THE WAR ON POVERTY’S EXPERIMENT IN PUBLIC MEDICINE: COMMUNITY HEALTH CENTERS AND THE MORTALITY OF OLDER AMERICANS

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ABSTRACT

This paper estimates the effect of the Community Health Center (CHC) program on mortality among older Americans (50 and older). CHCs, now called Federally Qualified Health Centers, have provided low-cost primary care in poor neighborhoods since 1965. We use their initial role-out (1965-1974) to provide well-identified estimates of a large (2%) negative effect on mortality rates.

BACKGROUND

Economic Opportunity Act, 1964:
• Created the Office of Economic Opportunity and funded programs such as Head Start and Job Corps.
• Community Health Centers established by the OEO and the DHHS in 117 counties between 1965 and 1974:

CHC Services:
• Primary care: diagnosis, labs, prescriptions
• Emphasis on non-medical services: outreach, extensive follow-up, transportation, translation, community involvement.

Question:
Did Community Health Centers reduce mortality of older Americans?

METHODS & RESULTS

Event-Study Model
We use the Vital Statistics Multiple Cause of Death Files (and the county-level population data collected by SEER), to generate a county-by-year panel dataset for older adult (50+) mortality between 1959 and 1988. We estimate the following equation (weighting by the 1960 county population):

\[ Y_{j,t} = \theta + X_{j,t}\beta + \sum_{y=-7}^{2} \pi_y D_{1}(t-T_y^{*}) = y + \sum_{y=0}^{15} \tau_y D_{1}(t-T_y^{*}) = y + \epsilon_{j,t} \]

• \( Y_{j,t} \) is the all-cause age-adjusted mortality rate (AMR) in county \( j \) in year \( t \).
• \( \theta \) are county fixed effects.
• \( X_{j,t} \) is a vector of covariates: cash public assistance (AFDC, SSI, GA) and retirement and disability payments, 1960 county characteristics interacted with time trends, and urban-group-by-year fixed effects.
• In some specifications this includes state-by-year fixed effects.
• \( D_{1}(t-T_{y}^{*}) = y \) equals one when county \( j \) is observed \( y \) years from CHC establishment.
• \( \pi \) are estimates of pre-treatment differences in mortality.
• \( \tau \) are estimates of county-level intention-to-treat effects.

Plots of Estimates (\( \pi \) and \( \tau \)):

DISCUSSION

Effects by Age and Cause:
• Similar effects (~2%) for ages: 50-64, 65-79, 80+.
• All-cause effects driven by cardiovascular disease.

ITT vs. ATET:
• Dividing ITT effect of 60 deaths per 100,000 by best estimates of the share of county residents “treated” yields an ATET between 240 and 320 deaths per 100,000 (about 6-8% of the mortality rate of poor adults over 50).

Threats to Internal Validity:
• CHC timing not correlated with:
  1. Other War on Poverty funding (no omitted policy variables).
  2. Expansions in hospital capacity (CHC establishment not caused by hospital growth).

Mechanisms:
• Increased use of Medicare-covered services?
  • No increase in pre-capita Medicare expenditures.
  • Anti-hypertensive drug use?
  • Maybe: treatment effects from the Hypertension Detection and Follow-Up Program could account for about 1/3 of our CHC estimates.

Primary Care?
• Surveys of Health Services Utilization and Expenditure (1963 and 1970) show increases in regular source of care and reductions in prescriptions drug spending for 50+ year olds in poor households:

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Observations: 956
R²: 0.16
Mean D.V.: 0.77

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