Environmental influences on healthcare expenditures: an exploratory analysis from Ontario, Canada

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**Study objective:** This paper explores the relation between healthcare expenditures (HCEs) and environmental variables in Ontario, Canada.

**Design:** The authors used a sequential two stage regression model to control for variables that may influence HCEs and for the possibility of endogenous relations. The analysis relies on cross sectional ecological data from the 49 counties of Ontario.

**Main results:** The results show that, after control for other variables that may influence health expenditures, both total toxic pollution output and per capita municipal environmental expenditures have significant associations with health expenditures. Counties with higher pollution output tend to have higher per capita HCEs, while those that spend more on defending environmental quality have lower expenditures on health care.

**Conclusions:** The implications of our findings are twofold. Firstly, sound investments in public health and environmental protection have external benefits in the form of reduced HCEs. Combined with the other benefits such as recreational values, investments in environmental protection probably yield net social benefits. Secondly, health policy that excludes consideration of environmental quality may eventually result in increased expenditures. These results suggest a need to broaden the cost containment debate to ensure environmental determinants of health receive attention as potential complements to conventional cost control policies.
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Socioeconomic conditions in Stage 1 are represented by the incidence of low income relative to the average family, which proxies for inequality; an educational location quotient that measures the proportion of the adult population that exceeds a high school education in each county compared with the provincial adult population proportion; and median household income variable. We expect education and household income variables to relate negatively to mortality, while the low income variable should have a positive relation.

Employment structures can influence population health. We have chosen primary industry as an indicator of dangerous and insecure work, and we expect this variable to relate positively to mortality. Manufacturing employment represents safer work environments and generally more stable employment. Both anticipation of unemployment and unemployment itself can adversely affect health or health behaviours. Based on these and other Canadian findings, we expect manufacturing to relate negatively to mortality.

Stage 2 includes the following variables:

\[ Y_{i2} = 1991–92 \text{ provincial health expenditures per person in the } i \text{th county}; \]
\[ Y_{i1} = \text{ predicted male mortality (from Stage 1) for 1991 in the } i \text{th county}; \]
\[ X_{i2} = \text{ location quotient of general practitioners and family physicians for the } i \text{th county}; \]
\[ X_{i3} = \text{ indicator variable representing the presence of a teaching hospital in the } i \text{th county}; \]
\[ X_{i4} = \text{ municipal environmentally defensive expenditures per resident, in 1991 Canadian dollars, in the } i \text{th county}; \]
\[ X_{i5} = \text{ total toxic pollution emissions from all environmental media, in metric tonnes, in the } i \text{th county}; \]
\[ e_{i} = \text{ residual term for the } i \text{th county.} \]

We include two variables to measure possible supply influences on current health expenditures along with predicted mortality to estimate the need for expenditures. A physicians location quotient, measured as the ratio of family physicians per 1000 residents in the county over the comparable rate through the entire province, is used to estimate the relative availability of medical services. The county units of analysis leave open the possibility that patients from one county may seek medical services in another county, particularly for specialised treatments. Large teaching hospitals are more likely to have specialists that draw patients from other counties. Such movement toward specialists must be accounted for in the model, and we have done so with the teaching hospital indicator variable. Furthermore, we expect these facilities to retain more highly paid physicians and more expensive capital equipment than other hospitals resulting in a positive relation with expenditures.

We have included two variables as measures of environmental quality and protection. The first measures total pollution emissions and is derived from Environment Canada's National Pollutant Release Inventory. These data estimate total toxic pollution from sources emitting over 10 tonnes per year and were extensively checked for locational and typographical errors. The second includes expenditures made by all municipal governments in a county to defend environmental quality. These broadly defined expenditures incorporate sewer and water works, waste management, emergency planning, and recreational facilities, all supplied through the municipal budget. In Canada, these municipal expenditures account for more than 60% of total environmental expenditures.

We manually selected the model in Stage 1 based on evaluation of the Mallows's Cp statistic, the adjusted \( r^2 \), the standard error of model prediction, and theoretical considerations. The models were fit using ordinary least squares estimation, and variables were transformed to approximate Gaussian normality. In Stage 2, we tested variables together in a multivariate model.

RESULTS

Figure 1 shows a map of the 1991–92 per capita expenditures in the 49 counties of the study area. The map illustrates that considerable variation in HCEs exists throughout the Province, ranging from a low of $723 in Haliburton county to a high of $2960 in Frontenac county. Counties with teaching hospitals are in the highest category.
Table 1 shows the results from both stages of the model. In Stage 1, there are four significant variables: per capita health expenditures 1990–91, education, manufacturing, and primary industry. These variables are associated with 65% of the variation in male mortality. Other variables were tested, but found to be insignificant. To minimise collinearity, we removed insignificant variables from this stage. All significant health determinant variables take the expected sign. The lagged health expenditures coefficient takes a positive sign, which probably would not indicate that past expenditures have contributed to increased population mortality. Instead, it may suggest that some aspects of the medical care system have responded to population need, or that through some historical accident, the location of those in need coincides with the location of physicians or medical expenditures.

In Stage 2, we used predicted mortality as an independent variable along with a physicians location quotient, an indicator variable for teaching hospitals, and the environmental variables. The predicted mortality variable (representing population need adjusted for past expenditures) shows a positive, significant relation with current expenditures. The teaching hospital variable is highly significant, but the physician variable is insignificant. This variable may be insignificant because of the mortality and hospital variables adequately represent supply of and need for HCEs. The results show that both toxic pollution and municipal defensive expenditures

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient</th>
<th>SE</th>
<th>t/Value</th>
<th>Prob &gt; t</th>
<th>VIF</th>
<th>Partial r²</th>
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<tr>
<td><strong>Stage 1 Predicting mortality as a proxy for need controlling for past expenditures</strong></td>
<td></td>
<td></td>
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<tr>
<td>Constant</td>
<td>205.51</td>
<td>20.42</td>
<td>16.74</td>
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<td>Health expend t−1</td>
<td>0.011544</td>
<td>0.004556</td>
<td>2.53</td>
<td>0.015</td>
<td>1.1</td>
<td>0.36</td>
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<td>Education</td>
<td>−101.24</td>
<td>21.24</td>
<td>−4.77</td>
<td>0.000</td>
<td>1.7</td>
<td>−0.39</td>
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<tr>
<td>Primary industry*</td>
<td>4.72</td>
<td>2.13</td>
<td>2.22</td>
<td>0.032</td>
<td>1.4</td>
<td>0.32</td>
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<td>Manufacturing</td>
<td>−17.07</td>
<td>6.27</td>
<td>−2.72</td>
<td>0.009</td>
<td>2.0</td>
<td>−0.39</td>
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<tr>
<td>Adj. r² 65.4%</td>
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<tr>
<td><strong>Stage 2 Predicting current expenditures</strong></td>
<td>2604.25</td>
<td>1295.50</td>
<td>2.01</td>
<td>0.051</td>
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<td></td>
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<tr>
<td>Constant</td>
<td>10.88</td>
<td>2.52</td>
<td>4.32</td>
<td>0.000</td>
<td>1.1</td>
<td>0.56</td>
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<td>Predicted mortality</td>
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<td>121.82</td>
<td>8.97</td>
<td>0.000</td>
<td>1.6</td>
<td>0.81</td>
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<td>Toxic pollution*</td>
<td>45.43</td>
<td>12.87</td>
<td>3.53</td>
<td>0.001</td>
<td>1.2</td>
<td>0.48</td>
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<tr>
<td>Environ expend*</td>
<td>−143.14</td>
<td>104.86</td>
<td>−1.01</td>
<td>0.011</td>
<td>1.6</td>
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<td>Adj. r²sq 67.1%</td>
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*Transformed with natural log.
have a significant relation with current health expenditures. Total toxic pollution output is positively related to health expenditures, while municipal defensive expenditures are negatively related. All four significant variables account for 67% of the variation in current health expenditures. We tested the unstandardised residuals for spatial autocorrelation with Moran's I. The results showed a negative coefficient (−0.17) with no significant autocorrelation (p>0.1). Visual inspection of the mapped residuals revealed no unusual patterns. Thus the assumption of independent observations required for efficient and unbiased OLS estimation seems to be fulfilled.

We transformed both environmental variables with the natural log because of a strong positive skew, so the coefficients are interpreted as $b/Y_{mean}$. Using this method, the results show that one tonne higher pollution, evaluated at the mean value of expenditures, associates with a 0.03 dollars or 3 cents higher per capita health expenditures. A one dollar increase in defensive expenditures is associated with health expenditures that are 31 cents lower per capita and are not accounted for by the mortality in a population or the presence of teaching hospitals. Interpretation of the coefficient times the range of data shows the magnitude of impact from the highest to the lowest county value. This analysis suggests pollution could exert a $355 difference in per capita health expenditures, when the lowest pollution level is compared with the highest level (0.03 dollars per tonne x range of 10800 tonnes = $355), while health expenditures would be about $200 lower based on a comparison of the lowest to the highest defensive expenditures (5×0.31 × range of 644 = $−200).

**DISCUSSION**

Our results show that, after control for other variables that influence health expenditures, both total toxic pollution output and per capita municipal environmental expenditures have significant associations with HCEs. Counties with higher pollution output tend to have higher per capita HCEs, while those that spend more on defending environmental quality have lower HCEs. The implications of this finding are twofold. Firstly, investments in environmental protection are likely to yield external benefits in the form of reduced HCEs. Given other benefits associated with environmental expenditures such as recreation values and maintaining the health of other species, municipal expenditures in environmental protection probably yield net social benefits (that is, expenditures of one dollar yield a benefit greater than one dollar).

Secondly, health policy that excludes considerations of environmental quality may result in increased HCEs, which then “crowd out” other socially beneficial investments. This relation may set in motion a cycle of cumulative consequences whereby environmental degradation leads to higher health expenditures which in turn reduce funds available for environmental protection thus leading to more degradation and so on. In theory, this relation will hold, although in the case of Ontario it is complicated by jurisdictional fragmentation. The provincial government makes the majority of health expenditures, and municipal governments spend more than other levels of government on environmental protection. Yet, the role of provincial grants in stimulating municipal environmental expenditures suggests that crowding out may still be important. Furthermore, many instances exist where crowding out by health expenditures will have a direct influence on provincial environmental programmes. This analysis implies that while many other factors must be taken into account in the cost containment debate, exclusion of environmental considerations may lead to social disbenefits.

This study represents an exploratory attempt to quantify the relation between HCEs and environmental variables, and the findings must be tempered with methodological caveats. Firstly, the comparatively small units of analysis used here may lead to possible spillover effects in environmental quality. Enhanced environmental programmes and expenditures in one jurisdiction would be negated if neighbouring regions pursue environmentally damaging policies. We were unable to address this issue directly, but the lack of spatial autocorrelation in the residuals suggests the variables included in our regression models account for spillovers. If this were not the case, we would expect to see some residual autocorrelation.

Secondly, time lags may influence the relations among environmental investments, environmental quality, and health expenditures. For example, environmental expenditures may not immediately improve environmental quality. Improvements in environmental conditions may take some time to influence health. In turn, improvements in health may not affect demand for health services because of lags in physician, patient, or administrative practices. The direct trade off between environmental and health expenditures as shown in our analysis of the regression coefficients probably overstates our ability to predict these complex relations.

Future research using micro-level data relating specific types of spending (for example, traffic pollution reductions) to individual ill health (for example, asthma) would perhaps better capture the complex environment-health relations explored in this ecological analysis. These refinements seem worth pursuing now that this initial research has established the possibility of a relation between environmental variables and HCEs.

**ACKNOWLEDGEMENTS**

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**Endnotes**

(1) SMR data were extracted from previous studies. The long run to mortality data is used to proxy need in 1991. We expect this variable to be representative of the long term mortality pattern and hence adequate for measuring need in 1991. Correlations with female mortality rates are quite high, r = 0.87, p<0.001, but male rates were found to correlate more closely with socioeconomic health determinants, so we have used these rates for the purpose of generating a predicted value for Stage 2.

(2) Data extracted from Ministry of Health and based on “Part I” classification that includes operation of hospitals and related facilities, Ontario Health Insurance Plan billings, long term care, mental health services, ambulatory and emergency services, and other primary care services. For the 1991–92 budget year, Part I expenditures accounted for $15 966 796 256 of $16 525 215 022 total expenditures or about 96.6% of the total.

(3) Data for the Region and District of Sudbury are combined by the Ministry of Health in expenditures reports. Because we were unable to discern which proportion of the expenditures was attributable to each county, we had to eliminate both cases, leaving 47 counties in the final analysis.