The Costs of Health Care Administration in the United States and Canada — Questionable Answers to a Questionable Question

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Since 1986, Woolhandler and Himmelstein, alone or with others, have written a series of articles that follow a simple template.[1-5] In them, the authors measure the administrative costs of the U.S. and Canadian health care systems, subtract the second from the first, and note the difference. This issue of the *Journal* contains another article in the series.[6] The authors report that the difference between the United States and Canada in outlays for health care administration seems to be increasing. Others have provided alternative estimates of administrative costs in the United States and elsewhere.[7-9] This literature has been motivated, in part, by speculation that the savings in administrative costs from switching to a single-payer system without cost sharing could pay for the added health care services that would result under a national health insurance system.[2,7]

In reviewing this literature, an economist is struck by how hard it is to identify and estimate administrative costs accurately at a single point in time in a single nation, how doubly hard it is to compare costs at a single point in time among nations, and how triply hard it is to make meaningful international comparisons of trends in administrative costs over time. All estimates depend on assumptions about which costs are purely administrative and how much of the costs of multipurpose functions should be allocated to administration. Accurate international comparisons must also account for differences among accounting conventions and institutional arrangements. In addition, international comparisons over time must deal with shifting exchange rates and divergent trends in relative wages. As a practical matter, the conditions for accurate comparison have proven impossible to satisfy.

Against this background, three questions arise. First, do administrative costs in the United States exceed those in Canada by about as much as Woolhandler and colleagues say? Second, would the difference in administrative costs really pay for the added services induced by universal coverage with no cost sharing? Third and, I think, most important, what is the significance of the answers to the first two questions in terms of policy?

First, a disclaimer: like many other observers, I look at the U.S. health care system and see an administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reason, as well as staggeringly complex public systems with mind-boggling administered prices and other rules expressing distinctions that can only be regarded as weird. (Consider Medicare's different rules for "Qualified Medicare Beneficiaries," "Specified Low-Income Medicare Beneficiaries," and "Qualifying Individuals," and I rest my case.) So, I approach the work of Woolhandler and colleagues with a yearning to believe. In fact, I would impose a very heavy burden of proof on any claim that the U.S. health care system does not spend more on administration than the Canadian system does, much of it to no constructive purpose. As others have noted, the Canadian system imposes other costs, notably waiting times, but these arise from resource limits and not from its single-payer structure.[8] Still, the comparisons made by Woolhandler and colleagues clearly exaggerate the differences between U.S. and Canadian administrative costs.

One aspect of the authors' methodologic approach results in an overestimate of about $50 billion (Table 1). Woolhandler and colleagues compute the difference between U.S. and Canadian administrative costs as follows. First, they calculate how much the United States and Canada each spend on administration. They then divide the spending in each country by its population to get per capita spending. They then use so-called purchasing-power parities to convert Canadian dollars into U.S. dollars so that both outlays are expressed in a common currency.[10] Next, they multiply the difference in per capita spending expressed in U.S. dollars by the U.S. population to reach their estimate of excess U.S. spending on medical administration: $209 billion.

To see one reason why this result is too high, one can apply the same method to a hypothetical country that devotes the same proportion of its national income as the United States to health care and health care administration but has wage levels

Table 1. Approaches to the Calculation of Differences between the U.S. and Canadian Health Care Systems.*

Approach	United States	Canada
Method of Woolhandler et al.		
Total administrative costs ($)	294.3 billion	9.4 billion
Per capita administrative costs ($)	1,059	307
Difference in per capita administrative costs	752 (71.0% of U.S. spending)	
Excess per capita administrative costs in U.S. ($)	752	
Excess spending on health care administration in U.S. ($)	209 billion	
Preferred method		
Administrative costs (% of total health care spending)	31.0	16.7
Difference in administrative costs (% of total health care spending)	14.3 (46.1% of U.S. spending)	
Excess per capita administrative costs in U.S. ($)	489	
Excess spending on health care administration in U.S. ($)	159 billion	

* All monetary amounts are given in U.S. dollars.

that are 1/10 those in the United States. If the United States adopted the health care system of this hypothetical country, it would save nothing on administration, since the proportion of income spent on health care and administration would be unchanged. But if one applied the methods of Woolhandler and colleagues, one would conclude that the United States would save 90 percent of its labor-related outlays for health care administration. A better procedure — and one that Himmelstein, Woolhandler, and others once used[2] — would be to multiply total U.S. health care spending by the difference between the percentage spent on administration in the United States and the percentage spent on administration in Canada (Table 1). The resulting estimate is three fourths the estimate presented by Woolhandler and colleagues.

There is an additional problem. Even estimates based on the preferred method described in the preceding paragraph would not be valid unless the relative compensation of clinical and administrative employees in Canada was the same as that in the United States. The question concerns how much clinical care or administration a given dollar amount buys in each country. Evidence that Woolhandler and colleagues cite[11] indicates that expenditures buy more care in Canada than in the United States. In 1999, 1 Canadian dollar had the purchasing power of $0.85 in U.S. dollars for general consumption but the power of $1.33 in U.S. dollars for health care. Canadian regulation of physicians' fees and the use of global budgets to control hospital spending make it likely that more of this added bang for the Canadian buck arises because Canada is squeezing the salaries of doctors, who have few opportunities outside the health care sector, rather than the salaries of secretaries and accountants, who can easily find work anywhere in the economy. If this inference is correct, then even applying the percentage of health care spending in Canada to that in the United States would overstate the potential savings associated with the U.S. adoption of Canadian methods.

Although differences between U.S. and Canadian spending on health care administration are probably smaller than Woolhandler and colleagues suggest, they may be large. But so what? The most important question is what these differences should tell policy makers. I believe the answer is, "Not much." The differences certainly do not tell them whether administrative savings from adopting a single-payer, no–cost-sharing system would cover the added service costs that would result from such a system. Furthermore, no plausible U.S. system would wholly exclude cost sharing or private insurance. A U.S. version of a national insurance system would include sizable costs for the administration of deductibles and copayments and for the administration of private insurance; in Canada, by contrast, private insurance for services covered under the various provincial health plans is prohibited.

More fundamentally, the administrative structure of any nation's health care system, and certainly those of Canada and the United States, evolves out of its political history and institutions.[10,12] The U.S. health care administration, weird though it may be, exists for fundamental reasons, including a pervasive popular distrust of centralized authority, a federalist governmental structure, insistence on individual choice (even when, as it appears to me, choice sometimes yields no demonstrable benefit), the continuing and unabated power of large economic interests, and the virtual impossibility (during normal times in a democracy whose Constitution potentiates the power of dissenting minorities) of radically restructuring the nation's largest industry — an industry as big as the entire economy of France. For these reasons, careful scrutiny of how the United

States administers its health care system, with an eye to how it can be improved within the limits imposed by history, politics, and economics, is useful. But analytically flawed comparisons with other nations, whose systems differ greatly from our own and that we are most unlikely to emulate, may titillate policymakers and others but provide them with little useful guidance.

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