners	324	107
Home care administration	42	13
Total	1,059	307

administrative costs amounted to \$89.9 billion, or \$324 per capita (Table 1).

Canadian physicians devoted 8.4 percent of their professional time to practice management and administration, valued at \$592 million. They spent 6.1 percent of their gross income on clinical office staff. The administrative portion (8.4 percent) of compensation of these employees amounted to \$53 million. Physicians' costs for clerical staff averaged 6.9 percent of their gross income, or \$716 million. The one third of physicians' office rent and expenses attributable to administration totaled \$193 million. Finally, the 50 percent of "other professional expenses" attributable to administration cost \$116 million. In total, physicians' administrative work and costs amounted to \$1.7 billion — \$55 per capita, or 16.1 percent of their gross income.

The administrative and billing costs of Canadian dentists and of other nonphysician practitioners totaled \$928 million and \$660 million, respectively. Overall, the administrative expenses of Canadian practitioners totaled \$3.3 billion, or \$107 per capita (Table 1).

#### ADMINISTRATIVE COSTS OF HOME CARE AGENCIES

U.S. home care agencies devoted 35.0 percent of total expenditures to administration — \$11.6 billion, or \$42 per capita (Table 1). Administration accounted for 15.8 percent of Ontario's home care expenditures. Throughout Canada, home care administration expenses totaled \$408 million, or \$13 per capita.

#### TOTAL COSTS OF HEALTH CARE ADMINISTRATION

In the United States, health care administration cost \$294.3 billion, or \$1,059 per capita (Table 1). In Canada, health care administration cost \$9.4 billion, or \$307 per capita. If the difference of \$752 per capita were applied to the 1999 U.S. population, the total excess administrative cost would be \$209 billion. After exclusions, administration accounted for 31.0 percent of health care expenditures in the United States, as compared with 16.7 percent of health care expenditures in Canada.

#### TRENDS IN ADMINISTRATIVE EMPLOYMENT IN HEALTH CARE

In the United States, 27.3 percent of the 11.77 million people employed in health care settings in 1999 worked in administrative and clerical occupations (Table 2). This figure excludes 926,000 employees

**Table 2. Administrative and Clerical Personnel as a Percentage of the Health Care Labor Force in the United States, 1969 through 1999.\***

Year	Percentage of Health Care Labor Force
1969	18.2
1974	21.2
1979	21.9
1984	23.9
1989	25.5
1994	25.7
1999	27.3

\* Calculations exclude insurance-industry personnel.

in life or health insurance firms, 724,000 in insurance brokerages, and employees of consulting firms.<sup>26</sup> In 1969, administrative and clerical workers represented 18.2 percent of the health care labor force (Table 2). In Canada, administrative and clerical occupations accounted for 19.1 percent of the health care labor force in 1996, 18.7 percent in 1986, and 16.0 percent in 1971. (These figures exclude insurance personnel). Although the United States employed 12 percent more health personnel per capita than Canada, administrative personnel accounted for three quarters of the difference.

#### DISCUSSION

Administrators are indispensable to modern health care; their tasks include ensuring that supplies are on hand, that records are filed, and that nurses are paid. Many view intensive, sophisticated management as an attractive solution to cost and quality problems<sup>27-29</sup>; that utilization review, clinical-information systems, and quality-improvement programs should upgrade care seems obvious. However, some regard much of administration as superfluous, born of the quirks of the payment system rather than of clinical needs.

How much administration is optimal? Does the high administrative spending in the United States relative to that in Canada (or to that in the United States 30 years ago) improve care? No studies have directly addressed these questions. Although indirect evidence is sparse, analyses of investor-owned HMOs and hospitals — subgroups of providers

with relatively high administrative costs — have found that for-profit facilities have neither higher-quality care nor lower costs than not-for-profit facilities.<sup>15,30-38</sup> Internationally, administrative expenditures show little relation to overall growth in costs or to life expectancy or other health indicators.<sup>39</sup>

Several factors augment U.S. administrative costs. Private insurers, which have high overhead in most nations — 15.8 percent in Australia, 13.2 percent in Canada, 20.4 percent in Germany, and 10.4 percent in the Netherlands<sup>40</sup> — have a larger role in the United States than in Canada. Functions essential to private insurance but absent in public programs, such as underwriting and marketing, account for about two thirds of private insurers' overhead.<sup>40</sup>

A system with multiple insurers is also intrinsically costlier than a single-payer system. For insurers it means multiple duplicative claims-processing facilities and smaller insured groups, both of which increase overhead.<sup>41,42</sup> Fragmentation also raises costs for providers who must deal with multiple insurance products — at least 755 in Seattle alone<sup>43</sup> — forcing them to determine applicants' eligibility and to keep track of the various copayments, referral networks, and approval requirements. Canadian physicians send virtually all bills to a single insurer. A multiplicity of insurers also precludes paying hospitals a lump-sum, global budget. Under a global-budget system, hospitals and government authorities negotiate an annual budget based on past budgets, clinical performance, and projected changes in services and input costs. Hospitals receive periodic lump-sum payments (e.g.,  $1/12$  of the annual amount each month).

The existence of global budgets in Canada has eliminated most billing and minimized internal cost accounting, since charges do not need to be attributed to individual patients and insurers. Yet fragmentation itself cannot explain the upswing in administrative costs in the United States since 1969, when costs resembled those in Canada. This growth coincided with the expansion of managed care and market-based competition, which fostered the adoption of complex accounting and auditing practices long standard in the business world.

Several caveats apply to our estimates. U.S. and Canadian hospitals, nursing homes, and home care agencies use different accounting categories, though we took pains to ensure that they were comparable. The U.S. hospital figure is consistent

**Table 3. Number of Enrollees and Employees of Selected Major U.S. Private Health Insurers and Canadian Provincial Health Plans, 2001.\***

Plan Name	No. of Enrollees†	No. of Employees	No. of Employees/10,000 Enrollees
<b>U.S. plans</b>			
Aetna	17,170,000	35,700	20.8
Anthem	7,883,000	14,800	18.8
Cigna	14,300,000	44,600	31.2
Humana	6,435,800	14,500	22.5
Mid Atlantic Medical Services	1,832,400	2,571	14.0
Oxford	1,490,600	3,400	22.8
Pacificare	3,388,100	8,200	24.2
United Healthcare	8,540,000	30,000	35.1
WellPoint	10,146,945	13,900	13.7
<b>Canadian plans</b>			
Saskatchewan Health	1,021,288	145	1.4
Ontario Health Insurance Plan	11,742,672	1,433‡	1.2

\* Data are from the Annual Reports filed with the Securities and Exchange Commission,<sup>49</sup> the Government of Saskatchewan,<sup>50</sup> and the Government of Ontario.<sup>51</sup>

† Numbers include administrative-services-only contracts as well as Medicare, Medicaid, and commercial enrollees; numbers exclude recipients of pharmacy-benefit management, life, dental, other specialty, and nonhealth insurance products.

‡ The estimate is based on wage and salary expenses and on the assumption that the average annual wage is \$38,250.

with findings from detailed studies of individual hospitals.<sup>44-47</sup> The California data we used to estimate the administrative costs of U.S. nursing homes resulted in a lower figure (19.2 percent of revenues) than a published national estimate for 1998 (25.2 percent).<sup>48</sup>

Our figures for physicians' administrative costs relied on self-reports of time and money spent. We had to estimate the time spent by other clinical personnel on administrative work and the share of office rent and expenses attributable to administration (together, these estimated categories account for 5 percent of total administrative costs in the United States). Physicians' reports and our estimates appear congruent with information from a time-motion study<sup>45</sup> and Census data on clerical and administrative personnel employed in practitioners' offices. Our estimates of employers' costs to administer health care benefits rely on a consultant's survey of

a limited number of U.S. firms. Though subject to error, this category accounts for only 5 percent of administrative costs in the United States.

Cross-national comparisons are complicated by differences in the range of services offered in hospitals and outpatient settings. For instance, many U.S. hospitals operate skilled-nursing facilities, whose costs are lumped with hospital costs in the national health accounts. Similarly, the costs of free-standing surgical centers, more common in the United States than in Canada, are lumped with practitioner costs. Although these differences shift administrative costs among categories (e.g., from nursing homes to hospitals), their effects on national totals should be small.

Price differences also affect international comparisons, a problem only partially addressed by our use of purchasing-power parities to convert Canadian dollars to U.S. dollars. (Using exchange rates instead would increase the difference between the United States and Canada by 27 percent.) Canadian wages are slightly lower than those in the United States, distorting some comparisons (e.g., per capita spending), but not others (e.g., the administrative share of health care spending or personnel).

Our dollar estimates understate overhead costs in both nations. They exclude the marketing costs of pharmaceutical firms, the value of patients' time spent on paperwork, and most of the costs of adver-

tising by providers, health care industry profits, and lobbying and political contributions. Our analysis also omits the costs of collecting taxes to fund health care and the administrative overhead of such businesses as retail pharmacies and ambulance companies. Finally, we priced practitioners' administrative time using their net, rather than gross, hourly income, conservatively assuming that when physicians substitute clinical for administrative time, their overhead costs rise proportionally; using gross hourly income would boost our estimate of total administrative costs in the United States to \$320.1 billion.

The employment figures used for our time-trend analysis exclude administrative employees in consulting firms, drug companies, and retail pharmacies, as well as insurance workers, who are far more numerous in the United States than in Canada<sup>49-51</sup> (Table 3).

Despite these imprecisions, the difference in the costs of health care administration between the United States and Canada is clearly large and growing. Is \$294.3 billion annually for U.S. health care administration money well spent?

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## CORRECTION

**Costs of Health Care Administration in the United States and Canada**

*To the Editor:* There is little doubt that per capita health care administrative costs are lower in Canada than in the United States, as Woolhandler et al. report (Aug. 21 issue),<sup>1</sup> even though the precise magnitude of the gap is open to debate, a point that Aaron makes in his accompanying editorial.<sup>2</sup> However, the Canadian single-payer system results in chronic shortages of medical services because of underfunding. The underfunding problem is usually considered to be a separate issue from the single-payer system itself,<sup>2</sup> but the very structure of the single-payer system may cause the problem.

In the United States, persons who wish to spend more on health care than the norm have a simple way of doing so: they can purchase premium private medical insurance. Notwithstanding the Medicare prescription-drug plans currently being discussed, it is generally not an option in the United States to increase medical expenditures through the taxation system, given contemporary political and fiscal constraints. In Canada, however, increases in medical expenditures are possible largely only through the taxation system. And even if, as some surveys suggest, most Canadians are willing to spend more on health care,<sup>3</sup> taxpayers cannot be sure that any given tax increase will actually go to health care expenditures. Therefore, Canadian taxpayers generally resist tax increases, and underfunding and chronic shortages result.

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*To the Editor:* Aaron's commentary on the report by Woolhandler and colleagues is much too dismissive of their work. Tacitly assuming that the *Journal* is read only by Americans and that "policymakers" means "American policymakers," he probably would dismiss most cross-national studies of health care systems, on the grounds that

culture and interest-group politics chain (American) policymakers forever to a health care system that Aaron himself admits is an "administrative monstrosity."

Policymakers beyond America's borders, however, do read the *Journal*. They are not nearly so constrained by cultural blinders. During the 1990s, for example, Taiwan moved to universal health insurance coverage and opted for a single-payer system, after carefully studying health care systems abroad. Similarly, Canadian policymakers are forever being encouraged by critics to move Canada's health care system closer to the U.S. approach. These foreign policymakers and their policy analysts will find cross-national work on administrative costs highly relevant, quibbles over methodology notwithstanding.

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*To the Editor:* Aaron concludes that the article by Woolhandler et al. is an interesting academic exercise but is irrelevant for policy circles. This conclusion is based on the perception that the United States and Canada are very different and that this difference limits the relevance to the United States of the Canadian single-payer system. But the method of health care funding in Canada before it established a single-payer system was similar to that in the United States. It included both voluntary and for-profit insurance; the roles of such insurance were dramatically reduced with the establishment of the single-payer system. Moreover, although one would be politically naive to assume that a country as large as the United States can simply import a foreign model (however similar that country's system may have been to the U.S. system at one time), one would be wrong to assume that the uniqueness of the United States precludes our learning from other countries in designing our system of health care.

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*To the Editor:* The report on the cost of health care administration in the United States and Canada is inaccurate. Table 3 of the article shows the results of the authors' efforts to tally the number of people enrolled in our health insurance plans, which in 2001 included Uniprise in addition to United Healthcare. They then attempt to calculate the number of people employed per 10,000 enrollees. These calculations are incorrect and misleading to readers. In 2001, United Healthcare and Uniprise combined provided health insurance products to about 16.5 million people, not 8.5 million, as listed in Table 3. At the time, the entire corporation employed 30,000 people. However, only 20,117 were involved in the administration of these products. Therefore, 12.2 employees per 10,000 enrollees should have been reported, not 35.1.

With 21 business units diligently working to provide affordable health services to 50 million Americans, UnitedHealth Group will continue to invest in information technology and efficient business practices that reduce the cost of health care administration. We appreciate this opportunity to correct the record.

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*The authors reply:* As Sekhon points out, Canada's health care spending is low — 57 percent of the U.S. figure per capita<sup>1</sup> — despite universal, nationwide health insurance. Modest differences in net physician income account for little of the cost differential, about 2 percent. However, Canada's frugality has caused shortages of some expensive services. These shortages are overblown in the press, which seldom reports that the rates of most services provided to Canadians — doctor visits, hospital days, immunizations, and even transplantations and hip replacements — are similar to American rates.<sup>1</sup> Moreover, the quality of care appears to be similar to that for insured Americans.<sup>2</sup>

Since the implementation of nationwide health insurance, infant mortality and life expectancy have improved faster in Canada than in the United States.<sup>1</sup> Although Canadians may spend too little, they get far better value for their money. A system combining Canadian efficiency and U.S. spending levels, as we have proposed elsewhere,<sup>3</sup> would be the world's best.

We disagree with Sekhon that tax-based funding automatically means underfunding. In the United States, government expenditures for health care have expanded faster than private expenditures. Moreover, the government generously supports medical education and research, along with defense contractors and tobacco prices. In Canada, the electorate has recently forced governments to boost health care spending. Government spending can be skimpy or exuberant, depending on who is for it and who is against it.

Navarro and also Reinhardt and Cheng criticize Aaron's political judgment. His economic critique of our methods was also flawed, because it was based on incorrect assumptions about comparative wages. He started from a hypothetical example of a nation with wages 1/10 those in the United States, positing that lower wages (a feature of Canada's system that could not be imported) account for much of Canada's administrative savings. Yet Canada's lower health care prices are not explained by lower wage rates. In 1996 (the latest year for which data are available), the average annual pay of hospital administrative workers in the two nations was virtually identical: \$26,807 in Canada and \$27,570 in the United States (unpublished analysis of data from the March 1997 U.S. Current Population Survey and the 1996 Canadian Census). Aaron's recalculation of our figures is based largely on his incorrect wage assumption.

Finally, Tuckson calls our attention to errors in Table 3 of our article. The correct enrollment figure for United Healthcare is 16,500,000,

putting United Healthcare's number of employees per enrollee at the low end of U.S. insurers, rather than the high end (though still 10 times as high as Canada's provincial plans). Our error derives from our incorrect assumption that a table in UnitedHealth Group's annual report provided complete data on enrollment. In fact, after a recent reorganization, UnitedHealth Group began doing about half of its health insurance business under the Uniprise name.

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*The editorialist replies:* Navarro alleges that the similarity of the pre-reform Canadian payment system and the current U.S. payment system indicates that the evolution of policy in the United States could easily follow the same pattern as that in Canada. I believe that this inference is a non sequitur. The fact that the Canadian payment system once resembled ours does not bear on whether the postreform Canadian system is relevant to current U.S. policy debates. The histories of the United States and Canada have many similarities and differences. The operative question is whether conditions in the United States now resemble past conditions in Canada. I think they do not.

Reinhardt and Cheng observe that other nations can learn from the mistakes of the United States. They suggest that my showing that the estimated difference between U.S. and Canadian administrative costs is exaggerated and my argument that today's Canadian institutions for health care administration have little relevance to the current debate about U.S. health care reform means that I think other nations have nothing to learn from the many policy blunders of the United States. This allegation is unfounded. Nothing in my editorial or my other work supports it.

Reinhardt and Cheng also dismiss as a “quibble” my demonstration — based on one of several questionable procedures — that Woolhandler and colleagues overstate the difference between Canadian and U.S. administrative costs by \$50 billion, or nearly one third. It is not clear to me just how much larger than \$50 billion an error would have to be to graduate from being a “quibble.”

Sekhon notes that a single-payer system need not ration care but can be readily used for that purpose. He sees the capacity to ration as a drawback, because rationing causes queues and other distortions. In contrast, I regard the capacity of single-payer plans to ration effectively as a potential virtue. The need to ration care for the well insured is rapidly becoming inescapable in the face of an avalanche of new and costly technology. No system of rationing will be free of distortions, and a single-payer system may do the job well or poorly, depending on how it is organized and run. But creating politically sustainable institutions to ration health care sensibly and compassionately is one of the leading challenges that our nation cannot avoid and has yet to meet.

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