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HEALTH CARE PAPER CHASE, 1993:

The Cost to the Nation, the States, and the District of Columbia

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Executive Summary

The U.S. health care payment system is an elaborate and increasingly wasteful paper chase. This report presents new state by state estimates of health care administrative costs in the U.S., and savings that could be realized under a single payer reform. In 1993, health care bureaucracy will consume 24.7 cents of every health care dollar, $232.3 billion. Administration's share of health spending is up from 23.9 percent in 1987, and from 21.9 percent in 1983.

Reducing the cost of administration to Canadian levels by adopting a single-payer health care system would cut U.S. health care bureaucracy by more than half (50.7%), saving at least $117.7 billion in 1993; $456 for every American, or $3,325 per uninsured person. The savings achievable with a single-payer system could fund universal access for the uninsured and improve benefits for the tens of millions of Americans who currently have only partial coverage, without any increase in overall health spending.

These results are derived from new data on U.S. hospital costs published in the August 5, 1993 New England Journal of Medicine, and Commerce Department projections of health spending in 1993.

Administrative waste imposes a crippling toll on states struggling to meet the health care needs of their uninsured residents. Minnesota and Hawaii, which have recently implemented multi-million dollar programs to subsidize insurance premiums for a fraction of their uninsured residents, could annually save $1.8 and $0.7 billion respectively by reducing administrative overhead to Canadian levels, more than enough to cover all their state's uninsured and to improve coverage for the underinsured. The Vermont Health Care

Between 1983 and 1987, administrative costs in the U.S. increased from 21.9 to 23.9 percent of health spending, while they declined in Canada from 13.7 to 11.0 percent. Since 1987, the cost of insurance overhead has risen in the U.S. from 5.1 to 5.8 percent of health spending, while the administration of Canada's public insurance program appears to be falling. The share of U.S. physicians' income devoted to overhead (excluding malpractice premiums) increased by 2.8 percent between 1987 and 1991 (American Medical Association. Socioeconomic Characteristics of Medical Practice 1993).

ADMINISTRATIVE WASTE: THE COST TO THE STATES

Excess bureaucracy imposes a staggering toll at the state level. The potential savings possible under a single-payer system range from a low of $156 million in Wyoming (with an estimated 53,000 uninsured residents) to a high of $16.8 billion in California (with 5.8 million uninsured residents)(Table 2).

In Vermont, administrative overhead could be reduced by $200 million if a single-payer system were adopted, more than enough to raise the $71 million that the Vermont Health Care Authority estimates is needed to provide universal access to acute care in that state. Indeed, the savings would also fund the coverage of long-term care to elderly and disabled Vermont residents, without any overall increase in health spending. In contrast, the Authority projects that a proposed multi-payer system, with "integrated delivery systems" of managed care (similar to managed competition), would only reduce administrative costs by $26 million, necessitating additional taxes and out-of-pocket payments by consumers. Even this meager level of savings is unlikely, because evidence shows that many managed care plans have higher overhead costs than traditional plans.

Minnesota and Hawaii have recently implemented programs to subsidize insurance premiums for a fraction of their poor, uninsured residents. Since incremental reforms fail to capture the administrative savings possible under a single-payer system, these programs, while well intentioned, are expensive and will leave out many of the uninsured. Minnesota will spend an additional $64 million in 1994 to provide partial health benefits to 63,000 residents, or 15 percent of that state's uninsured. Adoption of a single-payer program in Minnesota could save the state $1.8 billion this year, more than enough to cover all 406,000 Minnesotans without health insurance, and to improve coverage for underinsured residents. Hawaii will spend $14.5 million this year to cover 22,000 persons, approximately one-quarter of their uninsured. In contrast, Hawaii could save $694 million by adopting a single-payer system.

The cost of excess bureaucracy in states such as Hawaii offers a dramatic example of the failure of insurance industry consolidation to reduce administrative waste in the absence of single-payer reform. Only two major private insurers, plus Medicare and Medicaid, cover the majority of Hawaii's residents. Yet the share of hospital spending consumed by administration (30.6 percent) is the highest of any

state. Although a single-payer would reduce waste to Canadian levels, reducing the number of insurers to a handful does not.

Washington State recently passed a managed competition health care reform plan similar to the model favored by the White House's Task Force on Health Care Reform. Its staggering cost and inadequate scope are sobering: In fiscal years 1993 and 1994, the state will spend an additional $227 million to cover 138,000 poor children and to subsidize premiums for partial coverage for 57,000 adults, a total of less than 40 percent of the state's uninsured. While the projected costs of the plan do not even include the costs of creating and operating the proposed Health Insurance Purchasing Cooperatives, funding for the plan is already jeopardized by an upcoming ballot initiative to roll back new taxes. In contrast, Washington State could save nearly $2.0 billion in 1993 alone by reducing overhead to Canadian levels.

MACROMANAGEMENT: THE SINGLE PAYER ADVANTAGE

The widening gap between administrative overhead in the U.S. and Canada arises from our differing ways of paying for health care and containing utilization of health services. While Canada has a single insurance plan, or "single payer" in each province, the U.S. has a complex and fragmented payment structure built around 1,500 competing insurance plans. Because all health care payments in Canada flow through a single fund, Canada is able to set and enforce overall budgets. Canadian hospitals operate on annual budgets negotiated with the single public insurer in each province, eliminating the need for the financial computer systems, personnel, and paperwork to generate individual hospital bills. This global, "macromanagement" approach to cost-containment requires far less administrative resources than U.S. systems of utilization review and "managed care".

In the U.S., hospitals must keep detailed accounts to generate itemized bills for every aspirin tablet and penicillin shot for each patient and insurer. Additional hospital resources are consumed in providing highly detailed data on individual patients to insurers reviewing hospital utilization. The Mayo Clinic already employs 70 full time staff just to talk on the phone with managed care utilization reviewers. Because of the complexity of billing and administration, U.S. physicians hired an additional 74,700 clerical personnel between 1988 and 1990, and doctors routinely spend hours each week on the phone getting permission from insurance company clerks for their decisions to hospitalize a patient or seek a consultation with a specialist.

Electronic billing has been proposed as an alternate route to streamlining administration in the U.S. Because providers would still have to generate and report detailed per-patient information, this approach would not significantly reduce overall administrative costs. A recent study by Lewin-VHI estimated that implementing electronic billing might save between $2.6 and $5.2 billion in 1993, but would cost nearly $800 million per year to implement (Lewin-VHI, April 30, 1993). Thus, the

net savings would be less than 4 percent of the savings available from adopting a single-payer system.

Other strategies to reduce administrative costs, such as consolidating the insurance industry from some 1,500 insurers to a few insurance giants, and increasing competition among insurers, would also fail to capture most of the savings possible under a single-payer system. Winnowing the number of insurers to a handful would save little on hospital billing and nothing on internal cost tracking (as evidenced in Hawaii). Large insurers' overhead is as high as small firms'. Larger size risk pools, assembled through new purchasing cooperatives or "alliances", may trim insurance company overhead, but only because the purchasers have taken on the task (and expense) of assembling the groups. Most of the savings are achievable only by entirely excluding private insurance companies.

Insurance industry consolidation might actually increase administrative waste if it were accompanied by an increased reliance on managed care and the creation of new bureaucracies to purchase health insurance, a strategy known as managed competition and favored by the Clinton administration. A recent survey of 36 hospital-based HMOs found that overhead and profits consumed 18 percent of total revenues (Modern Healthcare, May 10, 1993), higher than the average of 14 percent for traditional insurance plans, and much higher than the 3.5 percent for Medicare, or the 1 percent for Canada's single-payer program. Indicative of what might be expected at a national level under managed competition, administrative costs at three of the nation's largest, highly competitive, for-profit HMOs (prototypes for managed competition) ranged from 18 to 25 percent in 1991 (Health Economics, 1993; 2:13). The experience of a single Prudential managed care plan in New Jersey is illustrative: to cover 110,000 enrollees, the plan employs almost 200 full time administrative and utilization review personnel, about as many as work for a typical Canadian provincial health insurer covering one and a half million provincial residents.

CONCLUSION

The administrative efficiency of U.S. health care has deteriorated markedly since 1983. The U.S. could save $117.7 billion this year if it reduced administrative overhead to Canadian levels by adopting a single-payer system, more than enough to fund universal access to health care. Managed competition, the reform strategy favored by President Clinton, is likely to increase administrative waste.

TABLE 1

Administrative Savings Possible with a Single-Payer System, U.S. 1993 (in billions)

Category	Administrative Costs	Potential Savings / (percent)	
Hospital Care	81.7	49.1	(60.1)
Physician's Services	84.3	23.8	(28.3)
Nursing Home Care	12.0	1.6	(13.3)
Insurance Overhead	54.3	43.2	(79.6)
Total	$232.3	$117.7	(50.7)

Note: Percent savings is expressed as a percentage of administrative costs.

Table 2

Potential Administrative Savings Achievable with a Canadian-style Single-payer Health Program, by State: 1993

State	Projected 1993 Health Expenditures (in millions $)	Projected Administrative Costs in 1993 (in millions $)	Potential Administrative Savings in 1993 (in millions $)	Uninsured Residents (in thousands)
Alabama	12,932	3,053	1,531	749
Alaska	2,147	464	244	69
Arizona	13,038	3,365	1,698	607
Arkansas	7,218	1,783	877	385
California	136,258	33,615	16,784	5,750
Colorado	12,899	3,038	1,559	334
Connecticut	13,239	3,328	1,647	249
Delaware	2,412	573	285	94
D.C.	2,152	536	281	136
Florida	50,431	13,683	6,942	2,496
Georgia	21,584	5,552	2,744	885
Hawaii	4,350	1,300	694	82
Idaho	2,848	685	331	184
Illinois	45,911	10,834	5,750	1,361
Indiana	18,831	4,510	2,245	721
Iowa	9,960	2,326	1,130	249
Kansas	9,706	2,330	1,160	295
Kentucky	10,877	2,733	1,370	476
Louisiana	14,309	3,941	2,085	868
Maine	4,038	985	508	135
Maryland	18,284	4,145	2,056	625
Massachusetts	27,079	6,796	3,651	633
Michigan	36,409	8,881	4,588	835
Minnesota	16,665	3,728	1,767	406
Mississippi	7,076	1,690	834	507

State	Projected 1993 Health Expenditures (in millions)	Projected Administrative Costs in 1993 (in millions)	Potential Administrative Savings in 1993 (in millions)	Uninsured Residents (in thousands)
Missouri	20,118	4,724	2,386	611
Montana	2,602	644	317	104
Nebraska	5,893	1,443	2	137
Nevada	5,674	1,264	620	232
New Hampshire	3,299	864	452	112
New Jersey	26,131	6,482	3,178	838
New Mexico	4,369	1,051	563	335
New York	77,174	19,477	10,450	2,206
North Carolina	19,379	4,578	2,166	990
North Dakota	2,528	623	294	48
Ohio	41,414	10,109	4,994	1,147
Oklahoma	10,569	2,527	1,275	579
Oregon	10,581	2,503	1,219	422
Pennsylvania	45,951	11,295	5,861	954
Rhode Island	4,065	943	466	96
South Carolina	9,355	2,480	1,300	465
South Dakota	2,483	541	258	68
Tennessee	17,448	4,470	2,258	644
Texas	59,730	15,365	7,680	3,755
Utah	4,980	1,168	569	238
Vermont	1,679	385	200	74
Virginia	20,425	4,959	2,475	1,002
Washington	18,361	4,106	1,961	518
West Virginia	5,763	1,467	765	287
Wisconsin	18,456	4,337	2,076	396
Wyoming	1,235	302	156	53
Total	**$939,900**	**$232,300**	**$117,700**	**35,400**

Note: State figures may not sum to national total due to rounding error.

SPECIAL ARTICLE

ADMINISTRATIVE COSTS IN U.S. HOSPITALS

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Abstract *Background.* Previous estimates of administrative costs in U.S. hospitals have been based on figures for California, and nationwide extrapolation has been controversial. If the costs of bureaucracy are high, major policy reforms may yield substantial savings.

Methods. We obtained detailed data on hospital expenses for fiscal year 1990 from reports submitted to Medicare by 6400 hospitals. We calculated each hospital's administrative costs by summing expenses in the following Medicare cost-accounting categories: administrative and general, nursing administration, central services and supply (excluding the purchase cost of supplies), medical records and library, utilization review, and the salary costs of the employee benefits department. We classified costs in most other categories as clinical. Some small categories of expenses (e.g., gift shop) were excluded from both our clinical and administrative groupings, and for others (e.g., plant operations), a proportional share was allocated between the two groupings.

Results. Nationwide, administration accounted for an average of 24.8 percent of each hospital's spending in fiscal 1990. Average hospital administrative costs ranged from 20.5 percent in Minnesota to 30.6 percent in Hawaii. Administrative salaries accounted for 22.4 percent of the average hospital's salary costs. Administrative costs were similar in states with high and low rates of enrollment in health maintenance organizations (HMOs).

Conclusions. Hospital administrative costs in the United States are higher than previous estimates and more than twice as high as those in Canada. Greater enrollment in HMOs, with more competitive bidding by hospitals for managed-care contracts, an important element of proposed managed-competition health care reforms, does not seem to lower hospital administrative costs. (N Engl J Med 1993;329:400-3.)

HOW much does it cost to administer America's hospitals? This seemingly arcane matter divides health care reformers. Some see an obese bureaucracy gobbling billions of dollars; to others, administrative costs appear not unreasonable. If administrative costs are high, much may be saved by fundamental reforms that move toward a Canadian-type system. If they are low, more limited changes would suffice.

Previous estimates have relied on a few published figures from California, where one in five hospital dollars went for administration in 1987.[1-5] But nationwide extrapolation from these data has been controversial.[6-8] This paper presents data on the administrative costs of virtually all acute care hospitals in the United States.

METHODS

Medicare requires that participating hospitals file detailed reports classifying all their expenses into standard categories. In response to a request under the Freedom of Information Act, the Health Care Financing Administration supplied us with a computerized copy of the data from Worksheet A of the Medicare Cost Report for each of 6400 hospitals. Each hospital reported expenses for the fiscal year that began in calendar year 1989.

Table 1 shows the major categories used to classify expenses in the Medicare Cost Report. For most categories, hospitals report total expenses as well as salary expenses. However, Medicare requires hospitals to adjust the total cost figures (but not the salary figures) to reflect true hospital costs more accurately. For our municipal hospital, for instance, city hall rather than a hospital department manages parking and pensions. The parking and pension costs attributable to hospital operations would appear in the adjusted total cost figures on the Medicare Cost Report, but would be excluded from the salary figures. Hence, our analyses of the overall cost of administration are more reliable than those based solely on salary figures.

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We considered the following Medicare categories to represent administration: administrative and general, nursing administration, central services and supply (excluding the purchase cost of supplies), medical records and library, skilled nursing facility, utilization review, and the salary costs of the employee benefits department. The category of administrative and general subsumes most financial functions (e.g., chief financial officer, fiscal department, financial management and planning, accounts payable, patient billing, payroll, and cashier), as well as administrative services not attributable to an individual clinical unit (e.g., chief executive officer, patient registration, purchasing, data processing, mail room, communications, professional services administration, hospital utilization review, quality assurance, risk management, and the portion of marketing and public-relations expenses allowed under Medicare). We classified most other categories as clinical (Table 1). We considered the following categories neither clinical nor administrative and excluded them from our analysis: nursing school, intern and resident programs (except salaries and benefits), paramedical-education programs, and five nonreimbursable-cost centers (gift, flower, and coffee shops and canteens; research; physicians' private offices; nonpaid workers; and other).

The costs of the hospital's physical plant are not allocated to individual services or hospital functions in the Medicare Cost Report. For example, the reported costs of a coronary care unit or billing department would include salaries and supplies but not the costs of building, maintaining, and equipping the unit. We assumed that the proportion of the hospital's physical plant that houses administration is the same as administration's share of overall costs (excluding the costs of the physical plant). In our analysis of total administrative costs we therefore allocated 24.8 percent of the costs for capital, plant operations, and maintenance and repairs to administration. In analyzing salary costs, we allocated 22.4 percent of the salaries for plant operations and maintenance and repairs to administration (the Medicare Cost Report attributes no salary costs to capital).

The rubric "employee benefits" on the Medicare Cost Report subsumes the expense of administering benefits as well as actual disbursements for health insurance and other fringe benefits. We classified the salary costs of the employee benefits department as entirely administrative. All other employee benefits costs were allocated between the administrative and clinical categories in the same manner as the physical-plant costs.

We calculated the proportion of costs attributable to administration in each hospital by summing the total costs in the administrative categories plus the allocated share of the physical-plant and

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Table 1. Distribution of Hospital Costs According to the Categories of the Medicare Cost Report.

Category	Percentage of Total Hospital Costs
Categories classified as administrative	
Administrative and general	14.22
Nursing administration	1.82
Central services and supply	0.94
Medical records and library	1.56
Employee benefits department (salary costs only)	0.62
Administrative and general — home health	0.19
Skilled-nursing-facility utilization review	0.00
Categories classified as mixed administrative and clinical	
Capital related costs — buildings and fixtures	5.93
Capital related costs — movable equipment	3.20
Employee benefits (except benefits-department salaries)	6.80
Maintenance and repairs	1.27
Operation of plant	3.58
Interest	0.00
Categories excluded from both clinical and administrative	
Nursing school	0.04
Intern–resident and other approved-teaching-program costs (except house-staff salaries)	0.22
Paramedical-education programs	0.00
Gift, flower, and coffee shops and canteen	0.05
Research	0.09
Physicians' private offices	0.21
Nonpaid workers	0.02
Other nonreimbursable-cost centers	1.08
Categories classified as clinical	
Laundry and linen	0.84
Housekeeping	2.00
Dietary	3.38
Cafeteria	0.33
Maintenance of personnel	0.01
Pharmacy	1.49
Social service	0.36
Other overhead	0.54
Nonphysician anesthetists	0.23
Intern–resident salaries, fringe benefits, unapproved-teaching-program costs	0.35
Adult and pediatric general routine care	14.05
Intensive care unit	1.93
Coronary care unit	0.34
Nursery	0.54
Skilled nursing facility	1.12
Intermediate care facility	0.29
Other long-term care	0.52
Other inpatient units	1.06
Operating room	3.47
Recovery room	0.22
Delivery room and labor room	0.61
Anesthesiology	0.34
Radiology — diagnostic	3.89
Radiology — therapeutic	0.10
Radioisotopes	0.19
Laboratory	5.31
Whole blood and packed red cells	0.12
Blood storage, processing, and transportation	0.17
Intravenous therapy	0.18
Respiratory therapy	1.50
Physical therapy	1.22
Occupational therapy	0.27
Speech pathology	0.11
Electrocardiology	0.50
Electroencephalography	0.05
Medical supplies charged to patients	2.39
Drugs charged to patients	2.91
Renal dialysis	0.14
Other ancillary services	0.78
Outpatient clinics	0.64
Emergency	2.27
Other outpatient services	0.02
Home dialysis	0.01
Ambulance services	0.35
Durable medical equipment rented or sold	0.01
Home health agency (except administration)	0.42
Organ acquisition	0.01
Ambulatory surgical center (distinct part)	0.01
Hospice	0.04
Other	0.06

employee benefits costs and dividing the result by total hospital costs less excluded categories. We then calculated the mean share spent for administration by hospitals in each state, in the District of Columbia and Puerto Rico, and nationwide.

Results

Table 1 shows the major categories used to classify expenses in the Medicare Cost Report and our designation of each cost category as administrative, clinical, mixed administrative and clinical (allocated proportionally as described above), or neither administrative nor clinical (excluded from both numerator and denominator in the analysis). Table 1 also shows the proportion of the average hospital's costs reported within each category.

Administration accounted for an average of 24.8 percent of hospitals' spending nationwide in fiscal 1990. Average hospital administrative costs ranged from 20.5 percent in Minnesota to 30.6 percent in Hawaii (Table 2).

Administrative salaries accounted for 22.4 percent of the average hospital's salary costs. Table 3 shows the average share of salary costs devoted to administration, ranging from 18.6 percent in New Jersey to 27.6 percent in Puerto Rico.

To assess the effect of the market share of health maintenance organizations (HMOs) on hospital administrative costs, we analyzed states where HMOs enroll more than 25 percent of the population (California, Massachusetts, Minnesota, and Oregon). In these states, administration accounted for 25.6 percent of the average hospital's total costs and 22.6 percent of salary costs, as compared with 24.6 percent of total costs and 22.3 percent of salary costs in states with lower HMO enrollment. When we repeated this analysis using an HMO-enrollment rate of 20 percent as the dividing line (thus adding Arizona, Colorado, Connecticut, Hawaii, Maryland, and Wisconsin to the list of high-enrollment states), we again found similar hospital administrative costs in the high- and low-enrollment states — 25.4 percent of total costs, as compared with 24.6 percent, and 22.4 percent of salary costs, as compared with 22.3 percent.

Discussion

In fiscal 1990 administration accounted for nearly one quarter of U.S. hospital spending, more than the highest previous estimates. In many hospitals, as the number of patients declined, the number of bureaucrats increased to battle with competing hospitals over market share and with insurers over payment. On an average day in 1968, U.S. hospitals employed 435,100 managers and clerks (unpublished data) to assist in the care of 1,378,000 inpatients.[9] By 1990, the average daily number of patients had fallen to 853,000[10]; the number of administrators and clerks had risen to 1,221,600 (unpublished data).

Our state-level findings yield no evidence that managed care and competitive bidding, as envisioned under a managed-competition strategy,[11] will prune hospital administration. Indeed, hospitals in states with higher HMO enrollments had higher administra-

tive costs, as did those in the two states (California and Arizona) that have experimented most extensively with competitive bidding for hospital services. Although local administrative savings attributable to HMOs or competition might be obscured in statewide figures, this seems unlikely in California, where 80 percent of employees are insured through managed-care plans and where hospital markets in much of the state are fiercely competitive. Moreover, hospital administrative costs in the Boston area, which has a very high level of HMO enrollment and competition for managed-care contracts, are comparable to those in other U.S. hospitals.

Other regulatory reforms have not significantly streamlined hospital administration. Maryland and New Jersey, states with all-payer rate-setting systems, had administrative costs that were somewhat lower than average. But New York, which operated an all-payer system during the 1980s, did not. We found evidence against the claim that Hawaii's hospitals have strikingly low administrative costs.[12] Certainly, no state had administrative costs nearly as low as those at most Canadian hospitals — on average between 9 and 11 percent of total hospital expenditures[3,13] (and Fortin G and Rehmer LW, Health Information Division, Health and Welfare Canada: personal communication). (The Canadian estimates

Table 2. Hospital Administrative Costs as a Percentage of Total Hospital Spending.

State or Area	Rank	Administration as a Percentage of Hospital Spending
Minnesota	1	20.5
Nebraska	2	21.2
North Dakota	3	21.5
Mississippi	3	21.5
New Jersey	3	21.5
Maryland	6	21.6
South Dakota	7	21.7
Delaware	8	22.0
Iowa	9	22.1
Wisconsin	10	22.4
Rhode Island	11	22.6
Connecticut	12	22.9
North Carolina	12	22.9
Alabama	12	22.9
South Carolina	15	23.2
Ohio	16	23.3
Montana	17	23.4
Georgia	18	23.5
Pennsylvania	19	23.6
Missouri	20	23.8
Kentucky	21	23.9
Kansas	22	24.0
Virginia	23	24.1
Michigan	24	24.4
Vermont	25	24.5
Idaho	25	24.5
Illinois	25	24.5
Wyoming	25	24.5
Indiana	25	24.5
Oregon	30	24.6
New Hampshire	31	24.8
Arkansas	31	24.8
Tennessee	33	24.9
New York	34	25.1
Oklahoma	35	25.3
Washington	36	25.4
Massachusetts	37	25.5
Maine	38	25.7
West Virginia	39	25.9
District of Columbia	40	26.0
Texas	41	26.1
Utah	42	26.3
Louisiana	43	27.0
California	44	27.4
Colorado	45	27.7
Florida	46	27.8
Nevada	47	28.5
Puerto Rico	48	28.7
Alaska	49	29.4
New Mexico	50	29.5
Arizona	51	29.6
Hawaii	52	30.6
United States	—	24.8

Table 3. Salary Costs for Hospital Administration as a Percentage of Total Hospital Salary Costs.

State or Area	Rank	Administrative Salaries as a Percentage of Hospital Salaries
New Jersey	1	18.6
Minnesota	2	18.8
Connecticut	3	19.0
North Dakota	3	19.0
South Dakota	5	19.3
Mississippi	6	19.7
Alabama	7	20.3
Delaware	8	20.4
Nebraska	9	20.7
District of Columbia	10	20.8
South Carolina	11	20.9
Rhode Island	12	21.0
Maryland	12	21.0
Montana	12	21.0
Wisconsin	12	21.0
North Carolina	16	21.1
Georgia	17	21.2
Pennsylvania	18	21.5
Kentucky	18	21.5
Massachusetts	20	21.6
Virginia	21	21.9
Wyoming	22	22.0
Maine	23	22.1
Illinois	24	22.3
Iowa	24	22.3
Missouri	24	22.3
Ohio	24	22.3
Arkansas	24	22.3
Michigan	29	22.4
Florida	29	22.4
Utah	29	22.4
Washington	32	22.6
Tennessee	32	22.6
New Hampshire	34	22.7
Texas	34	22.7
West Virginia	34	22.7
Indiana	37	22.8
Idaho	38	23.0
New Mexico	38	23.0
Vermont	40	23.2
Arizona	40	23.2
Oregon	42	23.3
Oklahoma	43	23.7
Kansas	44	23.8
California	45	23.9
Louisiana	46	24.0
Colorado	47	24.4
Hawaii	48	24.7
Alaska	49	25.6
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Nevada	51	26.1
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are based on cost categories similar, although not identical, to those in our analysis.[3])

We did not perform statistical tests on our data and we omit confidence intervals, since the figures reflect the costs of virtually all U.S. hospitals rather than a sample. Medicare Cost Reports surely include some inaccuracies, but we see no reason to believe that hospitals systematically overstate their administrative expenses. Although a few clinical nurses may be included in the category of nursing administration, thus falsely inflating our figures for administration, most other Medicare reporting conventions tend to understate the costs of administration. Salary and other expenses for clerical personnel in clinical units (e.g., ward clerks, receptionists, and secretaries) are attributed to the clinical unit and would be counted as clinical costs in our analysis. In addition, most advertising and marketing costs (about 1 percent of total hospital spending[14]) are not included in the categories we classified as administrative.

Our allocation of capital, interest, and plant-maintenance costs may slightly overstate the share of these items attributable to administration. However, even under the extreme assumption that all costs for physical plant are clinical (i.e., that administration occupies no space and uses no capital equipment), 20.8 percent of total hospital expenses would still be attributable to administration.

In summary, administrative costs account for 24.8 percent of the average hospital's budget in the United States. State reforms, even those incorporating elements of a managed-competition strategy, have not lowered hospital administrative costs. Trimming the hospital bureaucracy to the Canadian level would save about $50 billion annually. A similar amount could be saved on insurance overhead and physicians' paperwork.[3]

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