Executive Summary of

"The War on Poverty's Experiment in Public Medicine: Community Health Centers and the Mortality of Older Americans"

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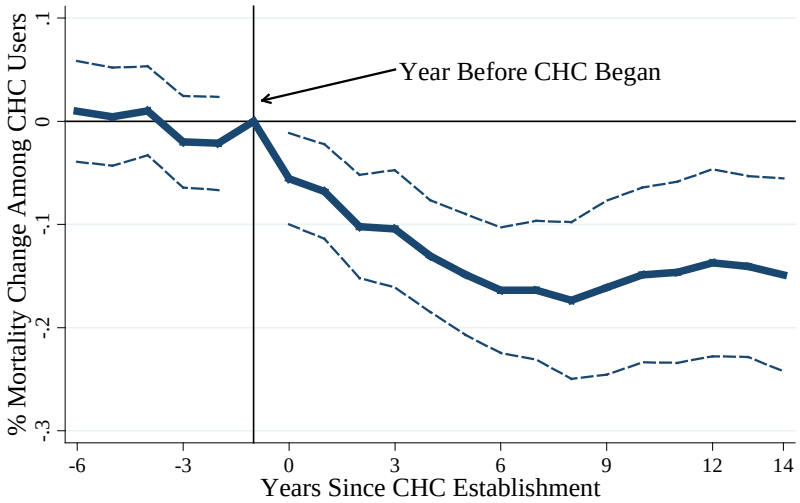
Over the last fifty years, Community Health Centers (CHCs) have used federal funds to deliver primary care to underserved populations. The recent (2010) passage of the Affordable Care Act (ACA) appropriated an additional $11 billion dollars in funding for the expansion of CHCs. Part of the rationale for this expansion is the widely-held belief that CHCs both improve access to primary care *and* curb health care cost increases. Available evidence provides only limited support for these claims, and no study examines the long-run effects of CHCs on health or their implications for health care costs.

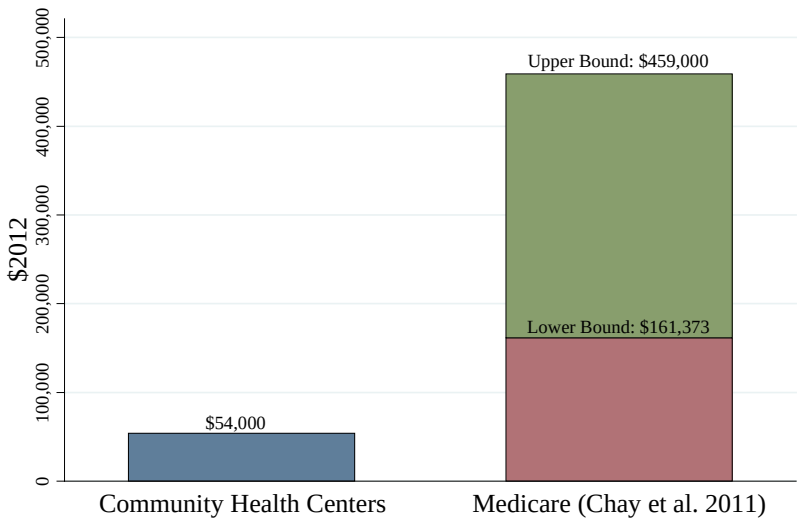
This paper uses the rollout of CHCs from 1965 to 1974 to provide the first evidence on their long-term health effects. Our results show that the establishment of CHCs predicts sharp and persistent reductions in age-adjusted mortality rates. Within ten years, CHCs reduced mortality rates of likely CHC patients ages 50 and older by 7 to 13 percent. They reduced the mortality gap between the poor and non-poor by 20 to 40 percent for the same age group. We also document large effects for those 65 and older, a group with universal health insurance through Medicare. This finding suggests that CHCs' *provision* of primary care has longer-term health benefits beyond those conferred by health insurance. The most important proximate factor was the reduction in deaths due to major cardiovascular causes. We hypothesize that CHCs' testing for, treating, and managing hypertension played an important role.

Figure 1. The Effect of CHC Establishment on the Mortality Patients Ages 50 and Older



Notes: The figure plots the estimated effect of CHC establishment on mortality rates for those 50 and older, divided by the share of the population estimated to have used CHCs within 5 years (11 percent) and also divided by the estimated mortality rate for poor adults over 50 in 1965, 4,127 deaths per 100,000 people. The dashed lines are 95-percent confidence intervals. The vertical line represents the year *before* counties received their first CHC grant.

Figure 2. A Comparison of the Cost per Life-Year Saved for CHCs and Medicare at the Time of Program Implementation



Notes: The figure shows ratio of total public expenditures on each program in the years after their establishment to the number of life-years saved. The estimates for Medicare are the authors' calculation from the treatment effects in Chay et al (2011) and administrative data on Medicare costs. The lower and upper bound are based on the assumption that the estimated mortality reductions *at* age 65 apply to only those ages 65-69 (upper bound cost estimate) or everyone over 65 (lower bound cost estimate).

CHCs also achieved these gains at very low costs. CHCs saved 81,644 lives of those 50 and older within the first ten years they operated at a total program cost of roughly $4.4 billion in 2012 dollars. This yields a cost-per-year-of-life ratio for CHCs of approximately $54,000. By comparison, Medicare's cost-per-year-of-life ratio at implementation in the 1960s ranged from $161,373 to $459,000 in 2012 dollars (Chay et al. 2011)—3 to 8 times the ratio for CHCs begun in the same period.

These cost ratios likely understate the broader effects of increasing access to primary care through CHCs because mortality fails to capture changes in morbidity, disability and other gains in health and well-being. These cost ratios, however, suggest that CHCs achieved their primary objective of improving health at much lower cost than larger public insurance programs—especially for the elderly. Whether CHCs' health benefits remain this large today and whether CHCs benefited the non-elderly remain important areas for future research.

The analysis is based on two newly compiled data sources: the National Archives Community Action Program (NACAP) electronic files and hand-entered annual Public Health Service Reports. These data allow us to pinpoint the counties where CHCs delivered services from 1965 to 1980 and when these CHCs began operating. These data facilitate the paper's research design, which relies on variation in *when* and *where* CHC programs were established in order to quantify their effects on mortality.