PART III

Chapter 6

Administrative spending in OECD health care systems: Where is the fat and can it be trimmed?

by
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Administrative tasks are essential at all levels of the health care system, from ministries and insurers to health providers. Many tasks are vital to ensure access, equity and quality of health care provision. Other activities may be of limited use, adding no value for patients.

This chapter looks into differences in administrative costs at the level of the health care system, for both health care facilities and individual health workers. Some differences are related to the way health care is financed. Many countries see the need to tackle inefficiencies in health care administration. The most promising strategies to increase efficiency are centred on simplifying procedures – partly by making better use of ICT – and optimising the size of administrative bodies to generate economies of scale. Additionally, regulatory changes can have an enormous and immediate effect on administrative costs and the administrative workload of health providers.

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Introduction

Spending on administration comprises a rather modest share of overall health expenditure – only around 3% on average in OECD countries in 2014 – but it is often perceived as a soft target when it comes to cutting waste in the health care system. Indeed, when austerity measures have to be implemented, the resources that go into administration are often the first to be considered, while the more politically sensitive provision of frontline medical services remains largely exempt from cuts. This was certainly true during the recent financial and economic crisis, when administrative spending was seen as a clear target for cost-saving measures in a number of countries. In addition to the widespread view that bureaucracy can be cut when times are hard, the extra workload pushed onto providers simply to satisfy administrative requirements is often perceived as inappropriate or inefficient (Maarse et al., 2005; Morra et al., 2011; Cutler et al., 2012).

But are administrative costs higher in health compared to other sectors? A comparison with other governmental functions may shed light on this. In Germany, for example, administrative costs for public pension funds are around 1.4% of total expenses (mainly pension payments) while accounting for almost 5% of total spending of public health insurance funds. But many of the health sector's resource-intense activities such as purchasing or co-ordination of service delivery are not required in most pension schemes.

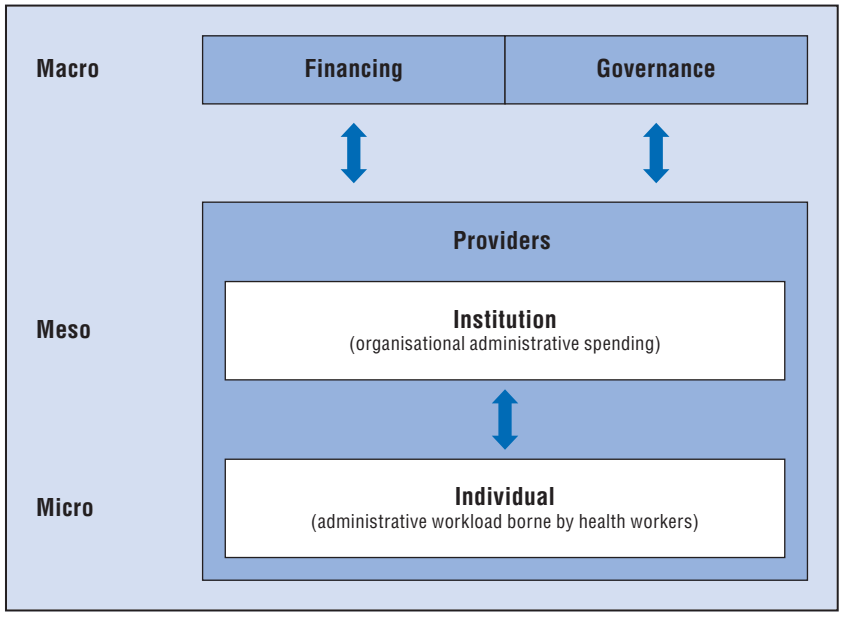
Spending on administrative activities should not be seen as "bad" *per se*: administration has its costs but provides core public health functions such as ensuring patient safety. And the range of administrative functions has multiplied over the years as important health policy objectives such as improving equity, access and efficiency came to the fore. For example, elaborate mechanisms are put in place – both at the provider and financing level – to avoid risk-selection and meet the goal of universal health care coverage. Secular trends such as the increased autonomy of providers, which must be harnessed by proper mechanisms to ensure accountability, or innovations such as pay-for-performance (P4P) induce a higher administrative burden for providers and payers alike as they typically involve the reporting and analysis of additional data to evaluate progress towards improved quality of care (OECD and WHO, 2014). In fact, by increasing the efficiency and responsiveness of care delivery and patient safety, administrative efforts can even generate savings down the line. So a certain level of administration is both necessary and vital in any modern health care system. Indeed, the role of administration is likely to grow even more as countries implement strategies encouraging value for money in health care delivery, further complicating governance and financing activities (Mathauer and Nicolle, 2011).

Thus it is clearly inappropriate to equate all administrative costs with waste. Wasteful administrative spending – in line with the general definition of waste in this report – refers to:

- administrative outputs that add little or no value
- administrative processes that are inefficient and could be carried out at lower cost.

The framework in Chapter 6 refers to administrative waste generated at the level of the regulator, but it can also be a concern at the provider level. In fact, the more refined analysis herein looks at three different levels of administration and their interactions, as shown in Figure 6.1.[1] The first – the macro (or system) level relates to health financing (collection and pooling of resources, and reimbursement of providers) on one hand, and governance activities, such as health care system planning and regulation, on the other. But administrative costs are not only incurred at the level of ministries and insurance funds. Health care providers likewise allocate a certain amount of their resources to administrative functions. They do so at two levels: i) the meso level, which captures the financial resources health care facilities spend on administration, ranging from overall planning and accounting to documenting care delivery; and ii) the micro level, which covers the time spent by health care workers performing administrative duties rather than providing clinical services.

Figure 6.1. **Levels of administrative inputs in health care systems**



Source: Authors' analysis.

Administrative costs and benefits across these three levels are clearly interconnected: easing the administrative burden on one level may impact a different level within the system if institutional arrangements remain similar. For instance, if the size of a hospital's administrative staff involved with coding, reporting and billing (meso) is reduced, more of the administrative workload may be pushed onto health workers within this institution (micro).

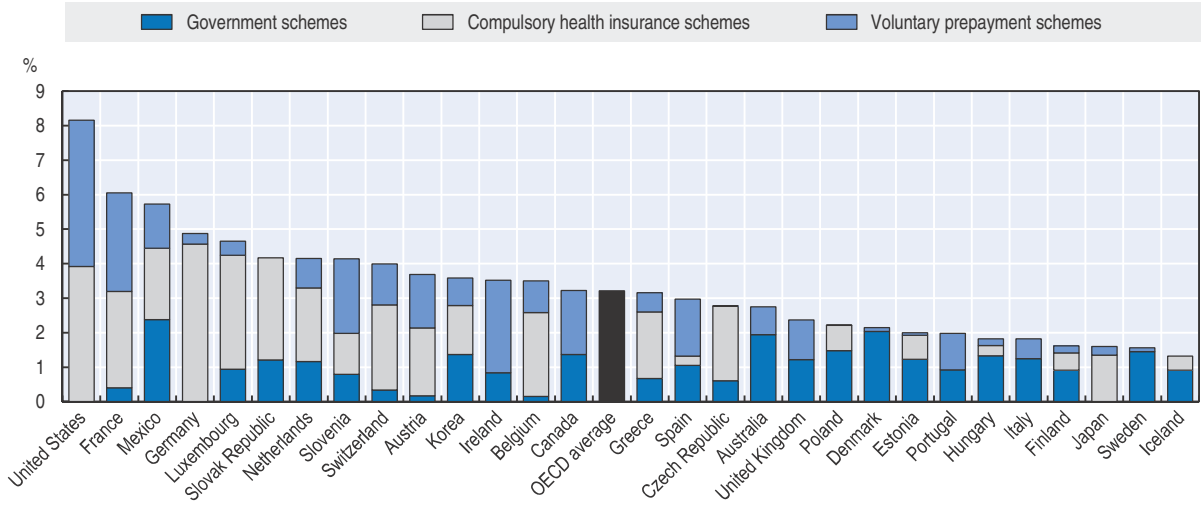
Administrative costs at the macro level are seldom studied and discussed in depth. The first section of this chapter uses internationally comparable health expenditure data to scale country differences in the administrative expenditure of bodies that finance and govern health care systems and to shed light on their determinants. The second section focuses on administrative costs incurred at the level of both health care providers and individual health workers. The third section summarises recent measures taken in OECD countries to address administrative waste across different parts of the health care system, followed by a set of recommendations on how best to identify and tackle low-value administrative output and inefficiencies.

1. At the macro level: Wide variation in spending on governance and administration

1.1. Administrative costs are influenced by the type of financing system

The resources that countries allocate to administrative activities at the system level vary substantially. While the OECD average was around 3% of health spending in 2014, it was double that level in France and higher still in the United States (Figure 6.2). On the other hand, a number of countries report administrative expenditures of less than half that level.

Figure 6.2. **Administration as a share of current health expenditure by financing scheme, 2014 (or nearest year)**



Note: Compulsory health insurance schemes predominantly refer to social health insurance (SHI) funds but can also refer to compulsory health insurance provided by private insurers. Voluntary prepayment schemes mainly refer to voluntary health insurance schemes. The OECD average includes 30 countries.

Source: OECD Health Statistics (2016), *http://dx.doi.org/10.1787/health-data-en.*

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While establishing completely comparable data remains a challenge (Box 6.1), a number of factors undoubtedly play a role in explaining the differences. For example, the costs involved in collecting revenues may be higher in countries with inefficient tax collection systems, large informal economic sectors, or a geographically scattered population. Skills can impact the efficiency of administration: a shortage of skilled workforce and low staff productivity due to insufficient information and communications technology (ICT) support will have an upward effect on costs. Cultural factors such as acceptance of schemes or the level of corruption within a country may impact the cost of regulation and monitoring (Nicolle and Mathauer, 2010). Finally, the legal culture and risk of litigation, with the resulting level of premiums and claims, can affect administrative costs. While differences in the size and scope of planning and management of health care systems can lead to some variations in overall costs, the way that health care is financed in a country – whether mainly tax-based, by social health insurance (SHI) funds, or by private insurance –appears to play a more pivotal role.

Indeed, Figure 6.2 suggests that financing schemes organised around SHI funds or some kind of compulsory insurance generally feature higher administrative expenditure than those managed by general governments (covering both central and regional/state-level governments). Frequently offered by for-profit corporations, voluntary private

Box 6.1. **Administration services in the System of Health Accounts**

The System of Health Accounts (SHA) provides an international framework for the definition, demarcation and categorisation of health expenditure. The SHA proposes a tri-axial accounting approach, classifying transactions used in the consumption of health care goods and services around the core dimensions of financing (who pays), provision (who provides) and function (what is the purpose). One of the health care functions refers to governance, health care system and financing administration.

While progress in recent years improved the comprehensiveness and comparability of international health spending data, comparability issues remain in some areas. One such area is the accounting of administrative activity. A 2013 study found that approaches in the estimation and valuation of administrative spending differ considerably across countries, potentially affecting the comparability of data (OECD, 2013). Common accounting issues relate to:

- underestimation of spending by governance agencies of all different layers of government (central, regional and local) due to lack of data
- overestimation of administrative spending that should methodologically be considered as spending on prevention due to inclusion of agencies concerned with public health issues
- differences in cost items (e.g. depreciation) considered administrative spending
- valuation of administrative expenditure of private health insurance as the sum of costs instead of following the recommended accounting practice of including profits and brokerage fees
- general differences in the use of data sources.

Source: OECD/WHO/Eurostat (2011), *A System of Health Accounts: 2011 Edition*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264116016-en*.

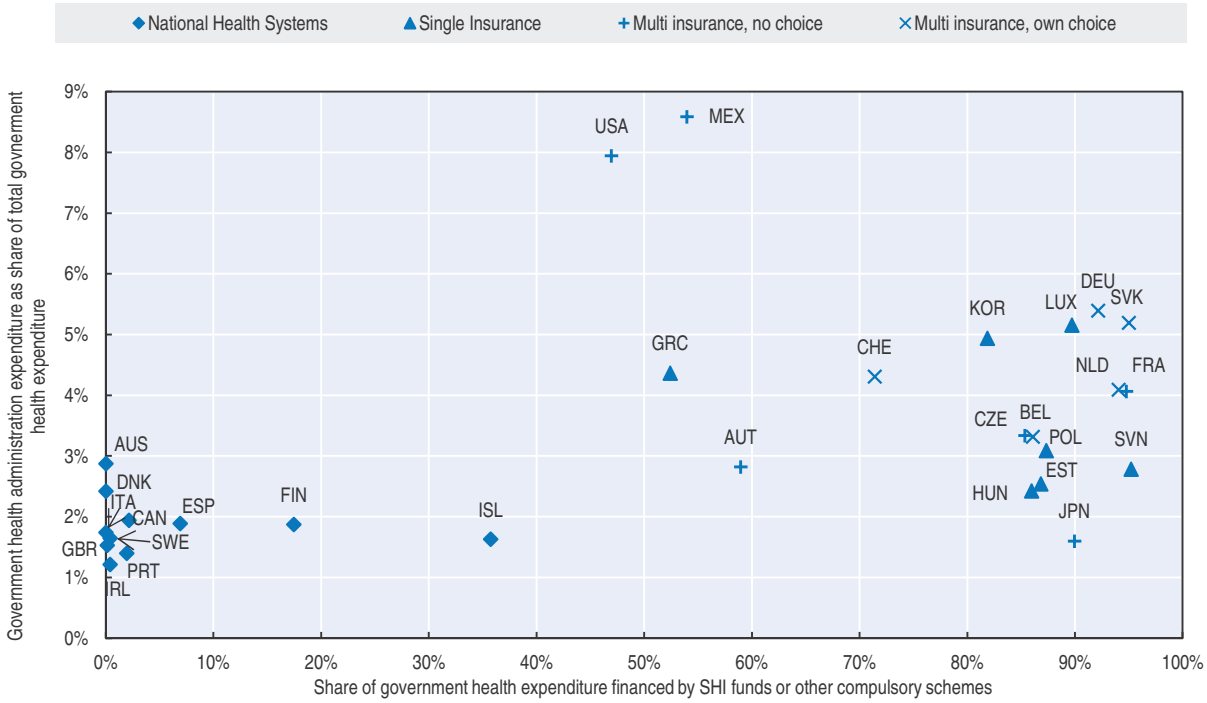
insurance incurs a relatively high share of total administrative expenditure, albeit accounting for a comparably low share of overall health spending. Thus systems featuring a high proportion of health care financing via SHI funds and/or private insurance generally demonstrate a higher share of administrative spending overall. The following sections explore in more detail the institutional characteristics that lead to these differences.

1.2. The multiplication of funds has a significant impact on administrative costs

The high cost of administration is often cited as one of the main disadvantages of (multi-payer) insurance-based, public health financing compared with health care systems where coverage is based on residency and that are mainly financed through taxes (Saltman et al., 2004). Figure 6.3 shows that those systems with a more predominant SHI scheme tend to have higher administrative costs. On average, in countries where social security spending constitutes less than 40% of public health expenditure, administrative costs accounted for less than 2% of public spending on health in 2014, whereas it was more than double that in countries where social security funds accounted for the bulk of public health spending.

Interestingly, while administrative costs appear similar for systems with residence-based entitlements, a much larger spread occurs across insurance-based health care systems. Ultimately, this variation reflects the number of different funding pools and the presence of competition, ranging from single-payer to multi-payer systems either with automatic affiliation or with a choice of insurers. Generally, countries with a single SHI

Figure 6.3. **Government health administration expenditure related to share of total government expenditure financed by SHI or other compulsory schemes, 2014 (or nearest year)**



Note: The US Government health financing system was categorised as a multi-insurance system with no choice of insurer due to entitled persons' direct affiliation with either Medicare or Medicaid.
Source: OECD Health Statistics (2016), *http://dx.doi.org/10.1787/health-data-en.*

StatLink http://dx.doi.org/10.1787/888933444262

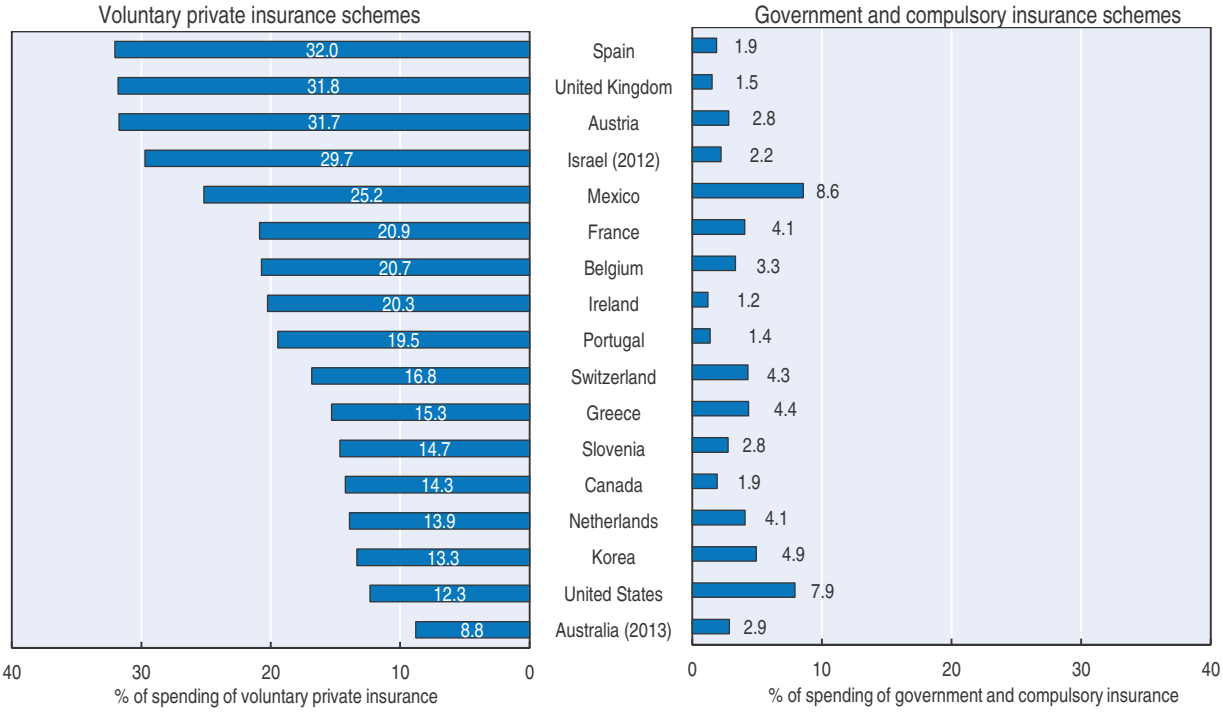
fund (e.g. Hungary, Poland and Slovenia) show lower levels of administrative spending; indeed, levels are similar to those seen in health care systems with residence-based entitlement, such as Australia and Denmark.

While administrative costs are higher in multi-payer systems, the distinction between those with choice and those with automatic affiliation is less clear-cut. For example, in the Czech Republic, Germany and the Netherlands, people can choose between competing insurers; the resulting administrative costs range from 3.3% of public health spending in the Czech Republic to more than 5% in Germany. In Austria, Belgium, France and Japan, multiple insurance funds also exist, but affiliation with a specific insurer is generally linked to a profession and not a matter of individual choice. While Austria and particularly Japan report administrative cost levels below those in countries where insurers do compete, Belgium and France have government administrative costs at a similar level. The United States and Mexico have notably higher government administrative costs – pointing to other inherent organisational and cultural factors. The litigious environment, but also scrutiny from regulatory bodies and efforts devoted to utilisation management and quality improvement, may partially explain why administrative costs in the United States are so high (Kahn et al., 2005). In Mexico, distinct health financing systems exist for different sections of the population, creating many administrative duplications (OECD, 2016).

1.3. Administrative costs for private insurance are much higher than for public schemes

Not surprisingly, given that profits more often than not play an integral role, administrative costs associated with the private health insurance (PHI) market are significantly higher than those in public systems, albeit they generally cover less people and purchase fewer services. Across the OECD, administrative costs of PHI schemes range from 9% of spending in Australia to more than 30% in Spain, the United Kingdom and Austria (Figure 6.4). Administrative costs in public schemes represent at the most 9% of health spending in any country. This is in line with the analysis of Mathauer and Nicolle (2011), who stipulated that administrative costs are about three times higher in PHI schemes compared to their public counterparts globally, with large variations across and within countries.

Figure 6.4. **Health administration expenditure as a share of financing schemes' total health spending, 2014 (or nearest year)**



Source: OECD Health Statistics (2016), *http://dx.doi.org/10.1787/health-data-en.*

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In summary, analysis of the existing data suggests that:

- Little difference arises in governments' administrative costs between tax-based systems with residence-based entitlement and single-payer, insurance-based systems.
- Single-payer systems have lower administrative costs than multi-payer systems.
- Multi-payer systems with free choice of insurer tend to have higher administrative costs than multi-payer systems with automatic affiliation.
- Private insurance schemes have much higher administrative costs than any public schemes.

The next section sheds more light on how the range of activities linked to different financing systems can help explain these differences.

1.4. Cost differences relate to the scope of administrative functions associated with different financing schemes

In any health financing environment, the regulator and the entity running the scheme(s) must perform a number of tasks to ensure achievement of system goals and to best operate in their business environment. Table 6.1 lists various tasks related to collection and pooling of funds, purchase of goods and services, and stewardship of the system. It then shows, from a purely conceptual point of view, how these tasks might apply and affect costs across various types of health financing schemes.[2] As mentioned above, the extent to which insurers are permitted to generate profits has a significant impact on total administrative "costs". The rest of the section elaborates on these initial findings and provides a more detailed explanation of structural differences in the level of administrative costs required to operate different financing schemes.

Table 6.1. **Functions of various administrative tasks across health financing systems**

Health financing function	Administrative activities	Residence-based entitlement (mainly tax-financed)	Insurance-based			
			Single payer	Multi payer		
				Social insurance, no choice	Social insurance, own choice	Private insurance
Resource mobilisation	Product communication	0	0	0	+	++
	Member enrolment	0	+	++	++	++
	Collecting contributions	+	+	++	++	++
	Managing exemptions	0	+	++	++	0
Pooling	Underwriting	0	0	0	0	+
	Pooling and resource transfers	+	+	+	+	+
	Managing risk equalisation information	0	0	+	+	0
Purchasing	Purchasing, contracting and provider negotiations	+	+	++	++	++
	Claims processing, provider payment, patient reimbursement	+	+	++	++	++
	Care co-ordination	+	+	++	++	0/++
Stewardship and management	Executive management, HR management, supervision	+	+	++	++	++
	Policy planning incl benefit basket design	+	+	+	++	++
	Surveillance, monitoring, enforcement and appeal	+	+	+	+	++

0 Function not relevant in financing system or only marginally performed.
+ Function performed in financing system.
++ Function performed in financing system with estimated higher costs per unit through lower economies of scale.
Source: Authors' own assessment based on framework of Nicolle and Mathauer (2010), "Administrative Costs of Health Insurance Schemes: Exploring the Reasons for their Variability".

Little difference arises between administrative activities of different single-payer systems

Residence-based entitlement schemes and single-payer insurance systems perform roughly the same services with regard to pooling, purchasing and stewardship. There is therefore reason to assume that similar resources would be required to perform these functions.

Differences can exist in relation to member enrolment and subsequent collection of funds. Coverage in residence-based schemes occurs automatically and revenues are usually collected as part of general taxation. In social insurance systems, where coverage is compulsory or voluntary, additional resources are required to identify, register and enrol

members or to verify entitlements at the point of service (Paris et al., 2010). The management of contributions – and perhaps even their collection – can add a burden to insurance-based schemes. Additionally, in an insurance scheme, if coverage is not universal, specific mechanisms or programmes may have to be put in place to ensure that all citizens have access to care before contributions can be collected.

Multi-payer systems duplicate many of the same activities

Health care systems in which coverage is provided by a single entity generally have lower administrative costs than multi-payer systems, partly because they enjoy more economies of scale (Mossialos et al., 2002). Enrolment, collection of contributions, claims processing, benefits management, sales and marketing, and insurance funds' compliance with government and non-government regulations and accreditation need only a single accounting and processing system in single-payer schemes, whereas multi-payer systems by their nature multiply the same functions (Bentley et al., 2008). The same holds true for purchasing and contracting, which creates an additional burden at the provider level.

Moreover, in multi-payer systems, costly and technically demanding risk-equalisation and resource transfer mechanisms are frequently required to counter issues of patient selection, ensure equal basic benefit packages, or indeed avoid budgetary difficulties of payers. Such systems exist, for instance, in Belgium, the Czech Republic, Germany, Japan, the Netherlands and Switzerland (Paris et al., 2010; van de Ven et al., 2013) but are not required in single-payer systems.

Patient choice can drive up administrative costs

Multiple social insurance funds with free choice of insurer exist in a number of OECD countries, including the Czech Republic, Germany, the Netherlands, the Slovak Republic and Switzerland. Competition among insurers is credited with stimulating innovation and responding better to patient needs (Paris et al., 2010; Saltman et al., 2004; Carrin and Hanvoravongchai, 2002). The complexity of fostering competition in health insurance markets while guaranteeing universal access is nevertheless associated with higher administrative costs.

Competition in the insurance market only works when consumers can make informed decisions. But the need to provide information on benefits, premiums or contribution rates as well as the related advertising and marketing all comes with a cost. Moreover, when switching insurers is an option, such information needs to be up-to-date and communicated regularly to clients (Paris et al., 2010). Naturally, where affiliation is automatic these requirements do not normally apply. Of course, competition can lead to a more efficient organisation of insurers, with costs offset by more streamlined procedures. The sharp decrease in insurers' administrative overheads in the Netherlands from 4.5% in 2006 to 2.9% in 2010, for instance, was linked to the effects of such competition (Jeurissen and Trienekens, 2014). But in many instances, competition in health insurance markets with multiple insurers is limited without leading to any detectable gains in efficiency (Mathauer and Nicolle, 2011).

Competing insurers may also contract selectively with providers. This can lead to a multiplication of transactions, such as contract negotiations and claims management, and may require additional data collection on prices and quality. But again, these additional administrative costs may lead to savings elsewhere in the system. It was hypothesised, for

instance, that the threat of selective contracting and associated negotiations alone put pressure on prices and increased the efficiency of care delivery in the Netherlands (Jeurissen and Trienekens, 2014).

Private health insurance schemes face strong competition but lack economies of scale

PHI can play different roles, for example providing coverage for a basic benefit package when public schemes are absent or for additional services not covered by public schemes. What is common is that in countries where PHI plays a role in health care financing, a high degree of competition is typically present. In contrast to the public system, many administrative functions are less likely to be shared, leading to a duplication of processes and a lack of economies of scale. More resources are therefore required for: distribution of information; registration and enrolment of patients; billing and underwriting of members' insurance policies; and negotiation, contracting and payment of providers. PHI schemes also spend more on marketing and acquisition, product innovation and agents' commissions (OECD, 2004).

One key difference between PHI and SHI is the fact that private insurance may be offered by insurance corporations that are allowed to make a profit from their operations (although limits may exist) while SHI funds are typically not-for-profit entities.

The importance that private insurance plays in financing health expenditure in a country does not appear linked to the level of administrative costs, however. France and Slovenia, for example, both have complementary PHI (mainly reimbursing co-payments) and similar shares of PHI in total health spending (14-15%). But the share of administrative costs in PHI expenditure appears significantly higher in France (21%) than in Slovenia (15%), indicating that country-specific factors, for example related to regulation, play a more pivotal role in determining administrative costs in private insurance (Box 6.2).

1.5. *Administration at the health care system level cannot be equated with waste*

Keeping in mind that macro level administrative cost data have some limitations and that other factors play a role, this analysis indicates that differences for a large part reflect structural choices countries made in the organisation of their health financing system. These choices are made in part because they generate system-level impacts (for instance, higher financial protection in France, or more responsiveness in competitive systems) that cannot be measured. In other words, the "benefit" of administrative activities cannot be captured. A simple comparison of costs, therefore, cannot conclude that one system's administration is more efficient than another's nor can it help much in identifying waste.

2. Unpacking administrative costs at the health care provider level

This section examines the resources allocated to administrative functions at the level of health care provision, in terms of: i) inputs in health facilities (meso level); and ii) the time devoted by health care workers to non-clinical tasks (micro level). At these levels, no comprehensive data are collected with which to identify and compare the costs by health care providers or professionals across countries. Nevertheless, certain consistent relations can be identified between health care system characteristics and administrative inputs at the provider level.

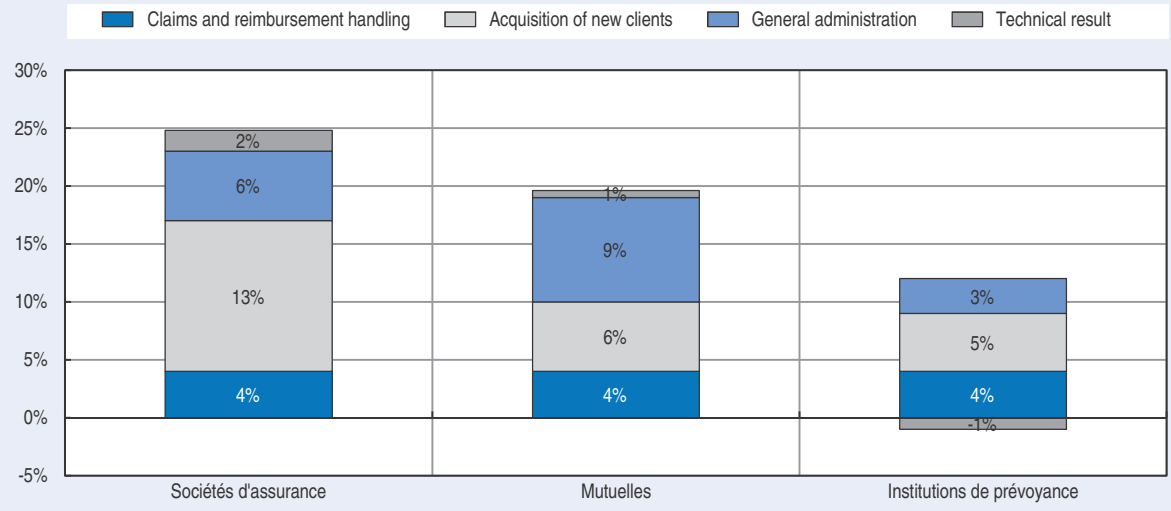
Box 6.2. **Spending on administration by French private and public insurance schemes**

In France, almost the entire population (95%) has complementary PHI ("assurance maladie complémentaire", AMC) to cover cost-sharing in the social security system ("assurance maladie obligatoire", AMO). Three categories of insurers are present in the AMC market:

- The "mutuelles" are not-for-profit entities that aim to achieve solidarity in cost-sharing. Mutuelles mainly focus on health care and make limited use of risk-rating but sometimes adjust premiums according to income. Mutuelles mainly cover people on an individual basis. Their market share stands at 54%.
- The "sociétés d'assurances" are profit-making companies that mainly provide life insurance for groups, and coverage for unemployment, disability, and judicial assistance purchased by individuals. Health care coverage is only a by-product. Sociétés d'assurances make use of a large set of indicators including health status to rate premiums. Their market share is the second highest, at 28%.
- The "institutions de prévoyance" are non-profit-making and focus on collective contracts for companies that have a mandatory enrolment of employees in AMC. Their market share stands at 18%.

Functions related to management of claims and reimbursements are similar across all types of AMC, but levels of administrative spending differ between them. Total administrative costs are highest in sociétés d'assurance, because of higher profits and higher acquisition costs for clients. Institutions de prévoyance have the lowest administrative spending as they mainly offer group contracts and therefore enjoy economies of scale, reflected in lower spending on general administration (Figure 6.5). Mutuelles, which focus on the individual market, have relatively high general administrative costs.

Figure 6.5. **Administrative spending including profits among complementary PHI schemes in France, 2013**



Source: Adapted from Montaut, A. (2015), *Rapport 2014 : La situation financière des organismes complémentaires assurant une couverture santé*, Direction de la recherche, des études, de l'évaluation et des statistiques (DREES), Paris; and DREES (2015), *Les dépenses de santé en 2014*, Direction de la recherche, des études, de l'évaluation et des statistiques, Paris.

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One additional factor explaining France's relatively high administrative costs (recall Figure 6.2) is the duplication of transactions: for example, patients can pay some medical costs upfront before filing two reimbursement requests, first to the SHI and then to their PHI to cover part of the co-payments.

2.1. Meso level: Administrative overheads can be considerable in health care organisations

Generally, organisations that provide health care must allocate a certain amount of resources to manage, finance, organise and document health care delivery. This section gives an overview of the multiple administrative tasks health providers have to perform and why this may differ between providers and across countries.

A clear demarcation of administrative costs is challenging because many tasks performed across health facilities can serve both an administrative and a clinical purpose; for instance, documenting care delivery. It is therefore almost impossible to clearly define what entails "administrative overheads", let alone compare it across settings or countries. Table 6.2 categorises some of the main tasks on a continuum from purely administrative functions to those that also have a more clinical purpose. Beyond looking into administrative tasks, a number of costs (such as for site maintenance, utilities, depreciation and interest payment) are frequently classified as "administrative" in nature and also affect administrative costs of health care facilities.

Table 6.2. **Conceptual overview of administrative activities in health care settings**

Administrative activities			Primary care providers	Hospital
Purely administrative	Boards and strategic governance		0/+	++
	Financing	Payrolls	0/+	++
		Accounting and auditing	+	++
		Billing and insurance related	+	++
	Organisational	HR management	0/+	++
		Planning and scheduling	+	++
		Material purchasing, distribution, administration	+	++
	Clinical governance		0/+	++
Mixed administrative and clinical	Care delivery documentation	Patient admission and discharge co-ordination	+	++
		Quality and risk data processing	+	++
		Medical records	+	++

Note: For Primary Care Providers intensity of administrative activities varies depending whether it refers to a solo GP practice or primary care clinic.
0 Not relevant or activity is only marginally performed in this health care setting.
+ Activity performed in this health care setting.
++ Activity performed more extensively in this health care setting.
Source: Authors' own assessment.

In principle, two main institutional factors appear to explain variation in resources allocated to administration across different health care facilities within and across countries:

- Complex and large health care organisations like hospitals have higher administrative costs than smaller and less complex facilities.
- Administrative costs incurred by health care facilities are higher in countries with high data-reporting demands, activity-based payment mechanisms and multi-payer systems.

While this may seem rather obvious, a number of other factors also contribute to differences in administrative costs, such as the size of separate medical groups within a facility, its legal status (public, private, for-profit, not for-profit), the quality of management, the uptake of ICT in facilities, and regional aspects such as differences in wages and other costs.

Complex health care organisations are likely to have higher administrative costs

Costs in health care facilities related to administrative tasks differ across levels of care (e.g. primary care, hospital care, long-term care). The more complex health care delivery becomes (i.e. longer episodes of care delivery, higher variety of diagnostics and treatments used, more diverse workforce composition), the more resources are necessary to perform these functions and consequently, more administrative overheads are required to monitor the provision of care. Costs for maintenance and equipment are also higher in more complex settings.

Health care system characteristics affect administrative costs of health care provision and higher administrative spending may lead to benefits elsewhere in the system

The administrative costs borne by health care facilities depend on aspects of the health financing and governance systems in which they operate. For instance, activity-based payment systems such as fee-for-service (FFS) and diagnosis-related groups (DRGs) are likely to lead to a greater administrative burden for providers compared with global budgets. Individual case billing may require additional staff to code and translate medical records into billing forms and to monitor reimbursements. That said, these payment systems may come with other potential benefits or cost-savings elsewhere in the system. DRG-based payment systems, for example, are associated with reduced average length of stay (ALOS) in hospitals, thus increasing technical efficiency. In the Netherlands, they contributed to a reduction in cost per care episode (Westert and Klazinga, 2011). Similarly, multi-payer systems can increase the administrative burden at the provider level with their duplicative contracting and billing activities.

Other country-specific factors are related to reporting requirements of regulatory bodies, public or professional demands in relation to the reporting of quality measures or data processing, the autonomy of medical professionals and their culture in co-operating with administrators and boards, and the reporting requirements for different financing agents. But higher regulatory requirements may, too, come with certain benefits. Resource-intensive and costly pretreatment authorisation requirements, for instance, can increase the appropriateness and quality of care (Hussey and Anderson, 2003).

Despite differences in accounting standards and definitions, some research compares administrative costs across countries, even if it is mainly limited to hospitals (Himmelstein et al., 2014; Table 6.3).

Of the countries where comparison was limited to *central* administrative costs, Canada reported a share of hospital costs (7.4%) less than half that of the United States. When expanding the analysis to total hospital administrative costs, Scotland reported the lowest figure (11.6%). In the United States, this figure was, again, more than twice as high. Procurement and co-ordination of facilities, supplies and personnel were found to be the core tasks of hospital administrators, as they constitute about 12% of total hospital expenditure in countries where administrators have few responsibilities beyond such logistics.

As mentioned, differences in the way hospitals generate financial income may explain why hospital administrative overheads are considerably higher in some nations. Countries with case-based (DRG-type) hospital billing systems (England, France, Germany, the Netherlands and the United States) exhibit higher administrative costs than countries where hospitals receive global budgets (Canada, Scotland and Wales). Additionally, the way

Table 6.3. **Hospital administrative costs and spending in eight nations, 2010**

	USA	CAN	FRA	DEU	NLD	UK		
						ENG	SCO	WAL
Total hospital expenditure								
Per capita, (USD PPP)	2 634	1 271	1 357	1 245	1 631	1 458	1 416	1 482
Share of GDP (%)	5.63	3.25	3.98	3.33	3.87	4.09	4.39	4.60
Central administration								
Share of hospital costs (%)	15.51	7.40	8.77	9.00	10.85	..	..	..
Hospital administration								
Share of hospital costs (%)	25.32	12.42	..	..	19.79	15.45	11.59	14.27

Note: Hospital costs data of these nations were classified under clinical and administrative functions (including IT) using the Medicare hospital costs reporting format. Mixed costs like plant maintenance and repairs and capital costs were apportioned between clinical and administrative costs. Research and teaching costs were excluded. Central administration costs excludes IT costs and administrative work on wards or otherclinical locations.
Source: Adapted from Himmelstein, D. et al. (2014), "A Comparison Of Hospital Administrative Costs In Eight Nations: US Costs Exceed All Others by Far", *Health Affairs*, Vol. 33, No. 9, pp. 1586-1594.

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hospital investments are financed seems to affect administrative costs. Countries where investments are largely generated out of operational revenues (the Netherlands, the United States and increasingly England) show higher administrative costs than countries where direct capital transfers from the central or regional governments account for a substantial share of hospital investment (Canada, France, Germany, Scotland and Wales). In countries where capital investment is funded out of hospitals' revenues, additional activity appears to be required to identify opportunities to generate profits. Higher administrative cost may also be related to the extent to which capital investment is financed out of loans and their subsequent interest payments.

Interpreting the data, Himmelstein et al. (2014) highlight a positive correlation between the role of market mechanisms in a country's health system and the share of administrative costs. Analysing data for the United States in more detail they find a higher share of administrative spending in for-profit hospitals than in non-profit or public hospitals. But they admit that other factors such as the higher intensity of care in US hospitals or the heavier regulatory burden in the United States and the Netherlands may partly explain the higher administrative costs in those countries.

Higher administrative costs at the provider level in the United States are confirmed in several other studies comparing the United States to Canada (Evans, 2013; Berwick and Hackbarth, 2012; Bentley et al., 2008). One study found that extra administrative expenses accounted for the largest share (39%) of the spending difference for physicians and hospitals (Pozen and Cutler, 2010). The high overheads of providers in the United States can also be linked to the need to claim reimbursements from multiple payers that have little incentive to synchronise their communication with providers (Bentley et al., 2008; Berwick and Hackbarth, 2012; Cutler et al., 2012). A study that investigated this in more detail compared the resources allocated to "Billing and Insurance Related" (BIR) functions in US health facilities with Canada to estimate the "added BIR costs". It found that BIR costs in the US health care system represented 13% of US national health spending on physician practices, 8.5% on hospitals, and 10% on other health services and supplies. Around three-quarters of these costs were considered "added" due to complexities associated with the US multi-payer system (Jiwani et al., 2014).

Differences in administrative costs at the provider level within a country suggest inefficiencies

Differences in administrative costs at the provider level across countries cannot automatically be considered wasteful. As mentioned, some administrative activities may come with other potential benefits or may save costs elsewhere in the system.

A large variation in administrative costs for similar health providers within a country, however, may hint at inefficient use of resources in some facilities. A recent report analysing variations in productivity and performance across National Health Service (NHS) acute hospitals in England found huge variations for clinical and non-clinical resources, highlighting the potential for substantive efficiency gains (Department of Health of the United Kingdom, 2016). Between the cheapest and most expensive 5% of NHS trusts, procurement costs varied by 100%; the difference for facility running costs was almost three-fold, and more than double for cleaning costs and food costs per meal. Even corporate and administrative staff costs were almost 50% higher. For the latter, the variation across NHS trusts was equivalent to between 6-11% of the trusts' income. Large staffing differences were also found. The ratio of administrative staff to managers ranged from 5:1 to more than 25:1 among the different NHS trusts, while the clinical to administrative staff ratio ranged from 2.3:1 to 7.9:1. Overall, estimated efficiency gains of around GBP 2 billion could be achieved in the areas of procurement, facilities and administrative costs by reducing unexplainable cost variation. Improving the quality of management is one possible lever to increase health facilities' performance.

Related to this are missed managerial opportunities to optimise the use of human resources. This extends the notion of "administrative waste" somewhat but it, too, concerns management capacity at the health provider level. One element is staff absenteeism, which can be a source of considerable inefficiency. Of course, this issue is relevant in all industries but seems to be more pronounced in the health sector. For instance, across NHS trusts in England, the average rate of sickness absence is around 4%, higher than both the public (2.9%) and private (1.8%) sector averages. Moreover, an unexplained variation arises across NHS providers, with those displaying the highest sickness absence rates at 1.6 times those with the lowest absence rates. Variations in staff absence also exist between professions, ranging from 1.2% for medical and dental staff to 5.6% for clinical support staff (Department of Health of the United Kingdom, 2016). This difference is observed in other countries; for example in public health facilities in France, sickness-related absence of medical staff (3.4%) is less than half that of non-medical staff (Agence Technique de l'Information sur l'Hospitalisation, 2016). Reducing sickness rates could potentially generate huge savings. For NHS trusts in England, a 1% improvement in sickness absence equates with GBP 280 million in staff costs (Department of Health of the United Kingdom, 2016). That said, reasons for sickness absence and in particular its variation across professions and providers must be better understood. High staff absence can hint at poor organisational management without a coherent strategy to address work conditions. A recent report in England made a number of recommendations both at the national and regional level mainly centred on improvement in staff health and well-being (NHS Employers, 2014).

Although efforts to reduce administrative costs at the level of health providers may be welcome, it needs to be stressed that these costs are a necessary part of all industries. A look beyond the health sector may give a clue as to whether administrative spending in health care facilities is exceptionally high. But again, data to make comparisons are scarce.

In other service-oriented industries such as the banking sector, overhead costs as a share of total assets averaged at just above 3% in OECD countries in 2009 (Beck and Demirgüç-Kunt, 2009). Profits aside, it is expected that banks would incur lower overheads than most health care settings, as delivery of financial products is much more standardised and less complex than the provision of health care services, and less labour-intensive. But industries with high administrative costs are not necessarily inefficient. Analysing the UK manufacturing sector's performance by comparing enterprises' skill mix and gross value added, Barnes and Haskel (2001) found a positive correlation between the ratio of administrative costs for operative workers and productivity.

2.2. Micro level: Time spent by health care workers on non-clinical administrative tasks is non-trivial

Concerns persist that health workers have seen an increase in administrative duties in recent years in many countries, thereby reducing the time available for patient treatment and care provision. This can be traced to the same causes that increase administrative activities at the macro and meso levels: increasingly complex health care systems and rising reporting and data demands.

From a conceptual point of view, the list of administrative tasks performed by health workers is similar to those at the facility level,[3] with the same discussion about what is "purely" administrative (Table 6.4). The extent to which these administrative activities are carried out by health workers depends on the different professions but employment status has an impact. The administrative workloads of various health professionals can also be very country-specific, as for some professions (e.g. nurses) a wide variety of different profiles exists across countries, associated with more or less autonomy and responsibility.

Table 6.4. **Conceptual overview of functions contributing to administrative workload borne by health workers**

Administrative activities			Salaried	Self-employed
Purely administrative	Financing	Accounting and auditing	0	+
		Claims, billing and insurance related	0	+
	Organisational	Planning and scheduling	0	+
		HR management	0	+
	Clinical documentation	Medical records	+	+
		Other data reporting (e.g. quality)	+	+
		Medication administration	+	+
Mixed administrative and clinical		Patient correspondence, discharge letters and documents	+	+

0 Activity not relevant or only marginally performed by health workers.
+ Activity performed by health workers.
Source: Authors' own analysis.

Three main factors explain variations in the administrative workload borne by different health workers within and between countries:

- Self-employed health workers in solo practices are likely to have a higher administrative workload than those working in group practices and much more than salaried health workers.

- High-skilled health workers may spend less time on administrative tasks than less qualified categories of health workers.
- The administrative workload across countries differs due to the organisation and financing of the health care system and other contextual factors such as labour market characteristics.

Self-employed health workers typically have higher administrative workloads

A large difference is present in the individual administrative workload of self-employed health professionals working in their own practice compared with salaried employees working in larger health care facilities. While the overall amount of time spent on administrative activities in larger structures certainly exceeds that in solo practices, it is usually distributed among several health workers or delegated to other non-clinical staff, hence unburdening health professionals. For instance, physicians employed by a hospital can often depend on non-clinical staff to take care of a number of administrative tasks, such as billing procedures. Self-employed general practitioners (GPs) working solo have to spend more time on these activities themselves. A French study found that GPs working in group practices are more likely to have secretarial assistants and help with bookkeeping (Box 6.3). The study suggested that the time spent on administrative activity depends on the level of clinical activity and hence on income and opportunity costs.

Box 6.3. **Organisation of administration by independent French physicians**

A study that surveyed how French GPs spent their time showed large variation in the administration of practices. Forty-four per cent of GPs reported conducting secretarial tasks themselves, such as scheduling and reception duties. Bookkeeping was done by GPs in 22% of cases, while 14% even reported cleaning their own practice. A significant difference arises between GPs working in solo versus group practices, though. While three-quarters of GPs in group practices had a secretariat, this was true for only a third of those working in solo practices. The share of GPs doing their own bookkeeping was also higher for those in solo practices than in group practices.

GPs with high levels of clinical activity tend to perform administrative tasks less frequently themselves. Among those GPs with more than 4 000 consultations per year, 63% had a secretariat and 16% did their accounting themselves. For less active GPs the shares stood at 43% and 32%, respectively. Age and region seem to be two other factors that influence the administrative workload among GPs.

Source: Jakoubovitch, S. et al. (2012), "Les emplois du temps des médécines généralistes", *Études et résultats*, No. 797, Direction de la recherche, des études, de l'évaluation et des statistiques, Paris.

High-skilled clinicians spend considerable time on administrative tasks

Measuring the time spent on administrative tasks by health workers is difficult. In addition to the problem of definition and distinguishing such tasks from clinical activities, issues around study design can impact results and comparability. Quantification based on self-reporting can be heavily biased, while observational studies in which the use of health workers' time is monitored and documented by a third party are costly and

resource-intensive. That said, observational studies conducted across different settings in different countries found the following:

- Time spent by physicians on "documentation" ranged from 8% to 27%. Austrian inpatient physicians were found to spend more than a quarter of their time on documentation, although much was defined as "clinical" with the rest purely administrative (Ammenwerth and Spötl, 2009). An Australian study conducted among emergency department specialists found even higher figures, although these are overestimated because they contain activities related to indirect patient care that could not be reclassified (Kee et al., 2012). Finally, a German study found that cardiologists dedicate 15% of their time on documentation (Mache et al., 2011).
- Other health workers devote a significant proportion of their time to administrative tasks: Australian clinical dieticians were found to spend 13.5% on "documentation" (Milosavljevic et al., 2011). For personal carers in Australian residential aged care facilities, the share was reported to be 10% of working hours (Munyisia et al., 2013). Pharmacists in geriatric hospitals in Malta were found to spend more than a quarter of their time on documentation (Wirth et al., 2009). Finally, a US study reported that intensive care unit nurses dedicated around 17% of their time to documentation (Dwibedi et al., 2011).

For the limited number of studies comparing across several professions, it appears that less-skilled workers devote more time on administrative activity than high-skilled health workers:

- Two studies conducted in Australian teaching hospitals found that the time spent on documentation ranged from 8% for registrars to 13% for residents and indicated that interns bore the brunt of the administrative workload (27%) (Westbrook et al., 2008; Arabadzhiyska et al., 2013).
- A study that surveyed physicians, nurses and clerical staff on their time spent on interactions with payers in the United States and Canada found that lower-skilled health workers take up more administrative tasks. Physicians reported interacting 3.4 hours (the United States) and 2.2 hours (Canada) per week on average with payers, whereas American and Canadian nurses spent 20.6 and 2.5 hours for the same tasks, respectively. In both countries, these tasks were predominantly done by clerical staff who spent 53.1 hours (the United States) and 15.9 hours (Canada) hours per week on them (Morra et al., 2011).

A division of labour where highly specialised physicians can concentrate on the treatment of patients makes economic sense, as purely administrative activities without clinical aspect can be performed by health workers with a lower skill set.

Health care financing systems can impact health professionals' administrative workload

As with health care facilities, variations across countries in the time spent by health workers on administration may reflect cultural differences, such as the autonomy of health workers or the extent to which regulatory bodies influence daily clinical practice. How health care delivery is organised may play a role. Finally, how health care is financed appears to be important as well. Studies comparing time spent by physicians, nurses and administrative staff interacting with payers show that this is significantly higher in a multi-payer system such as the United States than in Canada (a single-payer system). This

is partly because more time is spent on managing claims and billing activities in a multi-payer system but is also caused by additional interactions with payers in the US health care system, such as obtaining prior authorisations for many services under managed care programmes (Morra et al., 2011; Cutler et al., 2012).

Lack of data obscures health professionals' actual administrative burden

The limited amount of available evidence on health professionals' administrative burden makes it difficult to confirm the hypotheses made at the conceptual level. Efforts to quantify time spent by health workers on non-clinical tasks should be strengthened to give policy makers a better idea to what extent skill mismatches exist and to see whether complaints by health workers are justified. At the same time, any analysis should take into account the subjective burden of administrative tasks, which can impact job satisfaction. A survey conducted among US physicians, for instance, found that physicians who reported to be very satisfied with their work spent 16% of their time on administration, compared to 21% for those who reported to be very dissatisfied (Woolhandler and Himmelstein, 2014). Careful monitoring can help pinpoint inefficient administrative processes or outputs that add little value. Within that context, the most obvious case occurs when relatively simple administrative tasks are performed by highly skilled staff who could use their time for more valuable activities.

Going beyond administrative activities, the question about the right skill mix and whether all health workers are employed to the best of their abilities is also relevant to the managerial level of health providers. As in the case of sickness absence, suboptimal use of the available workforce can cause considerable inefficiency. In England, a recent report showed that nurses in acute and general medicine wards and community midwives only spend between 41% and 55% of their work time on direct patient care (McKinsey, 2009). Better organisation and staff planning at the provider level could increase health workers' face-time with patients. Related to this are discussions about changes in the scope of practice in health professions, but any changes in the skill set of that kind cannot be influenced by managers. These reforms are much more transformative in nature, requiring commitment for change at the policy level, and go beyond the scope of this report.

In an ideal scenario, administrative tasks should only be conducted at the macro and meso level, with health workers spending all of their time on patient care. Such a scenario is unrealistic, however. Quality indicators, for instance, are unlikely to offer meaningful information for health providers if information collected at the macro and meso level does not relate to what happens at the micro level. This linkage cannot occur without health workers' involvement (OECD, 2010a). But not all clinical data collected appear to add value. For NHS England, the time spent on the collection, recording and validation of data by clinical staff ranges from two to ten hours per week but only 65% of it is considered useful and relevant for patient care (NHS Confederation, 2013). It is therefore a matter of finding the right balance in the use of health workers' time, such that the benefits of administrative tasks exceed their costs and do not outweigh the value of core clinical work.

3. Policies targeted at reducing administrative costs

During the recent economic crisis, many OECD countries targeted a reduction in administrative spending as public finances were tightened. For example, in the Czech Republic the Ministry of Health budget was reduced by 30% between 2008 and 2010 (OECD, 2014). In Ireland, staff numbers at the Health Services Executive were cut by 6 000

in 2010, following a commitment to reduce administration, management and advertising costs by at least 3%. In Switzerland, staff costs in the health administration were lowered (by up to 10%) from 2008 onwards (European Observatory on Health Systems and Policies, 2015). Finally, in Greece, austerity measures included a 50% reduction in administrative staff at the central social security fund (Karanikolos et al., 2013). While an effective tool to contain administrative spending in the short term, cutting salaries or reducing the workforce does not necessarily tackle waste and can affect the provision of vital services. That said, such measures can potentially increase efficiency if it is seen that the remaining workforce delivers the same or even higher administrative output, or if cuts are concentrated in areas that add little value.

3.1. Best practices can identify wasteful spending

A prerequisite to avoid indiscriminate and across-the-board spending cuts in health care administration is identification of areas where wasteful spending actually occurs. Promising approaches in pinpointing and quantifying such areas or activities include an in-depth stocktaking of the administrative burden of health care providers or a comprehensive functional analysis of organisations. Development of subsequent strategies often results from these smaller- or larger-scale investigations of administrative activities.

Systematic reviews of administrative burden can help identify output that is not value for money

One method to identify wasteful administrative spending is a systematic review to assess the administrative burden of enterprises due to government regulation. A framework for these types of evaluations was developed with the Standard Cost Model (SCM). Developed in the Netherlands, the SCM (Box 6.4) measures the costs of administration imposed on business by governments and allows for comprehensive measurement and comparison of administrative costs across industries. This approach is limited to an assessment of administrative costs related to governmental regulation, and only shows the costs, not the benefits, of different administrative tasks. Nonetheless, the model contributes to the discussion by identifying activities that represent no value for money; as such, it helps streamline administrative activities.

Using this approach, a German review identified and costed the administrative burden on physicians, psychotherapists and dentists affiliated with the SHI system. The review was the basis of a German multistakeholder approach to identify low-value activities related to reporting, documentation and other administrative tasks of these health care providers (Statistisches Bundesamt, 2015). The discussions brought together the federal associations of doctors, dentists and public health insurers, the Ministry of Health and a task force at the Federal Chancellery concerned with reductions in bureaucracy. The measurement of administrative costs was carried out by the Federal Statistical Office. The results showed that provider groups' administrative workload due to reporting obligations, data requests and other administrative requirements amounted to EUR 4.3 billion per year. EUR 2.2 billion was due to obligations defined by physicians' self-governing institutions, EUR 1.1 billion by dentists' self-governing institutions, and EUR 1 billion to requirements set out by the Ministry of Health. The costs translated into 14 million days per year spent by physicians, psychotherapists and dentists on various information-reporting requirements, or 96 days per year for an average physician practice.

Box 6.4. **Methodology of the Standard Cost Model**

The Standard Cost Model (SCM) is a method to measure administrative costs imposed on business by government regulation. It applies a pragmatic approach to measurement and provides estimates that are consistent across policy areas. Costs can either be measured directly or determined through interviews and observations. The process to measure costs caused by government regulation requires the following steps:

1. The SCM breaks down regulation into manageable components that can be measured: information obligations,[1] data requirements[2] and administrative activities.[3]
2. The SCM then estimates the costs of completing each activity on the basis of a couple of basic cost parameters:
   - Price: price consists of a tariff, wage costs, plus overheads for administrative activities done internally or hourly costs for external services.
   - Time: the amount of time required to complete the administrative activity.
   - Quantity: quantity comprises the size of the population of businesses affected and the frequency with which the activity must be carried out each year.
3. The combination of these elements gives the basic SCM formula:
   Cost per administrative activity = Price × Time × Quantity

1. Information obligations are obligations to provide information and data to the public sector or third parties (e.g. energy labelling of domestic appliances).
2. A data requirement is each element of information that must be provided in complying with an information obligation. Each information obligation consists of one or more data requirements (e.g. statement of business's equity, identity of business).
3. To provide information for each data requirement, a number of specific administrative activities must be carried out. These may be done internally or outsourced. They can be measured (e.g. performing relevant calculations, submitting information, archiving information).

Source: International SCM Network to Reduce Administrative Burdens (2009), "International Standard Cost Model Manual", *www.oecd.org/gov/regulatory-policy/34227698.pdf*.

Based on this review, the various stakeholders jointly recommended 20 very detailed, sector-specific actionable measures to improve efficiency; many of them related to lifting regulations (Box 6.5). Taken individually, some of the detailed suggestions might seem to be of limited effect as they probably take up only a small portion of health workers' time, but taken together such small changes might eventually account for significant reductions in bureaucracy.

Quantification of potential savings is also possible with other approaches. In France, identification of wasteful spending, its quantification and development of strategies to achieve efficiency gains were part of a report of the financial and social affairs inspectorates (Box 6.6).

Wasteful administrative spending can be identified with other bottom-up and top-down approaches

In other countries, a combination of approaches is used to identify wasteful administrative costs. In the Netherlands, a working group comprising doctors, insurers, the government and patient representative bodies was set up to identify unnecessary administrative requirements for GPs, focusing on both short- and long-term solutions for key problems. As a result, a limit in reporting requirements through a reduction in forms requested by health insurance companies was signalled for action in 2016. This multistakeholder approach inspired six other sectors in primary care (district nurse, dental

Box 6.5. **Twenty recommendations following the in-depth investigation of administrative processes and requirements among physicians, psychotherapists and dentists in Germany**

ICT-related

- Adoption of electronic application and approval procedures for dental treatment plans.
- Digitalisation and simplification of archiving requirements to reduce physical space necessary for documents and dentistry models.
- The filling of forms by physicians can be done more efficiently by implementing easy-to-understand guidelines in the supporting software.

Optimisation of forms

- The current form to prescribe patient transport should be improved and simplified. Currently, it is generally considered confusing for physicians, leading to unnecessary additional communication between providers and sickness funds.
- Standardisation and merging of medical certificates for incapacity for work (for employers/sickness funds) and sick pay (sickness funds) that would allow for automatic processing. Currently, sick pay certificates are not standardised among sickness funds and physicians have to fill them out by hand.
- Duplication of certain forms related to medical rehabilitation could be avoided, for instance by transferring the responsibility to fill certain forms to insurers.
- Periodical reviews and standardisation of particular reporting forms, ideally using telematic infrastructures, to make them easier to understand and use for physicians.

Optimisation of procedures

- Adaptation of guidelines for internal quality management in outpatient care facilities to clarify that quality management should be jointly implemented by all physicians working within a facility across all care delivery processes.
- Simplification of procedures for physicians in prescribing long-term therapy (e.g. physiotherapy, ergotherapy, speech therapy) for certain chronic conditions. Some sickness funds still insist on approving some standard cases individually, requiring additional documentation by physicians.
- More flexibility regarding mandatory professional training could save dentists time, for instance by allowing online courses for the use of X-ray machines.
- Simplification of procedures to prescribe narcotics by adopting a system that allows for the use of regular laser printers. Currently, narcotics require special prescription forms for enhanced safety requirements, for which a special printer is needed.

Duplication of documentation or collection of data

- Streamlining the use of X-ray machines by centralisation of registration requirements for dental practices.
- Abandoning in-practice inspection of the efficacy of medical devices that have already been officially approved.
- Joint inspections of dental practices by different supervisory bodies to decrease the associated burden.
- Certain authorisation requirements related to software used for the printing of forms that require special safety paper should be abolished because whether practices use required software can be assessed from other data submissions.

Box 6.5. **Twenty recommendations following the in-depth investigation of administrative processes and requirements among physicians, psychotherapists and dentists in Germany** *(cont.)*

Reducing bureaucracy

- To test administrative alternatives that aim to reduce the bureaucratic burden for physicians, a standardised method to assess the effects of such alternatives in pilot-settings is proposed.
- Certain processes to assess the level of *ex ante* remunerations of administrative costs imposed on physicians and dentists following new legislation might be conducted more efficiently when information is collected from providers early in the assessment process.
- Simplification of the documentation of using medical instruments. Currently dentists (and physicians) need to document every step taken in using medical instruments to maximise hygienic use. Given the routine use of these products, the proposal is to only document exceptions in the use of medical instruments, at the end of a working day ("Negativdokumentation").
- Procedures for declarations of chronic illness could be streamlined and the form should be simplified. This declaration is required to limit co-payments for chronic patients and has to be signed by the treating physicians. Sickness funds should prefill the form with all available patient information to limit the burden of physicians.
- Streamline approval procedures for psychotherapy. Currently, an independent expert evaluation can be required. It is proposed to abolish this evaluation for short-term psychotherapy and additionally reduce paper documentation that is already available electronically.

Source: Statistisches Bundesamt (2015), *Mehr Zeit für Behandlung. Vereinfachung von Verfahren und Prozessen in Arzt- und Zahnarztpraxen*, Statistisches Bundesamt, im Auftrag des Nationalen Normenkontrollrates, Wiesbaden.

Box 6.6. **Menu of reform options in French health insurance**

In 2013, the French financial and social affairs inspectorates investigated potential approaches to save costs in social and private health insurance. Generally, the investigators pointed to the strict institutional separation between AMO ("assurance maladie obligatoire") and AMC ("assurance maladie complémentaire") and the lack of economies of scale due to the multi-payer system as reasons for high administrative costs. Strategies mentioned for improvement and their savings potential include:

- automating claims processing and file administration using ICT (estimated to save AMOs at least EUR 542 million per year)
- detecting and tackling differences in administrative performance across different insurers managing AMO (with a savings potential of between EUR 425-EUR 730 million)
- structural re-organisation of the operation of AMO by reducing the number of insurers managing AMO (with a savings potential of around EUR 440 million)
- integrating administrative processes between AMO and AMC by adopting a tele-transmission system ("Norme Ouverte d'Echanges Maladie") that exchanges reimbursement information between payers (with a savings potential of EUR 191 million for insurers managing AMC)
- increasing transparency on administrative costs of insurers managing AMC, including profits, which could put downward pressure on administrative costs in general.

Source: Inspection générale des finances and Inspection générale des affaires sociales (2013), *Les coûts de gestion de l'assurance maladie*, Inspection générale des finances and Inspection générales des affaires sociales, *www.igas.gouv.fr/IMG/pdf/RM2013-146P_2_.pdf*.

care, paramedics, mental health care, pharmacies and obstetrics) to constructively scrutinise their administrative relationship with health insurers. In the hospital sector, the *Kafka-Project* was supported by the Ministry of Health to identify and tackle bureaucratic bottlenecks preventing high-quality and efficient care, all seen from the perspective of the patient. Apart from these more bottom-up approaches, the Ministry of Health takes a leading role in exploring possibilities to reduce bureaucracy. For example, the Ministry develops strategies based on a survey that asks health care professionals to identify which pieces of legislation and regulation they perceive as adding no value and to put forward possible alternative solutions requiring less bureaucracy.

Bottom-up initiatives to find low-value administrative tasks exist in other countries as well, such as the *Administrative Simplification Initiative* set up by the American Medical Association. This platform advocates administrative simplification in the US health care system but also serves as a practical tool for health workers to point out a diverse array of support systems for clinical practices (AMA, 2015).

Generally, recommendations to curb administrative waste are more effective when they are a result of wide stakeholder consultations and ideally have wide stakeholder support. Of course, providers and payers frequently disagree about the usefulness of administrative tasks and their output, but both sides generally feel that the process of their interaction could improve (Morra et al., 2011; Micheau and Molière, 2010). This reality should be incentive enough in itself to bring stakeholders together to discuss administrative simplifications.

Functional reviews of governance activities on a macro level ask "Are we doing the right things?"

In a number of countries, governments have started to ask a more fundamental question. In addition to analysing how they can deliver services more efficiently they wonder whether they concentrate on the essential services in the first place. "Functional reviews" can help governments assess whether their administration is fit for purpose. Such reviews evaluate the effectiveness and efficiency of a governmental entity in its operations, programmes and administration. They also analyse whether the functions performed are in line with governmental objectives. In that sense, the term "function" refers to "a self-contained body of work likely to be at the sub-programme level, and includes all areas in which the government employs staffing or resources to achieve an output. This may include functions that contribute to service delivery, policy development or functions that support activities such as corporate functions" (Australian Department of Finance, 2016).

Australia, for example, conducted a functional review of the Commonwealth Department of Health as part of a broader assessment of the entire governmental activity. The *Efficiency through Contestability Programme* was introduced in 2014 to identify "the most efficient and effective way of designing and delivering government policies, programmes and services" (Australian Department of Finance, 2016). The programme has three components:

- Portfolio stocktakes assess all functions performed at the portfolio level across all entities within the portfolio and identify those functions that could be provided more efficiently through alternative means (e.g. by other organisations inside or outside the government).

- Contestability reviews analyse in detail specific functions identified in portfolio stocktakes and review the most efficient alternative means to provide them (including an implementation plan).
- Functional and efficiency reviews analyse for specific entities whether their current functions are aligned with government priorities, and identify those functions where efficiency in delivery could be improved and ways to achieve this (alternative means, operational improvements or additional efficiencies).

The objective of the Australian functional and efficiency review was to realign administrative functions to better position the Department to provide national leadership in the health care system. The review identified efficiency gains of around AUD 106 million in the Department's operations, partly by removing duplication of administrative activities.

3.2. Organisation and co-ordination are main areas in which to rein in administrative waste

Coming back to the initial framework set out in Chapter 1, the detailed analysis presented here suggests that the main drivers of wasteful administrative spending are problems in organisation and co-ordination. The solutions are therefore typically organisational in nature but may also require regulatory interventions. In many cases, these two policy levers overlap; large re-organisations of administrative functions must be based on legal changes. The key recommendations with regard to organisational changes emerging from more or less comprehensive reviews are typically country- and system-specific and range from smaller adjustments to re-organisation of regulatory functions. They can be broadly clustered into the following categories:

- making better use of ICT in communications between payers and providers
- simplifying administrative procedures
- finding the right size of administrative bodies.

Frequently, actions taken are accompanied by measures to generate and publicise information on administrative costs or the administrative workload to increase transparency. In many instances, measures introduced that affect administrative spending do not only tackle administrative waste, but also relate to operational or clinical waste. This refers, for example, to overall budget targets for public insurers that require them to find efficiency gains at all levels of service delivery and operations. Finally, some of the measures taken to combat administrative waste are not health-specific but relate to the entire public sector, and are thus much larger in scope.

In addition to action taken by governments, other public bodies or private payers, health providers themselves try to reduce administrative activity by streamlining their operations without the involvement of payers or the regulator – just like any other industry. Depending on the managerial autonomy of health providers this may refer to leaner management structures and more flexibility in staff numbers or better organisation of hospital management. Improving overall management quality and capacity can also be an aim. In England, for example, hospitals are encouraged to apply management strategies borrowed from the manufacturing industry, such as "Lean" or "Six Sigma" (NHS Institute for Innovation and Improvement, 2005). Whereas "'Lean" strives to improve the flow in the value stream and eliminate waste in companies' operations, "Six Sigma" is a framework to understand and limit variations in the quality of products. As seen in the previous section, better management of human resources at the provider level is an important strategy to

boost provider performance, albeit going beyond addressing only "administrative" inefficiency. Relying on e-solutions to optimise hospital staff planning can save money by limiting the use of additional temporary staff. To address costly staff absenteeism, a recent report in England made a number of recommendations mainly centred on improvement in staff health and well-being (NHS Employers, 2014). For the NHS trusts at the local level, the report recommended, for example, to embed staff health and well-being into the organisational culture, to develop further support for mental health issues for both staff and managers, and to encourage staff to be personally responsible for their own health and well-being.

Organisational changes can make administration more efficient

Make better use of ICT in communication between payer and provider. Generally, ICT solutions are seen as important to reduce paperwork, particularly in the interaction between payers and providers. Measures of this kind have been taken or are currently under development in many countries, including Belgium, France, Norway, Slovenia, Switzerland and Estonia (Box 6.7). This can refer to electronic support in a wide range of domains such as electronic reporting of performance measurement, implementation of e-prescription and/or e-referrals, development of electronic health records (EHRs), or more generally using a digital platform to exchange information between providers and payers. Such platforms, for example, are used in France where practitioners can submit electronically some of the compulsory declarations (e.g. sick leave for employees or pregnancies) to the social security and other authorities. ICT solutions are also developed for billing purposes: standardisation of electronic health care claims was the aim of two initiatives in the United States in recent decades (Box 6.8).

Box 6.7. **Estonia's use of e-prescription**

Estonia embarked on a comprehensive e-health strategy, with e-prescription as one element to improve efficiency. Launched in 2010, e-prescription is integrated in a platform that also incorporates EHRs, a digital image archive, a patient portal, an e-laboratory and e-emergency care solutions.

All e-prescriptions issued by physicians are sent to a national database that can be accessed by pharmacies, other physicians and the health insurance fund. Patients can pick up their medication at any pharmacy by identifying themselves with their ID card. Repeat prescriptions can be issued by physicians after an email or a phone call, no longer requiring physical visits to the doctor. Digitalisation reduced the administrative workload of pharmacists; the health insurance fund gained better information about the pharmaceutical market and can now monitor prescription habits more effectively. It also improved efficiency for the Estonian health insurance fund: staff costs related to administering incorrect prescriptions reduced by more than 90% between 2009 and 2015. The database can provide an overview of all prescriptions issued for a patient and help signal possible interactions between different pharmaceuticals. By May 2011, 84% of all prescriptions were issued digitally and over 95% of pharmacies were ready to process e-prescriptions. Over 90% of patients are satisfied with these services.

Source: Estonian Health Insurance Fund (2016), Information on Digital Prescription, *www.haigekassa.ee/en/digital-prescription*.

Box 6.8. **A history of health care claim simplification strategies in the United States**

The 1996 Health Insurance Portability and Accountability Act (HIPAA) introduced mandatory standards for electronic health care claims in the United States, but the eventual regulations were criticised as being relatively vague. HIPAA was also criticised for failing to take into account the different data needs of insurance companies, and for lacking payer and provider incentives for investment in technology needed to support electronic transactions. As part of the reform a single claim form was developed, but payers and providers never agreed on a truly common standard in filling the standardised form. This resulted in publication of more than a thousand instruction guides (Bentley et al., 2008).

A second standardisation attempt that, so far, seems more successful was included in the Affordable Care Act (ACA). There, the rules for processing administrative interactions are more detailed, leaving less room for disagreement between providers and payers, and are accompanied by financial penalties for health plans that do not adopt the standardised procedures (Cutler et al., 2012). Furthermore, the ACA represents a much wider health care reform that may be more conducive to administrative simplification strategies than the HIPAA, which can be characterised more as a stand-alone initiative.

In many cases where increased use of ICT at the provider level is proposed, higher-quality data and improved patient safety are additional important aims. Generally, moving towards electronic recording and reporting is associated with high up-front development and implementation costs, but in the long run these measures may generate savings for governmental oversight bodies, insurers and health providers alike.

The potential for ICT uses in health care is extensively documented but privacy concerns and the lack of common standards and co-ordination across systems remain and can be barriers to ICT adoption (OECD, 2009, 2010b). The final jury on their cost-effectiveness is still out for most ICT services in health care. At the same time, promising tools appear to be electronic transaction systems for billing and insurance-related tasks, and for integration of administrative and clinical health care systems. In the United States, adopting electronic transactions for the electronic processing of claim submissions, eligibility inquires and requests, claim status requests, and payment and remittance transactions is estimated to save providers USD 11 billion annually, with another USD 2 billion potential saved when administrative and clinical health systems are integrated (Cutler et al., 2012). Wide adoption of these initiatives could also benefit payers including the US federal government. However, these savings often remain untapped because providers lack incentives to invest in supporting technology (Bentley et al., 2008). In health care, this is a general issue. Experience with the introduction of ICT shows that providers frequently bear most of the costs and yet gain little of the benefits (OECD, 2010b). To overcome this problem, since 2011, health providers in the United States that successfully demonstrate "meaningful use" of certified EHR technology can benefit from financial support under the Medicare and Medicaid EHR incentive programmes. Under these programmes, "meaningful use" refers to the use of EHR to exchange health information or to submit quality measures, or to the use of EHR in another meaningful manner, such as for e-prescription. In 2015, financial penalties were introduced for those eligible providers not participating in the programmes. Despite

disbursement of significant funding under these programmes, physicians remain critical of the extent to which EHR improves efficiency. Three out of four believe that it increases costs and does not save time. Seven out of ten nevertheless think EHR provides useful analytics and 60% are convinced EHR contributes to value-based care (Deloitte, 2014).

At any rate, a careful implementation strategy needs to be planned, including extensive training of providers but also addressing patients' data security concerns from the outset if countries start moving towards better use of ICT for administrative purposes in health care.

Simplify administrative procedures. Regulatory processes – not directly related to treatment – can be simplified with the help of ICT, as was the case for accreditations for professionals and providers in Denmark (changes in hospital accreditation) and Israel. In Israel, the move towards digitalised procedures for medical graduates to receive their medical licenses and to apply for compulsory clinical internships helped speed up these processes considerably. It also led to a better matching of hospitals and interns, who are now more likely to work in the hospital of their choice. Other simplification measures include streamlining forms used by physicians for billing purposes or prescription forms.

Billing was simplified in Germany in 2013 when it abolished a EUR 10 co-payment per quarter for GP and specialist consultations. Between 2004 and 2012, patients made the co-payment to the doctor while insurers directly financed the rest of the services for publicly insured patients. Removal of the co-payment is estimated to have saved GPs and specialists around EUR 330 million annually in administrative costs associated with the collection and documentation of co-payments. Physicians' total revenues were not affected as insurers covered the foregone co-payments. Also in Germany, some recommendations from multistakeholder consultations related to simplifying and lifting regulations, such as allowing online courses for mandatory professional training in radiation protection for dentists using X-ray apparatus, or scrapping special prescription forms for narcotic prescription that would permit the use of regular laser printers (Statistisches Bundesamt, 2015).

Find the right size of administrative bodies to generate economies of scale. Finally, many recommendations to improve administrative efficiency with organisational changes are around redefining the size of governmental bodies and redesigning the portfolio and operations of health administration entities. The overall aim is to find the optimal size of an administrative entity to achieve efficiency gains without compromising responsiveness. These changes can be part of a major system overhaul or refer to smaller organisational changes and include the mergers of previously separate administrative entities, or in other cases, their separation.

For example, Korea's move from a multi-payer to a single-payer health insurance system considerably reduced resources devoted to administration. This move facilitated a more standardised use of ICT and a standardisation of processes, and is generally associated with greater economies of scale in purchasing, but also in performing administrative tasks. Merging insurers resulted in a reduction of health insurance staff by about a third. The share of administrative costs in total SHI spending went down, from 8.5% in 1997 to 2.4% in 2008 (Jeong, 2010). In Iceland, the Ministry of Health merged with the Ministry of Social Affairs in 2008, while in the Slovak Republic two state-owned insurance companies joined forces with insurance companies in 2010, reducing their number of staff by 10% between 2010

and 2011. As part of the rescue financing deal with the European Commission, the European Central Bank and the International Monetary Fund, Greece merged the health divisions of the four main social insurance funds into one health insurer – the National Organization for Healthcare Services Provision (EOPYY) – and limited its role to purchasing services. Previously separate administrative bodies were also merged in Belgium. In Denmark, however, organisational change referred to the separation of institutions; in this case the Medicines Agency was separated from the National Health Authority to better streamline procedures to license new medicines. Whether agencies are merged or separated depends on the country-specific context but generally countries try to find the most appropriate organisational size to achieve efficiency gains. Consolidation of administrative activities of public insurers or governmental departments can be the result of efficiency targets striving to improve operations within administrative institutions, as was done in France and Australia. These consolidation efforts typically result in a reduction of administrative staff. Again, improvements in the processes of governmental operations can be facilitated by better use of ICT, as seen for example in Korea and Slovenia.

Consolidation and separation initiatives typically involve regulators, while the finer organisational changes can also concern managers, and to a certain degree, physicians.

Some countries have introduced regulatory controls over administrative burdens

Most of the organisational changes described above already involve the regulator to a certain extent. This section covers strategies applied in countries that use regulatory levers to improve administrative efficiency on a broader scale. These tools can vary a lot in their scope, from very broadly defined measures of legislative principles to different approaches to impose budget ceilings.

Many countries aim at simplifying procedures for providers and governance bodies or payers through regulatory changes in different areas of the health care system:

- With the introduction of the *Protection Universelle Maladie* in 2016, France amended its legislation to ensure continuity of insurance coverage to the entire resident population. Previously, entitlement to public insurance was linked to personal circumstances (in particular, employment status). The insured had to prove that they were entitled when circumstances changed and to meet specific criteria in each case. This measure reduced the administrative burden associated with enrolment for the insured and insurers alike.
- Simplification also stretches to legislative procedures. The Netherlands became more flexible in terms of legislation for innovative health providers. If a piece of legislation is perceived as an obstacle to potentially successful alternative care models, part of the legislation can be temporarily deactivated under certain conditions for innovative providers. If these experiments are successful, the Ministry of Health will scrutinise and, if necessary, remove the legislation altogether.

Other regulatory measures try to limit administrative burden or administrative spending, directly or indirectly:

- Germany introduced “a one-in one-out” rule for administrative reporting requirements, aiming to limit red tape for businesses in 2015. This means that for each additional legislated administrative burden an equivalent existing burden needs to be removed. This measure is not health-specific but is applicable to health care-related legislation. In 2013, the Australian government committed to reduce or eliminate regulatory burden on business, community groups and individuals by AUD 1 billion per year. In 2015, the

Commonwealth Department of Health's contribution to this regulation was a reduction of around AUD 97 million (Commonwealth of Australia, 2015). Part of this broader initiative to cut red tape in Australia includes strengthening regulatory capabilities by measuring regulators' performance. This is expected to highlight areas for regulatory improvement, which can potentially reduce compliance costs for business in all sectors including health care. Legislation to reduce paperwork for companies was introduced on a broader scale also in the United States and other countries.

- Adoption of international standards and risk assessment can reduce duplication of and delays in regulatory approvals. This principle is currently implemented in Australia: if a system, service or product is approved under a trusted international standard or risk assessment, national authorities should not impose any Australian-specific requirement unless good reasons exist to maintain country-specific standards. In practice, this has been applied, for example, by the Therapeutic Goods Administration (TGA) co-operating with a range of international bodies to develop international standards and risk assessments in the field of medical devices (Commonwealth of Australia, 2015).
- To limit private and public payers' administrative costs, some countries defined upper limits for administrative costs, implicitly or explicitly. As the oversight body for statutory health insurance, the Swiss Office of Public Health (FOPH), which has to approve annually all premiums charged by insurers for public coverage, surveys the financial records of health insurance companies and requires insurers to reduce their administrative costs below a defined limit if they are deemed excessive. In the United States, the Affordable Care Act (ACA) stipulates a Medical Loss Ratio requiring insurers to spend at least 80-85% of premiums on medical claims and quality improvement. If insurers do not meet this minimum standard they are required to issue rebates to enrolees. Since its introduction in 2011, the share of non-medical overhead costs in net premiums decreased slightly, resulting in accumulated savings of USD 3.7 billion by 2013. It remains unclear to what extent these savings can be attributed to the new regulation (McCue and Hall, 2015). On an aggregate level, however, introduction of the ACA is believed to have increased administrative costs, as coverage for those previously uninsured is supposed to be provided by private insurers. One alternative, extension of the Medicare programme to people without insurance coverage, would have resulted in lower total administrative costs, according to one study (Himmelstein and Woolhandler, 2016).
- Without immediate consequences for administrative costs some countries reformed budget setting procedures or introduced automatic efficiency targets in budgets to reduce waste. Denmark introduced changes to strengthen the governance of public expenditure (including health) by defining mid-term spending ceilings. These ceilings are also relevant for the annual budget negotiations between the central government and regions and municipalities, requiring the autonomous regions to stay within their budgets. Related to overall budget ceilings, efficiency targets are set in other countries to limit spending growth. In France, budget ceilings are defined in the agreements between the Ministry of Health and the main public insurer (CNAMTS), the "Conventions d'objectifs et de gestion". These agreements already incorporate projected annual efficiency gains that have to be realised by CNAMTS. For NHS England, an estimated total of GBP 22 billion in efficiency savings needs to be generated by 2020 to close the NHS funding gap. That said, many of the efficiency gains may have to be found outside of the administration and are more related to reducing clinical or operational waste.

Generation and publication of information will increase transparency

All OECD countries have some level of transparency for public administrative costs in place. At the very minimum, annual budget procedures require governments to publish past and projected costs and staff employed in Ministries of Health and other relevant public health administration bodies. Additionally, most OECD countries report their administrative spending on an aggregate level as part of international data collections on health expenditure and financing or publish administrative costs in other formats.

But governments can, of course, engage more actively in generating and publishing information for increased transparency of administrative costs. One measure that falls into that category is the legal requirement to estimate any additional administrative burden associated with each piece of new legislation discussed in parliament. This tool is not health-specific but can raise awareness of administrative burden and increases transparency of administrative costs. Germany and the Netherlands are among the countries that have adopted this principle. In Australia, any proposed regulation must undergo an assessment of regulatory impact in the private sector but this could possibly be expanded to include impact on government administrative burden. Other, more health-specific measures that highlight administrative costs can be related to the obligation for public health bodies to publish the salaries of their chief executive officers or to make private health insurers disclose their brokerage fees and operational costs.

Conclusion

Administrative tasks must be carried out at all levels of the health care system: at the macro level related to the financing, governance and organisation of the system as a whole, as well as at the provider level, where health care facilities and professionals must perform a number of administrative activities related to the organisation of health care delivery. At the macro level, large differences in administrative spending between countries can be observed, some of which can be explained by the way health care is financed in countries. Countries with multi-payer systems exhibit higher administrative costs than countries with a single payer. Private insurers' administrative costs are generally higher than those of public schemes. This difference in financing can also affect the administrative burden of providers and professionals.

But more resources going to administration is not necessarily a bad thing – they can be related to measures increasing quality of care or enhancing patient choice or lead to efficiency gains in care delivery. But if waste in health administration can be detected it should not be tolerated.

Many examples of addressing administrative spending in health care are relatively simple. Reducing staff, decreasing wages, or implementing a policy of non-replacement of staff reaching retirement age can be done to control spending on administration but across-the-board cuts are not the most efficient solution to address administrative waste. Better strategies to tackle waste basically involve a two-step approach:

- identification and quantification of administrative outputs that add little value or could be done more efficiently, and
- finding the right measures to optimise administration.

The most promising strategies to increase efficiency are centred on simplification of procedures – partly by making better use of ICT – and optimising the size of administrative bodies to generate economies of scale. Additionally, regulatory changes can have an enormous and immediate effect on administrative costs or on providers' administrative workload.

Over and above this broad set of recommendations to cut wasteful administrative spending, it is difficult to find more universally applicable best practices. What administrative services to cut or which administrative bodies to reform depends primarily on the nature of the health care system and the scope and autonomy of the different providers and health professionals. Cultural aspects also play a role, such as how societies determine the balance between comprehensive regulation and risk management on the one hand and flexibility in their health care systems on the other. As mentioned throughout this chapter, the separate levels of administration are interconnected and administrative changes in one level may have repercussions on others – this should be borne in mind in all administrative reform.

At the system level, limiting the discussion to making health care administration more efficient may be somewhat short-sighted. Broader analysis of administration in general as a key government function would be desirable. The health sector may benefit from broader initiatives, be it more effective budgeting procedures, streamlined communication between public bodies and citizens, or identification of spill-over effects between administrative bodies of health and social care. More potential for efficiency gains may lie untapped in this field.

While this chapter shows that much potential remains to drive up administrative efficiency theoretically, administrative simplification might be more difficult in practice. A recent OECD report highlights that administrative simplification is not that easy given that societal pressure for risk management is increasing, as is demand for more decentralised governments that nevertheless need to create effective regulatory environments to address market failures and foster technological innovations (OECD, 2010c). Very much in line with the recommendations in this chapter, the OECD report finds that:

- Simplification projects should focus on a broad range of actors and costs and should be integrated with other regulatory reforms.
- Administrative burdens and targets for their reduction need to be quantified based on their value for money.
- Simplification strategies need an environment of communication and trust between those affected and those that have the means to change an existing situation.

One difference that sets health care apart from many other governmental functions is the much higher reporting burden imposed on service providers related to accreditation and licensing, the measurement of performance, and the need to warrant patient safety, all of which contribute to health care systems' complexity. Policy makers need to find a balance between the potential benefits of additional data and the burden to provide them. A decisive factor in this discussion should be what matters to patients.

More generally and going beyond reporting requirements, policy makers should aim to find a "balance in complexity" in health care systems. The benefits of any health policy that increases complexity should be weighed carefully against its associated administrative costs. Some trends, such as the increasing number of multimorbid patients, are already projected to make health care management more resource-intensive in the future.

Moving away from governance-related or governance-induced administration, potential exists to strengthen the management of health care providers to divert less money from patient care. Cost variations for administrative activities within countries should be monitored closely; strengthened management capacities and more exchange with other industries can help make health care operations more efficient. Health providers should also make the best use of health workers' skills. That means, for example, that clinical staff should be able to devote most of their time to the care and treatment of patients and be unburdened of administrative tasks as much as possible. Going beyond tackling inefficiencies in administrative activities, managers should strive to optimise the use of human resources in health facilities at large. Better optimising staffing plans or addressing absenteeism has huge potential for efficiency gains.

Notes

1. Figure 6.1 could be expanded to include the administrative efforts at patient level, for instance related to co-payments, reimbursement and insurance policies. This level, however, is not included in the analysis.
2. The assessment is very simplified, not taking into account country-specific aspects when performing the various functions, such as degree of centralisation and regulations, both of which will have an impact.
3. In certain cases, e.g. for a self-employed GP working in a solo practice, a distinction between the meso and micro level is unnecessary.

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