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ADMINISTRATIVE ISSUES IN HEALTH CARE REFORM

For many physicians, the report by Woolhandler et al.[1] on hospital administrative costs in this issue of the *Journal* will merely confirm their personal experience with the "suits and suites" syndrome — the apparent proliferation of well-appointed administrators and their office space in health care facilities of all varieties. From the standpoint of most physicians, it matters little that such administrators are often hired to help clinicians and patients negotiate our complex health care system. When added to the daily harassment from third parties questioning clinical decisions, the suits and suites syndrome only increases physicians' growing demoralization and anger over a health care system that seems not only dysfunctional but also oppressive.

Physicians, however, should avoid the temptation to personalize the breakdown of the health care system by seeing administrators and administration as the root cause. Blaming the problems of American health care on its administration is as useful as attributing a patient's septic shock to his or her fever or renal failure to an elevated serum creatinine level. The administrative expenses of our health care system are a symptom, not the cause, of our system's profound and worsening illness. The surest way to eliminate administrative waste is to attack its underlying cause through comprehensive health care reform. Providing universal access to health insurance for all Americans is a necessary, although not in itself sufficient, element in such reform, and it will assist in reducing administrative expenses by eliminating the complications of billing and collecting from uninsured patients. Another reliable way to reduce administrative expenditures will be to provide all Americans with a health card, equivalent to a credit card, that summarizes their health care coverage and medical records so that billing can be accomplished through paperless electronic methods and the "missing record" becomes a thing of the past.[2]

Numerous authorities have advanced their recipes for comprehensive reform using these and other approaches.[3] My purpose here is not to recapitulate their efforts but to make a few basic points about the administrative functions of our health care system. The fact is that administrative functions will figure prominently in any health care system that can possibly be devised. In advocating health care reform, it may be useful to treat administrative expenditures as though they were an unmitigated evil. But for the purposes of careful policy development, a more detailed analysis is necessary.

The administrative functions of health care systems are best assessed by relating them to the purposes they are intended to serve.[4] When the purposes are objectionable in themselves, the associated administrative functions are easy candidates for elimination, regardless of the details of the reform plan we ultimately adopt. When there is controversy about the purposes, the disputes will have to be resolved on their merits before agreement can be reached on whether the associated administrative expenditures are justified. And when we agree that the purposes are good, our focus should be on finding the most efficient and effective administrative approach to achieving them. Several examples illustrate these points.

There is now widespread consensus that competition among insurance plans on the basis of risk selection — trying to reduce costs by insuring those least likely to become ill — leads to such profound inequities that it is fundamentally illegitimate and should not be permitted under any reform plan. It follows that the administrative structures developed by private insurance companies to identify and market to such low-risk persons should be eliminated. Many small insurance companies exist entirely or largely on the basis of their ability to select such risks. Preventing private third parties from continuing such practices will force many of them out of business and will reduce administrative expenditures throughout our health care system at little social cost.

In contrast, intense controversy persists over whether health care reform should encourage other forms of competition in our health care system.[5,6] The Clinton administration is advocating managed competition based on price and quality between so-called accountable health plans. Opponents of this and other competitive plans object on several grounds. One is that competition among health care providers and insurers increases administrative costs in certain ways. Competing organizations, such as the proposed accountable health plans, must maintain duplicative administrative systems (accounting, billing, planning, purchasing, and personnel management, to name a few) and are driven to administrative activities, such as marketing and advertising, that some view as wasteful and inappropriate to the health care sector. Organizations that compete on the basis of

price may also be more inclined to manage the provision of health care by physicians in order to control expenditures. At least in the past, such managed-care plans have used methods such as pre-admission certification, utilization review, and mandatory-second-opinion programs that demand enormous administrative investments.

Advocates of competition, however, are persuaded that it has benefits that amply justify its administrative costs. Many argue that over the long term competition is essential to accountability, and accountability is the surest way to control expenditures, including administrative costs.[5] But for some of its advocates, competition has benefits independent of its alleged ability to control costs. Among the most compelling is that the existence of competing health care organizations guarantees a measure of pluralism in our health care system. Pluralism, it is argued, has value in itself. It protects against the concentration of power in the hands of any single group or actor (including the government) and ensures that consumers will always be able to vote with their feet if they are unhappy with aspects of their health care arrangements. The question of whether the administrative costs associated with competition are justified will not be answered until we resolve the ideological and empirical disputes over the benefits and risks of competitive health care arrangements.

Finally, administrative mechanisms serve some purposes that are (or should be, in my view) widely supported. The improvement of quality is one such purpose, and a compelling argument can be made that a reformed health care system should vastly increase investment in certain administrative functions that support quality improvement. I am referring to the data-based approaches to quality management that are advocated by Berwick and others.[7-9]

These approaches rely on a number of techniques that were pioneered in other sectors of our society and are increasingly applied to health care. One of their most distinctive features is their reliance on measuring quality, especially the outcomes of critical processes and the analysis of variation in such outcomes, in order to improve it. Unfortunately, however, the clinical-information systems of most health care organizations are woefully underdeveloped. This makes it extremely difficult to measure outcomes of care and to inform clinicians about areas for improvement. Developing and maintaining information systems that measure the outcomes of care should be a high priority under health care reform.[2] Nor will it be sufficient for the purposes of quality improvement merely to measure outcomes. Health care organizations must develop the ability to use such data effectively. This will require investing in personnel who can assist clinicians in the painstaking tasks of analyzing variation in outcomes, relating variation in outcomes to variation in health care processes, experimenting with improvements in process, and implementing and maintaining prescriptions for change. There is every reason to believe that administrative investments of this sort will pay off in reduced costs, but they should be made even if such savings cannot be demonstrated in the short term.[7]

The strong case for increased investment in administrative support for quality improvement illustrates two important additional points. First, the best administrative system is not necessarily the cheapest. The Canadian and Western European health care systems may very well underinvest in certain kinds of administrative systems that are necessary to support innovation and clinical improvement.[5] The General Accounting Office[10] has noted that Canadian hospitals underinvest in information systems. The correct amount to spend on health care administration is the smallest amount necessary to achieve the goals that our society agrees are necessary. In this regard, expenditures on administration are no different from other health care expenditures.

Second, administrative systems cannot be perfected without the full cooperation and even the leadership of the medical profession. Physicians must acknowledge that some of the administrative functions they find most objectionable, such as utilization review, are misguided efforts to compensate for the public's loss of confidence in the profession's ability or willingness to monitor the quality of care it provides. The reasons for this loss of confidence are complex and have been summarized elsewhere.[11] It is clear, however, that repairing the tattered contract between physicians and American society is absolutely essential if physicians are to be relieved of the administrative harassment they find most oppressive and if health care reform is to prove effective. This will require leadership from the profession. One of the most effective ways to exert that leadership may be to participate in the development of administrative systems that make the quality of health care the best it can possibly be.

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