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Estimating the Health and Economic Effects of Public Health Spending

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Estimating the Health and Economic Effects of Public Health Spending

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Preventable disease burden and national health spending

>75% of national health spending is attributable to chronic diseases that are largely preventable
  - 80% of cardiovascular disease
  - 80% of diabetes
  - 60% of lung diseases
  - 40% of cancers
  (not counting injuries, vaccine-preventable diseases)

≈5% of national health spending is allocated to public health and prevention

CDC 2011
Preventable mortality in the U.S.

U.S. Men and Women Under Age 65 Have Higher Rates of Potentially Preventable Deaths
Slowest Rate of Improvement, 1999–2007

Amenable mortality, men ages 0–64

Amenable mortality, women ages 0–64

Age-standardized death rate/100,000

1999

2007

* Data for Germany are 1999 and 2006.

Source: Commonwealth Fund 2008
Geographic variation in preventable mortality

Source: Commonwealth Fund 2008
Public health activities

Organized programs, policies, and laws to prevent disease and injury and promote health on a population-wide basis

- Epidemiologic surveillance & investigation
- Community health assessment & planning
- Communicable disease control
- Chronic disease prevention
- Health education
- Environmental health monitoring and assessment
- Enforcement of health laws and regulations
- Inspection and licensing
- Inform, advise, and assist school-based, worksite-based, and community-based health programming

...and roles in assuring access to medical care
Public health’s share of national health spending

USDHHS National Health Expenditure Accounts

$Billions

% of total health spending

State and Local

Federal
Factors driving growth in medical spending

Roehrig et al. Health Affairs 2011
$15 billion in new federal public health spending over 10 years (cut by $5B in 2012)

Public Health and Prevention Trust Fund

Incentives for hospitals, health insurers to invest in public health and prevention
2012 Institute of Medicine Recommendations

- Double current federal spending on public health
- Allow greater flexibility in how states and localities use federal public health funds
- Implement national chart of accounts for tracking spending levels and flow of funds
- Expand research on costs and effects of public health delivery

Some research questions of interest…

- How does *public health* spending vary across communities and change over time?
- What are the health effects attributable to changes in public health spending?
- What are the medical cost effects attributable to changes in public health spending?
The problem with public health spending

- Federal & state funding sources often targeted to communities based in part on disease burden, risk, need
- Local funding sources often dependent on local economic conditions that may also influence health
- Public health spending may be correlated with other resources that influence health

Sources of Local Public Health Agency Revenue, 2005

- Medicaid 9%
- Medicare 2%
- Medicaid 9%
- Federal direct 7%
- Federal pass-thru 13%
- Other 12%
- State direct 23%
- Local 28%

NACCHO 2005
Example: cross-sectional association between PH spending and mortality

- Public health spending/capita
- Heart disease mortality

Quintile of public health spending/capita

Deaths per 100,000

Quintile 1 | Quintile 2 | Quintile 3 | Quintile 4 | Quintile 5
--- | --- | --- | --- | ---
165 | 180 | 200 | 205 | 200
20 | 40 | 60 | 100 | 120

Quintile 1: Low public health spending/capita, high heart disease mortality.
Quintile 2: Moderate public health spending/capita, moderate heart disease mortality.
Quintile 3: Moderate to high public health spending/capita, moderate to high heart disease mortality.
Quintile 4: High public health spending/capita, very high heart disease mortality.
Quintile 5: Very high public health spending/capita, very high heart disease mortality.
Example: cross-sectional association between PH spending and Medical spending

Mays et al. 2009
Analyzing spending effects

1. Cross-sectional regression: control for observable confounders
2. Fixed effects: also control for time-invariant, unmeasured differences between communities
3. IV: use exogenous sources of variation in spending
4. Discriminate between causes of death amenable vs. non-amendable to PH intervention
Data used in empirical work

- Residual state and federal spending estimates from US Census of Governments and Consolidated Federal Funding Report
- Community characteristics obtained from Census and Area Resource File (ARF)
- Community mortality data obtained from CDC’s Compressed Mortality File
- HSA-level medical care spending data from CMS and Dartmouth Atlas (Medicare claims data)
Analytical approach

Dependent variables
- Age-adjusted mortality rates, conditions sensitive to public health interventions
- Medical care spending per recipient (Medicare as proxy)

Independent variables of interest
- Local PH spending per capita, all sources
- Residual state spending per capita (funds not passed thru to local agencies)
- Residual federal spending per capita

Analytic strategy for panel data: 1993-2008
- Fixed effects estimation
- Random effects with instrumental variables (IV)
Analytical approach: IV estimation

- Identify exogenous sources of variation in spending that are unrelated to outcomes
  - Governance structures: local boards of health
  - Decision-making authority: agency, board, local, state

- Controls for unmeasured factors that jointly influence spending and outcomes
Analytical approach

- Semi-logarithmic multivariate regression models used to test associations between spending, service delivery, and outcomes while controlling for other factors

\[
\ln(\text{PH}$\,_{ijt}) = \beta \text{Agency}_{ijt} + \delta \text{Community}_{ijt} + \lambda \text{State}_{jt} + \mu_j + \varphi_t + \varepsilon_{ijt}
\]

\[
\ln(\text{Mortality}_{ijt}) = \alpha \ln(\text{PH}$\,_{ijt-1}) + \beta \text{Agency}_{ijt} + \delta \text{Community}_{ijt} + \lambda \text{State}_{jt-1} + \mu_j + \varphi_t + \varepsilon_{ijt}
\]

\[
\ln(\text{Medical}$\,_{ijt}) = \alpha \ln(\text{PH}$\,_{ijt-1}) + \beta \text{Agency}_{ijt} + \delta \text{Community}_{ijt} + \lambda \text{State}_{jt-1} + \mu_j + \varphi_t + \varepsilon_{ijt}
\]

Sensitivity analyses using 1, 5, and 10 year lag structures
Analytical approach

Other Variables Used in the Models

- **Agency characteristics**: type of government jurisdiction, scope of services offered, *local governance and decision-making structures*

- **Community characteristics**: population size, rural-urban, poverty, income per capita, education attainment, unemployment, age distributions, physicians per capita, CHC funding per low income, health insurance coverage, local health care wage index

- **State characteristics**: Private insurance coverage, Medicaid coverage, state fixed effects
Variation in Local Public Health Spending

Gini = 0.485
Changes in Local Public Health Spending 1993-2008

- 62% growth
- 38% decline
**Determinants of Local Public Health Spending Levels: IVs**

<table>
<thead>
<tr>
<th>Governance/Decision Authority</th>
<th>Coefficient</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governed by local board of health</td>
<td>0.131**</td>
<td>(0.061, 0.201)</td>
</tr>
<tr>
<td>State hires local PH agency head†</td>
<td>-0.151*</td>
<td>(-0.318, 0.018)</td>
</tr>
<tr>
<td>Local govt approves local PH budget†</td>
<td>-0.388***</td>
<td>(-0.576, -0.200)</td>
</tr>
<tr>
<td>State approves local PH budget†</td>
<td>-0.308**</td>
<td>(-0.162, -0.454)</td>
</tr>
<tr>
<td>Local govt sets local PH fees</td>
<td>0.217**</td>
<td>(0.101, 0.334)</td>
</tr>
<tr>
<td>Local govt imposes local PH taxes</td>
<td>0.190**</td>
<td>(0.044, 0.337)</td>
</tr>
<tr>
<td>Local board can request local PH levy</td>
<td>0.120**</td>
<td>(0.246, 0.007)</td>
</tr>
</tbody>
</table>

F=13.4  p<0.001

log regression estimates controlling for community-level and state-level characteristics.  *p<0.10  **p<0.05  ***p<0.01
†As compared to the local board of health having the authority.
Determinants of Local Public Health Spending Levels

- Delivery system size & structure
- Service mix
- Population needs and risks
- Efficiency & uncertainty

Mays et al. 2009
Multivariate estimates of public health spending effects on mortality 1993-2008

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Elasticity</th>
<th>St. Err.</th>
<th>Elasticity</th>
<th>St. Err.</th>
<th>Elasticity</th>
<th>St. Err.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality</td>
<td>0.0516</td>
<td>0.0181 **</td>
<td>0.0234</td>
<td>0.0192</td>
<td>-0.1437</td>
<td>0.0589 ***</td>
</tr>
<tr>
<td>Heart disease</td>
<td>-0.0003</td>
<td>0.0051</td>
<td>-0.0103</td>
<td>0.0040 **</td>
<td>-0.1881</td>
<td>0.0292 **</td>
</tr>
<tr>
<td>Diabetes</td>
<td>0.0323</td>
<td>0.0187</td>
<td>-0.0487</td>
<td>0.0174 ***</td>
<td>-0.3015</td>
<td>0.0633 **</td>
</tr>
<tr>
<td>Cancer</td>
<td>0.0048</td>
<td>0.0029 *</td>
<td>-0.0075</td>
<td>0.0240</td>
<td>-0.0532</td>
<td>0.0166 **</td>
</tr>
<tr>
<td>Influenza</td>
<td>-0.0400</td>
<td>0.0200 **</td>
<td>-0.0275</td>
<td>0.0107 **</td>
<td>-0.4320</td>
<td>0.0624 **</td>
</tr>
<tr>
<td>Alzheimer’s</td>
<td>0.0024</td>
<td>0.0075</td>
<td>0.0032</td>
<td>0.0047</td>
<td>0.0028</td>
<td>0.0311</td>
</tr>
<tr>
<td>Residual</td>
<td>0.0007</td>
<td>0.0083</td>
<td>0.0004</td>
<td>0.0031</td>
<td>0.0013</td>
<td>0.0086</td>
</tr>
</tbody>
</table>

log regression estimates controlling for community-level and state-level characteristics

*p<0.10      **p<0.05      ***p<0.01
# Effects of public health spending on medical care spending 1993-2008

Change in Medical Care Spending Per Capita Attributable to 1% Increase in Public Health Spending Per Capita

<table>
<thead>
<tr>
<th>Model</th>
<th>Elasticity</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed effects</td>
<td>-0.010</td>
<td>0.002 **</td>
</tr>
<tr>
<td>Instrumental variables</td>
<td>-0.088</td>
<td>0.013 **</td>
</tr>
</tbody>
</table>

Log regression estimates controlling for community-level and state-level characteristics

*p<0.10        **p<0.05     ***p<0.01
Effects of public health spending on medical care spending 1993-2008

Change in Medical Care Spending Per Capita Attributable to 1% Increase in Public Health Spending Per Capita

<table>
<thead>
<tr>
<th>Model</th>
<th>N</th>
<th>Elasticity</th>
<th>S.E.</th>
</tr>
</thead>
<tbody>
<tr>
<td>One year lag</td>
<td>8532</td>
<td>-0.088</td>
<td>0.013***</td>
</tr>
<tr>
<td>Five year lag</td>
<td>6492</td>
<td>-0.112</td>
<td>0.053**</td>
</tr>
<tr>
<td>Ten year lag</td>
<td>4387</td>
<td>-0.179</td>
<td>0.112</td>
</tr>
</tbody>
</table>

log regression estimates controlling for community-level and state-level characteristics

*p<0.10    **p<0.05    ***p<0.01
Projected effects of ACA public health spending

- 10% increase in public health spending in average community:

  - Public health cost: $594,291
  - Medical cost offset: -$515,114 (Medicare only)
  - LY gained: 148
  - Net cost/LY: $534
Conclusions

- Local public health spending varies widely across communities.
- Communities with higher spending experience lower mortality from leading preventable causes of death.
- Growth in local public health spending appears to offset growth in medical care spending.
Mortality reductions achievable through increases in public health spending may equal or exceed the reductions produced by similar expansions in local medical care resources.

Increased federal investments may help to reduce geographic disparities in population health and bend the medical cost curve.

Gains from federal investments may be offset by reductions in state and local spending.
Limitations and next steps

- Aggregate spending measures
  - Average effects
  - Role of allocation decisions?
- Mortality – distal measures with long incubation periods
- Medical care spending relies on Medicare as a proxy measure (20% of total medical $)
- Ongoing exploration of lag structures
- Next step: Medicaid spending
What is Public Health Services & Systems Research?

A field of inquiry examining the **organization**, **financing**, and **delivery** of public health services at local, state and national levels, and the **impact** of these activities on population health

Mays, Halverson, and Scutchfield. 2003
Related Studies
Some more questions of interest...

- How can we derive greater value from public health expenditures?
- Are there economies of scale and scope in the delivery of public health services?
- Can regionalization improve availability, efficiency & effectiveness of public health services?
- Who contributes to public health “production” and does this matter?
Local public health delivery systems

Source: 2010 NACCHO National Profile of Local Health Departments Survey
Sources of Scale and Scope Effects

Economies of Scale
- Spread fixed costs of public health activities
- Allow specialization of labor and capital
- Enhance predictability of infrequent events
- Pool surge capacity
- Learn by doing
- Internalize spill-over effects
- Network effects

Economies of Scope
- Use common infrastructure for multiple activities
- Cross-train workforce
- Realize synergies across activities
- Network effects
Analytic Approach

- Estimate the effects of *scale* (population served) and *scope* (array of activities delivered) on:
  - public health expenditures
  - health outcomes (preventable mortality)

- Address the potential endogeneity of scope, quality

- Simulate the effects of regionalizing jurisdictions that fall below selected population thresholds
  - <25,000
  - <50,000
  - <100,000
  - <150,000
Data used in empirical work

- National Longitudinal Survey of Public Health Systems
- Cohort of 360 communities with at least 100,000 residents

Measures:
- **Scope**: availability of 20 public health activities
- **Effort**: contributed by the local public health agency
- **Quality**: perceived effectiveness of each activity
- **Network**: organizations contributing to each activity

Linked with data from NACCHO Profile
- **Scale**: population size served
- **Cost**: Local public health agency expenditures
- Agency characteristics
Data used in empirical work

- Survey data linked with secondary sources of area characteristics (Census, ARF)
- Small sample of jurisdictions under 100,000 (n=36) used to evaluate prediction accuracy
Analytical approach

Cost Function Model (semi trans-log)

\[ \ln(\text{Cost}_{ijt}) = \alpha_1 \text{Scale}_{ijt} + \alpha_2 \text{Scale}^2_{ijt} + \beta_1 \text{Scope}_{ijt} + \beta_2 \text{Scope}^2_{ijt} + \varphi_1 \text{Quality}_{ijt} + \varphi_2 \text{Quality}^2_{ijt} + \lambda X_{ijt} + \mu_j + \phi_t + \epsilon_{ijt} \]

Instrumental Variables Model

\[ \text{Scope}_{ijt} = \theta \text{Network}_{ijt} + \lambda \text{Agency}_{ijt} + \delta \text{Community}_{ijt} + \mu_j + \phi_t + \epsilon_{ijt} \]
\[ \text{Quality}_{ijt} = \theta \text{Network}_{ijt} + \lambda \text{Agency}_{ijt} + \delta \text{Community}_{ijt} + \mu_j + \phi_t + \epsilon_{ijt} \]

IVs: Network: degree centrality, average path length

All models control for type of jurisdiction, governance structure, centralization, population density, metropolitan area designation, income per capita, unemployment, racial composition, age distribution, educational attainment, physician and hospital availability.
## Results: Scale and Scope Estimates

<table>
<thead>
<tr>
<th>Variable</th>
<th>Partial Elasticity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coeff.</td>
<td>S.E.</td>
</tr>
<tr>
<td>Population size</td>
<td>0.0184</td>
<td>0.0029***</td>
</tr>
<tr>
<td>Population size squared</td>
<td>-0.0014</td>
<td>0.0002***</td>
</tr>
<tr>
<td>Scope</td>
<td>3.89</td>
<td>1.41***</td>
</tr>
<tr>
<td>Scope squared</td>
<td>-2.58</td>
<td>0.99***</td>
</tr>
<tr>
<td>Quality</td>
<td>-2.98</td>
<td>1.39**</td>
</tr>
<tr>
<td>Quality squared</td>
<td>2.72</td>
<td>1.23**</td>
</tr>
</tbody>
</table>

**p<0.05   ***p<0.01
Results: Scale and Scope Estimates

Scale (Population in 1000s) vs. Cost ($1000s)

Quality (Perceived Effectiveness) vs. Scope (% of Activities)
Simulated Effects of Regionalization

-20%  -15%  -10%  -5%  0%  5%  10%  15%

Per Capita Cost
Scope
Quality

Percent Change

Regionalization Thresholds
<25,000  <50,000  <100,000  <150,000
Conclusions

▲ Significant scale and scope effects are apparent in local public health production

▲ Gains from regionalization may accrue through efficiency, scope, and quality

▲ Largest regionalization gains accrue to smallest jurisdictions

▲ If savings are re-invested in public health production, possibility of important health gains
Limitations and next steps

- Limited data on small jurisdictions
- Inability to observe existing “shared service” arrangements
- Aggregated cost data
- Lack of data on service volume/intensity