Statistical Brief

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HEALTH COSTS IN NORTH CAROLINA – Where Do State Government Dollars Go?

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This report is the fourth in a series devoted to assessing health costs in North Carolina. Previous briefs have examined hospital costs and charges,[1] health insurance activity and costs,[2] and county government expenditures for health.[3] As soon as data for 1994 and 1995 become available, other briefs are expected to examine estimates of personal health care spending by type of service and expenditures by the Medicare and Medicaid programs. The purpose is to establish indicators for tracking health costs in the future.

In the case of state government, we especially need to establish baseline information and monitor trends as Medicaid beneficiaries are moved into private-sector managed care. Will that move truly result in cost efficiencies, and how is government then going to balance spending for direct care versus other important public health functions? Or will any monies saved by managed care even stay in the health care sector? Policy makers need to know.

As the current investigation has revealed, the accurate measurement of health costs to state government is a complex task requiring the dedication of budget analysts and many other players from a number of state agencies. The complexities begin with the very definition of health and involve the tedious task of unduplicating inter- and intra-agency transfers of funds. Systematic approaches to the latter problem do not currently exist. For these reasons, and following the suggestions of James Davies in the Office of State Budget and Management,[4] no attempt is made here to estimate the total cost of health. Rather, data are for specific programs and subprograms within the state's performance budget taxonomy for health. Given appropriate adjustments for future changes in the structure and application of the taxonomy, the individual funds should be trackable, regardless of intervening changes in the physical location of a health program. The performance budget taxonomy for health also provides for the measurement of population-based health spending as distinct from spending on personal health services. James Davies points out, however, that performance budgets are really more focused on performance than on program costs.[5]

Performance-Based Budgeting for Health

The state's Performance/Program Budget (P/PB) is an on-going data system that measures distinct funds within the context of overall goals of a program area, for example, health, human resources, environment, etc. There are three primary goals in the Health Program Area:

- Protect the public health
- Provide treatment for health problems
- Improve access to health care

These goals are served by seven different departments, each addressing specific needs or target populations. Each goal is defined by a distinct set of accounting funds that together comprise the taxonomy for health.

Data are from Volume 7A of *The North Carolina State Budget, 1997-99 Biennium*.[6] They do not include the health taxonomy codes 1998 (Support Services and Administration) and 1999 (Reserves, Transfers, and Other Accounting Funds) because those funds are not necessarily specific to the health area. According to the P/PB rules for assigning funds to a program area, a budget fund cannot be split and the entire fund is assigned to the most dominant program area. For example, health accounts for a majority of the budgets of the Department of Health and Human Services and the Department of Labor as well as UNC Hospitals. Therefore, **all** of the department-level funds for general support services and administration are assigned to the taxonomy for health.

Although most environmental programs directly or indirectly benefit the public's health, they are not included in the health taxonomy or in this brief. Performance budget data for the environmental area, like that for the health area, are contained in Volume 7A of the state budget.[6] They include DEHNR fund 1500, On-Site Wastewater, which is administered by the Environmental Health Section, a traditional public health agency.

Health funds are also found in other nonhealth taxonomies, for example, fund 3400-1120 in the Corrections taxonomy is for substance abuse treatment services throughout the state's prison system.

Despite its several limitations, the state's performance budget taxonomy for health provides a means for tracking selected health costs in the future. For that purpose, it may be desirable for a future analyst to expand the health taxonomy to include certain funds from other taxonomies, for example, those mentioned above. Meanwhile, it should be noted that federal expenditures not budgeted through the state (including Medicare) are not captured here. Also not included are state-paid capital improvements, local government expenditures (see reference 3), public expenditures for training health professionals, and state expenditures for teachers' and state employees' health insurance.

Performance Budget Summary for Health 1996-97

The table on the next page summarizes fiscal 1996-97 authorized requirements and personnel positions for programs, subprograms, and elements of the taxonomy for health. Figures 1 and 2 depict these data for each of 17 distinct entities. From these data, it is seen that Access to Health Care and Treatment for Health Problems dominate the health agenda.

Under Improve Access to Health Care, program code 1600 represents medical assistance through Medicaid. At $4.1 billion, the 1996-97 authorization is 3.4 times that for program code 1400, which largely represents spending of the state's mental health agency and UNC Hospitals. Following a distant third at $232 million are maternal and child health prevention services. All other health authorizations are small by comparison.

Changes from 1996-97 Authorized to 1998-99 Recommended Budgets

Numerically, the largest change recommended in budget requirement is an increase of $638 million in the Medicaid program, followed by a $41 million increase in the care and treatment of confirmed Thomas S. class members (developmentally disabled children and adults). An increase of $3 million is recommended for the Willie M. program for mentally ill children. A lesser increase of $2.6 million is recommended for the provision of medical care by UNC Hospitals. Other recommended changes in the performance budget for health are relatively minor. (Note: The UNC Hospitals increase is in addition to **restoration** of a state appropriation of about $20 million, which was withheld earlier.[7])

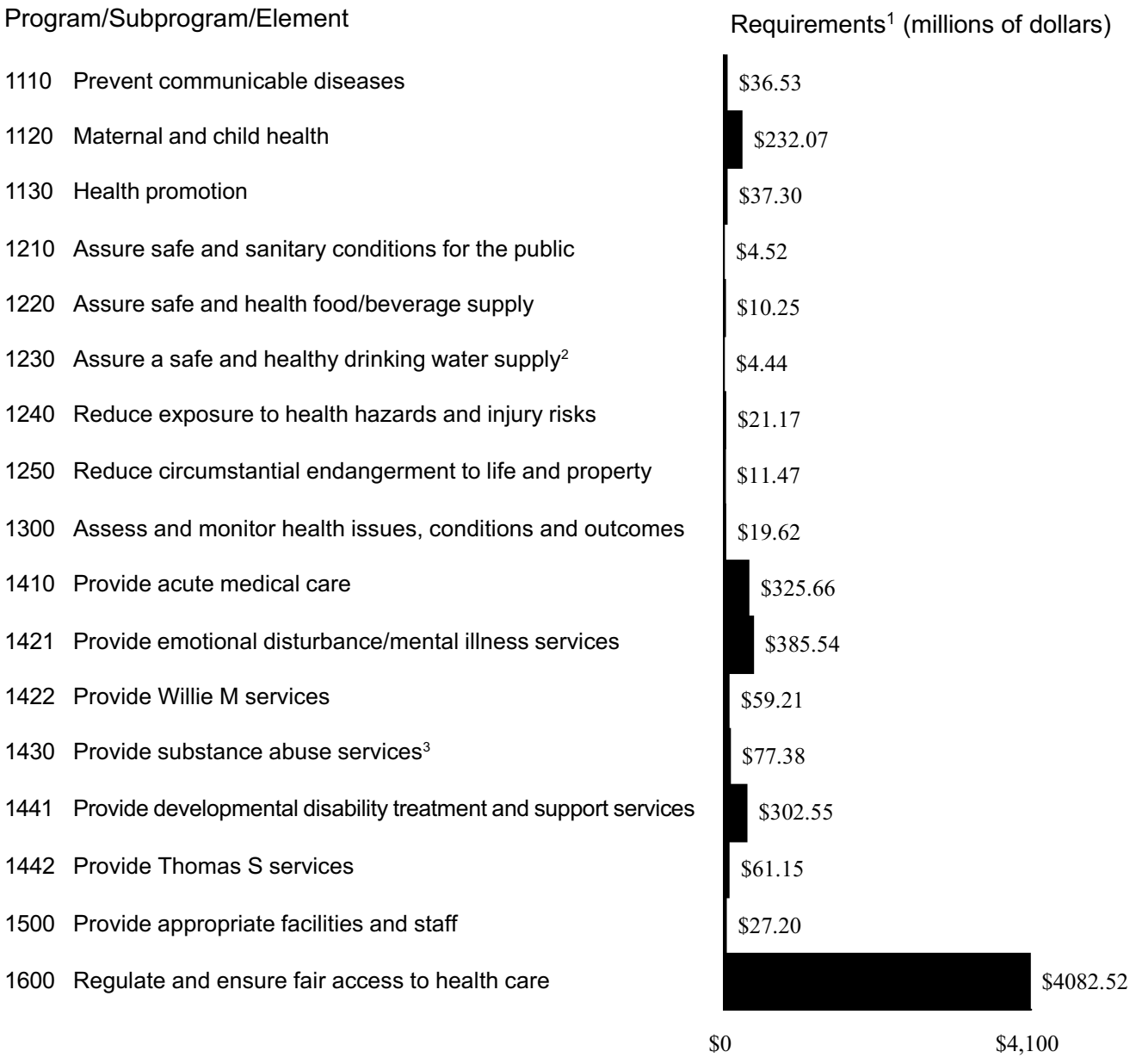
Percentagewise, the largest increases recommended are as follows: Thomas S. 67%, Medicaid 16%, Willie M. 5%, and Assess and Monitor Health Issues, Conditions and Outcomes 3%. Percentage increases for all other entities were under one percent. In the Assess and Monitor area, public health laboratory services account for about one-half of expenditures; the State Center for Health Statistics accounts for nearly one-fourth.

State of North Carolina
Performance Budget Summary for Health
FY 1996-97 Authorizations

Performance/Program Budget Fund Assignment	Requirements[1]	Number of Positions
PROTECT THE PUBLIC HEALTH		
1100 Prevent diseases and promote health	$ 305,895,051	906.48
1110 Prevent communicable diseases	36,526,871	150.51
1120 Maternal and child health	232,070,397	526.26
1130 Health promotion	37,297,783	229.71
1200 Assure safe and healthy working and living conditions	51,843,961	837.64
1210 Assure safe and sanitary conditions for the public	4,523,387	48.95
1220 Assure safe and healthy food/beverage supply	10,249,374	227.50
1230 Assure a safe and healthy drinking water supply[2]	4,436,417	76.55
1240 Reduce exposure to health hazards and injury risks	21,166,672	382.64
1250 Reduce circumstantial endangerment to life and property	11,468,111	102.00
1300 Assess and monitor health issues, conditions and outcomes	19,620,043	358.73
PROVIDE TREATMENT FOR HEALTH PROBLEMS		
1400 Maintain and improve health treatment services	1,211,491,464	16,345.30
1410 Provide acute medical care – hospital and ambulatory services[3]	325,659,865	4,331.08
1420 Provide mental health services – institutional & community-based	444,755,928	5,722.72
1421 Emotional disturbance/mental illness	385,542,468	5,567.72
1422 Willie M.[4]	59,213,460	155.00
1430 Provide substance abuse services – institutional & community-based[5]	77,375,818	397.02
1440 Provide developmental disability services – institutional and community-based	363,699,853	5,894.48
1441 Developmental disability treatment & support services	302,552,189	5,857.88
1442 Thomas S.[6]	61,147,664	36.60
IMPROVE ACCESS TO HEALTH CARE		
1500 Provide appropriate facilities and staff	27,197,498	322.50
1600 Regulate and ensure fair access to health care	4,082,524,018	258.00

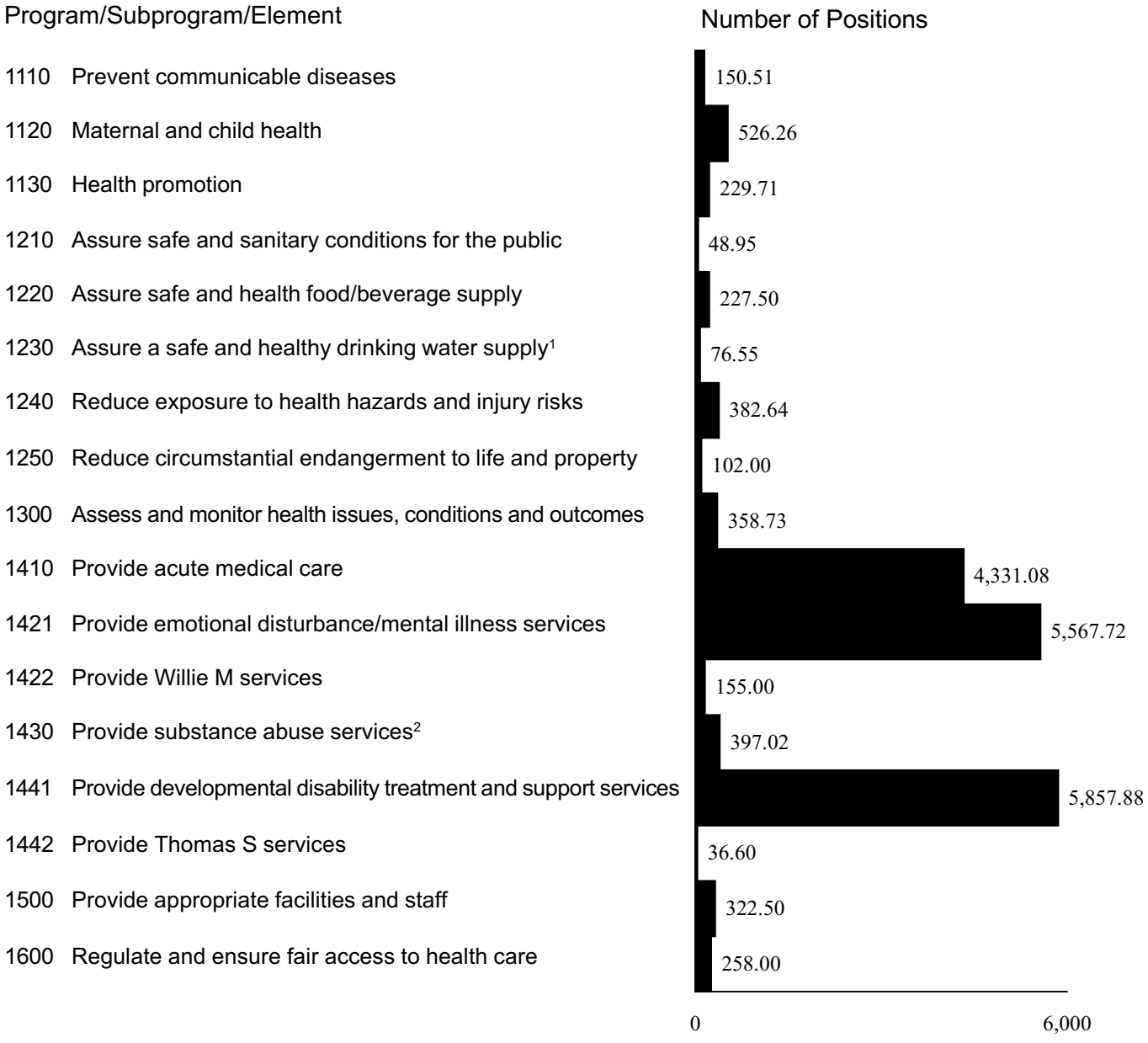
[1]Excludes administrative and reserve funds that could not be allocated by P/PB fund code.
Includes monies that are transferred to another fund for disbursement.
[2]Excludes private wells. That protection program is included in the environmental taxonomy.
[3]Treatment services provided by UNC Hospitals.
[4]Treatment for violent and assaultive mentally ill children.
[5]Excludes substance abuse services in prisons. That treatment program is in the corrections taxonomy.
[6]Treatment for developmentally disabled children and adults.

Figure 1
State of North Carolina
1996-97 Budget Requirements for Health



[1]Includes monies that are transferred to another fund for disbursement
[2]Excludes private wells. That protection program is in the environmental taxonomy.
[3]Excludes substance abuse services in prisons. That treatment program is in the corrections taxonomy.

Figure 2
State of North Carolina
1996-97 Personnel Requirements for Health



[1]Excludes private wells. That protection program is in the environmental taxonomy.
[2]Excludes substance abuse services in prisons. That treatment program is in the corrections taxonomy.

For the recommended increases cited above, state appropriations are expected to cover 35 percent of Medicaid; federal funding covers the rest.[5] Willie M., Thomas S., and Assess and Monitor increases are covered entirely by state funds.

In terms of number of staff, no change has been recommended for most programs. Exceptions are an increase of two positions in program code 1500 (Provide Appropriate Facilities and Staff) and **reductions** as follows:

P/PB Fund Code	No. of Positions
1421	– 24.91
1441	– 3.75
1442	– .60
1600	– 6.00

Discussion

Trends in health care expenditures are influenced by a complex array of factors such as population growth, population demographics, the number of uninsured and underinsured, technology, drug costs, medical care charges, and other factors.

The number of children meeting the criteria of Willie M. classification is expected to rise from about 1,351 in FY 1996 to 1,500 by the end of FY 1999. The number of Thomas S. class members was 1,312 in FY 1996; there are approximately 2,000 potential members. And the number of people covered by Medicaid continues to rise. Medicaid is a federal entitlement program, meaning that anyone who qualifies must be allowed to receive benefits.

Not counting Medicaid but including local health departments and environmental activities related to "essential public health services," public health-related agencies in nine other states spent more than half of their funds in 1995 on personal health care services, according to a pilot study by the Public Health Foundation.[8] The vast majority of those expenditures were by state mental health agencies. Spending on population-based health services, geared toward preventing disease and promoting health in populations as a whole, accounted for 24 percent of the tax-supported expenditures for health.

The present study similarly reveals the predominance of personal health services in this state's expenditures for health. We now need to monitor this pattern as private-sector managed care increases.

This study demonstrates that health expenditures by state government can be effectively measured and monitored using the on-going P/PB data system. The resulting order of magnitude for the various programs, subprograms, and elements should be useful for health policy discussions.

In the future, it is hoped that the Office of State Budget and Management can enhance the P/PB system by developing subsystems to:

- Apportion department-level support and administrative funds to estimate the program area shares.
- Unduplicate inter- and intra-agency transfers to attribute funds to **the program that controls the funds.**

Specific questions or requests for further information about P/PB may be directed to the Office of State Budget and Management, 116 West Jones Street, Raleigh, N.C., 27603-8005, or telephone (919) 733-7061.

References

[1]N.C. Department of Environment, Health, and Natural Resources, State Center for Health Statistics. "Health Costs in North Carolina — Recent Changes in Hospital Statistics," *Statistical Brief.* No. 9, July 1997.

[2]N.C. Department of Environment, Health, and Natural Resources, State Center for Health Statistics. "Health Costs in North Carolina — Accounting for Accident and Health Insurance Costs," *Statistical Brief.* No. 10, August 1997.

[3]N.C. Department of Health and Human Services, State Center for Health Statistics."Health Costs in North Carolina — County Government Expenditures for Health," *Statistical Brief.* No. 11, September 1997.

[4]Personal communication, Kathryn Surles with James Davies, N.C. Office of State Budget and Management. Raleigh, April 16, 1997.

[5]James Davies, N.C. Office of State Budget and Management. Note to Kathryn Surles, received June 9, 1997.

[6]James B. Hunt, Jr., Governor, *The North Carolina State Budget Performance/Program Analysis, 1997-99*. Vol. 7-A of *The North Carolina State Budget, 1997-99 Biennium*. Office of State Budget and Management, Raleigh.

[7]Personal communication, Kathryn Surles with James Davies, N.C. Office of State Budget and Management. Raleigh, June 13, 1997.

[8]Kay W. Eilbert et al. *Measuring Expenditures for Essential Public Health Services*. Public Health Foundation, Washington, D.C., November 1996.

Acknowledgments

Prior to preparing this report, considerable time was spent trying to (1) determine the health share of general support services and administrative funds in the several departments that administer health programs and (2) unduplicate inter- and intra-agency transfers in order to determine the total cost of health to state government. In the end, we abandoned those efforts in favor of a less complicated approach that would better lend itself to tracking. Nevertheless, we wish to thank those who provided data for the initial effort: Doug Lewis, DEHNR; Anna Wasdell, DHR; Deborah Atkinson, DMA; Becky Brown, Labor; and John Alford, Insurance.

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