

The Impact of Health Expenditure on COVID-19 mortality

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ABSTRACT

To be written.

Website: <https://ddtsvetkova.github.io/che-covid19/>

Contents

1	Introduction	3
2	Exploratory data analysis	4
2.1	Data	4
2.2	Statistical Analysis	4
3	Model Estimation	6
4	Results and Discussion	7
4.1	Multiple regression results	7
4.2	Discussion of internal and external validity	7
5	Conclusion	7
6	Teamwork evaluation	7
References		8
Appendix A		9
Appendix B		22

1 Introduction

In this project we aim to evaluate the degree to which health expenditure prevents deaths in the event of a global emergency such as the COVID-19 pandemic using multiple linear regression model. The relevance of the chosen research question is hard to understate. Indeed, it would be of interest for country-level and international policy-makers alike, as well as for the general public, to know whether spending on health is really worth it.

We use publicly available data in our calculations and control for a range of variables that may affect mortality from COVID-19, including measures of availability and quality of healthcare, public attitudes and behaviors during the pandemic, and several demographic characteristics. Full list of variables with their sources and intuition behind including them in the model is presented in Table 1 in the Appendix. In short, *mortality* is the dependent variable, and *che* is the explanatory variable of interest. Along with *beds*, *doctors*, *nurses*, and *dghe*, it could indicate greater preparedness for the pandemic, better health system, and as such, lower mortality. Higher measures of a country's citizens' behavior (*beh_*.), attitudes (*fob_*.), and government trust could also mean lower mortality from COVID-19, unlike higher shares of urban population (*urban*) and population over 65 (*pop65*). Complete cases are available for 96 countries; the data are as recent as possible. Admittedly, there are still variables which could be further included in the model, but for which we were unable to find adequate data, for example, availability of training in medical emergency for medical personnel, quality of ambulance services, etc.

One concern would be inadvertently replicating existing research in both research question and methodology. To the best of our knowledge, there is no such issue with our current specifications. Khan et al., 2020⁵ despite an overlap in some (but not all) of the data, use negative binomial regression and put more of an emphasis on healthcare capacity. Oshunibi et al., 2021⁶ use both linear and exponential models and analyze the impact of current health expenditure on the reproduction number R0 of COVID-19 instead of mortality rate. Kapitsinis, 2020⁸ uses multiple linear regression but limits his sample to the regions of nine EU countries. Elola-Somoza et al., 2021⁷ take into account only Spain and Europe and calculate only Pearson's correlation coefficient.

2 Exploratory data analysis

Now we turn to discussing the data collected in more detail. First, we describe data processing along with the features of the data themselves. Then, we look at how well this data can answer our research question.

2.1 Data

The data used in this project come from their respective sources (see Table 1). Due to these sources being under the jurisdiction of separate entities, there was some mismatch in the country names and/or the list of countries available in different sources. When at all possible, the retrieved datasets were merged by three-letter country codes, otherwise the inconsistencies in country names were adjusted manually before merging. As noted also in Table 1, the years selected were generally the latest available, with several notable conditions to their selection: (1) that the features of health systems were taken to be before the pandemic, even if more recent data were available; (2) that several variables (e.g. *nurses*) consist of the latest observations for their respective countries (not necessarily of the same year), in the interest of maximizing the list of countries for which such information was obtainable.

Then, only complete observations were selected, and only those for which there were no less than 20 respondents in the Global Behaviors and Perceptions survey² (the prior aggregation of the data of this survey is detailed in Table 1). The resulting dataset contains data on 60 countries.

2.2 Statistical Analysis

In order to make sense of possible outliers due to errors in variables one may look at descriptive statistics presented in Table 2. For example, one can observe that domestic general government health expenditure (*dghe*) on average comprises more than half of current health expenditure; 52% of countries available procure medical devices at the national level (*procur*); the scores of the residents' behavior and attitudes are usually very high (possibly due to the respondents' exaggeration, which is not, however, the subject of this study), unlike the scores detailing the evaluation of government's response, etc. Generally, all variables are within their expected ranges.

Turning to the only categorical variable in our analysis *region*, it is easy to

see that while only African region is absent from the analysis, there are very few observations in three of the remaining regions (Table 3, Figures 1-2). It is logical to aggregate them into *Other* (Table 3). Still, the distribution of *mortality* varies depending on the category, as is evident from Figure 2. By contrast, the medians of *mortality* distributions depending on the two values of the only binary variable *procur* seem close enough, though variances differ (Figure 3).

The correlogram (Figure 4) might well prove useful when trying to avoid the omitted variable bias during model specification. Extra attention should be paid to the first two rows of the matrix, which describe the variables that correlate with *mortality*, the dependent variable, and *che*, the variable of interest. As we face the trade-off between bias and variance of the coefficient of interest, we will likely include only some of the variables in our model, so having solid reasons to do so is a good thing. Another feature of note is a correlation of -1 between domestic private and government health expenditure (despite the supposed presence of external expenditures in current health spendings).

The scatterplots of all other variables against *mortality* (Figure 5) paint an alarming picture in the sense that there is a very nebulous observable relationship, if at all. After deep contemplation, we presumed that the reason for this unobservability of linear, let alone nonlinear, relationship was the noise attributed to the small number of observations in our dataset ($n=60$). The only remedy for this is returning the data to the drawing board and reconstructing the dataset from scratch, trying to wrangle out more observations in the process.

It is important to keep in mind that while various sources provide similar lists of countries, the number of observations available varies. The cause of shrinking number of complete observations, therefore, is twofold: at least one of the 26 variables not having data for a country (causing the country to be omitted), and our selection of countries for which there were no less than 20 respondents in the Global Behaviors and Perceptions survey.² While the latter we believe to be reasonable, the former we can inspect closer, as we have plenty of variables. As a result of such an inspection, the variables causing the most “shrinking”, namely *beds*, *tobacco*, and *procur* were got rid of, which increased the sample by more than 50% ($n=96$). At this point, the number of observations is greater than in Khan et al., 2020,⁵ for example (they study 86 countries), which we deemed satisfactory.

We will now provide a short overview of the exploratory data analysis we repeated for the new sample. Judging by the descriptive statistics (Table 4), all variables are again within their expected ranges. There are a few improvements in the new dataset, however: (1) there are now data on Africa available, completing the set of the WHO Regions (Table 5, Figures 6-7); (2) the correlogram yields more useful correlations (Figure 8); as expected, there exists only imperfect mul-

ticollinearity between $dphe$ and $dghe$; (3) the conclusions about the relationship between *mortality* and the explanatory variables, despite likely contradicting our expectations in some cases (Figures 9-11), are expected to hold up better due to the asymptotic nature of various hypothesis tests. We plan to use the updated dataset from this point onwards.

3 Model Estimation

We will use multiple specifications in order to estimate the expected effect of a (hypothetical) change in current health expenditure (measured as a percentage of a country’s GDP in 2018) on mortality from COVID-19 (measured as cumulative total per 100,000 population) in a country, holding all else constant. As there are numerous variables that potentially affect mortality and are correlated with the level of current health expenditure, it is necessary to include such control variables in the model to avoid omitted variable bias. For this reason our base specification includes *che* as well as the 5 control variables:

$$\begin{aligned} \text{mortality} = & \beta_0 + \beta_1 \cdot \text{che} + \beta_2 \cdot \text{pop65} + \beta_3 \cdot \text{urban} + \beta_4 \cdot \text{doctors} \\ & + \beta_5 \cdot \text{nurses} + \beta_6 \cdot \text{dghe} + u \end{aligned}$$

The descriptions of the variables included can be found in Table 1. The control variables are those which both economic intuition (occasionally shared by authors of the articles considered in Introduction) and significant correlation coefficients observed in data (Figure 8) suggest as remedies to omitted variable bias.

Notably, we do not include *dphe* in the base specification: it presents a choice between imperfect multicollinearity and omitted variable bias (as *dphe* is highly correlated with *che*). Imperfect multicollinearity does not introduce bias in itself; it might cause problems when interpreting the effect of *dghe*, which in our case is a control variable (and thus its effect is not critical to answering the research question). Hence, we do not expect imperfect multicollinearity to taint the coefficient of interest β_1 and may include *dphe* in another specification.

We must also construct a specification which takes into account behavioral variables from the Global Behaviors and Perceptions survey,² some of which are clearly correlated with current health expenditure. Finally, nonlinear effects are always worth considering.

4 Results and Discussion

4.1 Multiple regression results

4.2 Discussion of internal and external validity

5 Conclusion

6 Teamwork evaluation

References

- ¹ World Bank, World Bank Open Data. (n.d.). Retrieved from <https://data.worldbank.org/indicator/>
- ² Fetzer, T., Witte, M., Hensel, L., Jachimowicz, J.M., Haushofer, J., Ivchenko, A., Caria, C., Reutskaja, E., Roth, C., Fiorin, F., Gomez, M., Kraft-Todd, G., Goetz, F., Yoeli, E.. Global Behaviors and Perceptions in the COVID-19 Pandemic. <https://doi.org/10.31234/osf.io/3kfmh> Retrieved from <https://osf.io/3sn2k/>
- ³ World Health Organization. The Global Health Observatory Indicators (n.d.). Retrieved from <https://www.who.int/data/gho/data/indicators/indicators-index>
- ⁴ World Health Organization. WHO Coronavirus (COVID-19) Dashboard (2021). Retrieved from <https://covid19.who.int/table>
- ⁵ Khan, J. R., Awan, N., Islam, M., Muurlink, O. (2020). Healthcare capacity, health expenditure, and civil society as predictors of COVID-19 case fatalities: a global analysis. *Frontiers in public health*, 8, 347.
- ⁶ Oshinubi, K., Rachdi, M., Demongeot, J. (2021, October). Analysis of Reproduction Number R₀ of COVID-19 Using Current Health Expenditure as Gross Domestic Product Percentage (CHE/GDP) across Countries. In *Healthcare* (Vol. 9, No. 10, p. 1247). Multidisciplinary Digital Publishing Institute.
- ⁷ Elola-Somoza, F. J., Bas-Villalobos, M. C., Pérez-Villacastín, J., Macaya-Miguel, C. (2021). Public healthcare expenditure and COVID-19 mortality in Spain and in Europe. *Revista Clínica Española* (English Edition), 221(7), 400-403.
- ⁸ Kapitsinis, N. (2020). The underlying factors of the COVID-19 spatially uneven spread. Initial evidence from regions in nine EU countries. *Regional Science Policy Practice*, 12(6), 1027-1045.
- ⁹ Zheng, Z., Peng, F., Xu, B., Zhao, J., Liu, H., Peng, J., ... Tang, W. (2020). Risk factors of critical mortal COVID-19 cases: A systematic literature review and meta-analysis. *Journal of infection*, 81(2), e16-e25.
- ¹⁰ Gupta, A. K., Nethan, S. T., Mehrotra, R. (2020). Tobacco use as a well-recognized cause of severe COVID-19 manifestations. *Respiratory Medicine*, 106233.

Appendix A

Table 1: Variables and Definitions

Variable	Definition	Type	Intuition	Source
mortality	Deaths - cumulative total per 100,000 population (Retrieved 13.10.2021)	continuous	Dependent variable.	WHO Coronavirus (COVID-19) Dashboard
che	Level of current health expenditure expressed as a percentage of GDP. (2018). Estimates of current health expenditures include healthcare goods and services consumed during each year. This indicator does not include capital health expenditures such as buildings, machinery, IT and stocks of vaccines for emergency or outbreaks.	continuous (between 0 and 100)	Variable of interest. As it is the source of financing for the country's health system, higher health expenditure could mean better health system, greater preparedness for the pandemic, and consequently, lower mortality.	World Bank Open Data
beds	Hospital beds (per 1,000 people). (2017)	continuous	More beds could mean greater preparedness for the pandemic (and lower mortality). It is likely both to be correlated with che and have an effect on mortality.	
pop65	Population ages 65 and above (% of total population). (2019). Population is based on the de facto definition of population, which counts all residents regardless of legal status or citizenship.	continuous (between 0 and 100)	As elderly people face a greater risk of severe COVID-19 cases and comorbidities, ⁹ greater proportion of people over 65 could mean greater mortality rates.	

Variable	Definition	Type	Intuition	Source
popdens	Population density (people per sq. km of land area). (2019).	continuous	Higher population density could mean greater risk of contagion, more COVID-19 cases and greater mortality.	
urban	Urban population (% of total population). (2019). Urban population refers to people living in urban areas as defined by national statistical offices. The data are collected and smoothed by United Nations Population Division.	continuous (between 0 and 100)	People in cities may face higher risk of contagion (and higher mortality) due to population density; however, people in rural areas are more vulnerable in terms of access to timely healthcare.	
dphe	Domestic private health expenditure (% of current health expenditure). (2018). Domestic private sources include funds from households, corporations and non-profit organizations. Such expenditures can be either prepaid to voluntary health insurance or paid directly to healthcare providers.	continuous (between 0 and 100)	Private health expenditure making up a relatively large share of current expenditure (and government health expenditure making up a small share) could mean that a lot of health expenses households have to cover out-of-pocket; i.e. not many health services are guaranteed by the government. That is, there are barriers to health care access, and preparedness for the pandemic is relatively low.	

Variable	Definition	Type	Intuition	Source
dghe	Domestic general government health expenditure (% of current health expenditure) (2018).	continuous (between 0 and 100)	See above. The third category in current health expenditure is external expenditure.	
tobacco	Prevalence of current tobacco use (% of adults) (2018).	continuous (between 0 and 100)	As tobacco is a well-recognized cause of severe COVID-19 cases, ¹⁰ higher prevalence of tobacco use could mean higher mortality.	
procur	Procurement of medical devices carried out at the national level (Latest year).	binary (Yes=1, No=0)	A measure of quality of the national health system. Probably countries that procure medical devices at the national level are better prepared for the pandemic.	The Global Health Observatory Indicators
doctors	Medical doctors (per 10,000) (Latest year).	continuous	A measure of health system capacity. More doctors could mean more adequate care and less fatalities.	
nurses	Nursing and midwifery personnel (per 10,000) (Latest year).	continuous	A measure of health system capacity. More nurses could mean more adequate care and less fatalities.	

Variable	Definition	Type	Intuition	Source
Global Behaviors and Perceptions in the COVID-19 Pandemic				
beh_stayhome	Question asked to individuals in spring of 2020 was: “To what extent do the following statements describe your behavior for the past week? [0 = Does not apply at all; 100 = Applies very much] I stayed at home. We took the average of responses by country and selected countries with no less than 20 respondents.	continuous (between 0 and 100)	The success of emergency measures taken depends on the nation’s attitudes and behaviors; the better people followed recommendations, the less people could have died from COVID-19.	Global Behaviors and Perceptions in the COVID-19 Pandemic
beh_socgather ing	...I did not attend social gatherings.	continuous (between 0 and 100)		
beh_distance	...I kept a distance of at least two meters to other people.	continuous (between 0 and 100)		
beh_tellsymp	...If I had exhibited symptoms of sickness, I would have immediately informed the people around me.	continuous (between 0 and 100)		
beh_hand-wash	...I washed my hands more frequently than the month before	continuous (between 0 and 100)		

Variable	Definition	Type	Intuition	Source
fob_social	“What do you think: should people in your country cancel their participation at social gatherings because of the coronavirus right now? [No = 0; Yes = 1]” We took the average of responses by country (getting the percentage of people who said Yes) and selected countries with no less than 20 respondents.	continuous (between 0 and 1)	Another way to look not on people’s actions, but on their beliefs on whether recommendations are reasonable or not.	
fob_handshake	“What do you think: should people in your country not shake other people’s hands because of the coronavirus right now? [No = 0; Yes = 1]”	continuous (between 0 and 1)		
fob_stores	“What do you think: should all shops in your country other than particularly important ones, such as supermarkets, pharmacies, post offices, and gas stations, be closed because of the coronavirus right now? [No = 0; Yes = 1]”	continuous (between 0 and 1)		
fob_curfew	“What do you think: should there be a general curfew in your country (with the exception of grocery shopping, necessary family trips, and the commute to work) because of the coronavirus right now? [No = 0; Yes = 1]”	continuous (between 0 and 1)		

Variable	Definition	Type	Intuition	Source
perceived_reaction_d	"Do you think the reaction of your country's government to the current coronavirus outbreak is appropriate, too extreme, or not sufficient? [5-point scale; 1 = The reaction is much too extreme; 2 = The reaction is somewhat too extreme; 3 = The reaction is appropriate; 4 = The reaction is somewhat insufficient; 5 = The reaction is not at all sufficient]" We converted the categorical variable into binary (4,5 = 1, 1,2,3 = 0) and aggregated as before.	continuous (between 0 and 1)	Stronger civil responsibility and trust in the government's actions of the populace when emergency measures are taken could mean less deaths from COVID-19.	
govtrust_d	How much do you trust your country's government to take care of its citizens? [5-point scale; 1 = Strongly distrust; 2 = Somewhat distrust; 3 = Neither trust nor distrust; 4 = Somewhat trust; 5 = Strongly trust] Aggregated as above.	continuous (between 0 and 1)		
govfact_d	How factually truthful do you think your country's government has been about the coronavirus outbreak? [5-point scale; 1 = Very untruthful; 2 = Somewhat untruthful; 3 = Neither truthful nor untruthful; 4 = Somewhat truthful; 5 = Very truthful]	continuous (between 0 and 1)		

Variable	Definition	Type	Intuition	Source
perceived_effectiveness_d	What do you think: How effective are social distancing measures (e.g., through a general curfew) to slow down the spread of the coronavirus? [5-point scale; 1 = Not at all effective; 2 = Not effective; 3 = Neither effective nor ineffective; 4 = Effective; 5 = Very effective]	continuous (between 0 and 1)		
region	WHO Region (Americas, Europe, Western Pacific, Eastern Mediterranean, South-East Asia, Africa; there are no countries from Africa in our dataset)	categorical	Extra control variable to account for geographical influences	WHO Coronavirus (COVID-19) Dashboard
population	Total population is based on the de facto definition of population, which counts all residents regardless of legal status or citizenship. (2019). The values shown are midyear estimates.	continuous	Extra control variable to help with the relative data described above (percentages, etc.)	World Bank Open Data

Table 2: Descriptive Statistics (n=60)

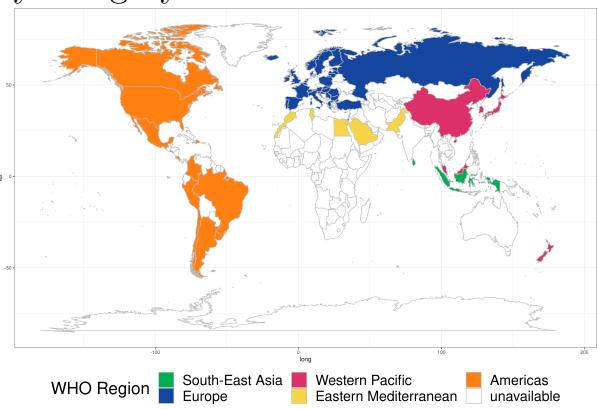
variable	mean	sd	min	Q1	median	Q3	max
mortality	134.62	106.71	0.39	50.64	125.66	204.73	605.68
che	7.62	2.58	2.50	5.69	7.54	9.26	16.89
beds	3.87	2.51	0.63	2.20	3.12	5.13	13.05
pop65	14.78	5.96	1.52	9.13	15.59	19.76	28.00
popdens	296.44	1043.79	3.58	34.63	99.85	218.33	8044.53
urban	75.39	16.11	18.59	66.55	79.73	87.03	100.00
dphe	35.83	14.43	13.67	25.91	34.44	48.15	70.60
dghe	63.96	14.56	28.73	51.75	64.81	74.09	85.32
tobacco	24.25	8.77	7.90	18.32	23.50	28.88	44.70
procur	0.52	0.50	0.00	0.00	1.00	1.00	1.00
doctors	33.81	16.05	4.65	23.62	32.37	43.60	80.13
nurses	69.25	50.03	2.80	26.46	61.65	102.38	216.70
beh_stayhome	83.46	7.33	58.68	81.24	84.83	87.91	94.41
beh_socgathering	92.33	4.99	75.30	90.95	94.35	95.56	99.00
beh_distance	78.76	9.12	47.87	74.07	81.32	85.27	90.56
beh_tellsymp	92.85	4.28	78.45	92.82	94.26	95.09	97.72
beh_handwash	91.69	2.83	83.72	90.47	92.06	93.75	96.57
fob_social	0.98	0.04	0.79	0.98	0.99	0.99	1.00
fob_handshake	0.97	0.04	0.74	0.96	0.98	0.99	1.00
fob_stores	0.81	0.17	0.20	0.77	0.87	0.91	0.97
fob_curfew	0.71	0.19	0.16	0.59	0.74	0.88	0.99
perceivedreaction_d	0.40	0.23	0.00	0.23	0.36	0.56	0.91
govtrust_d	0.57	0.24	0.09	0.38	0.58	0.80	0.96
govfact_d	0.63	0.24	0.09	0.49	0.71	0.82	0.98
perceivedeffectiveness_d	0.89	0.05	0.70	0.85	0.90	0.93	0.97
population (mln.)	64.587	187.688	0.361	5.428	10.730	47.935	1397.715

Table 3: *region*: Nº of observations by category

region	Nº of obs.
1 Americas	12
2 Eastern Mediterranean	7
3 Europe	33
4 South-East Asia	2
5 Western Pacific	6

region	Nº of obs.
1 Americas	12
2 Europe	33
3 Other	15

Figure 1: *region*: Countries available by category



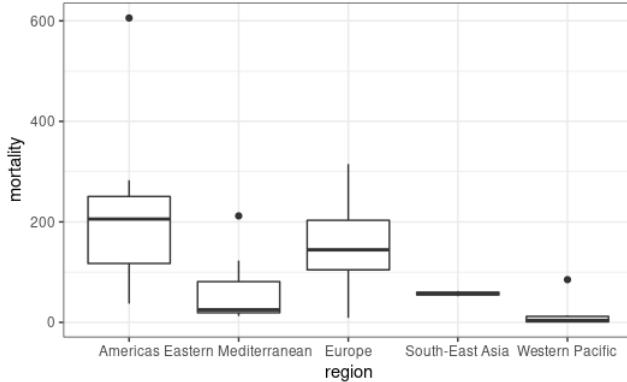


Figure 2: *mortality* distributions by WHO Region

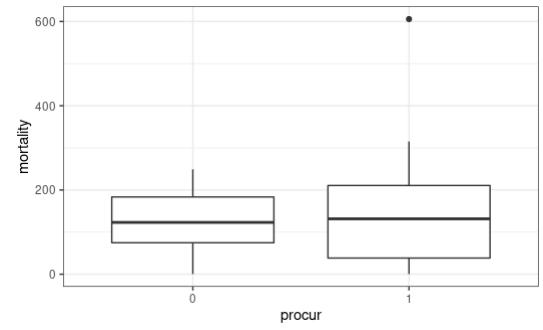


Figure 3: *mortality* distributions by Procurement of medical devices carried out at the national level (1=Yes, 0=No)

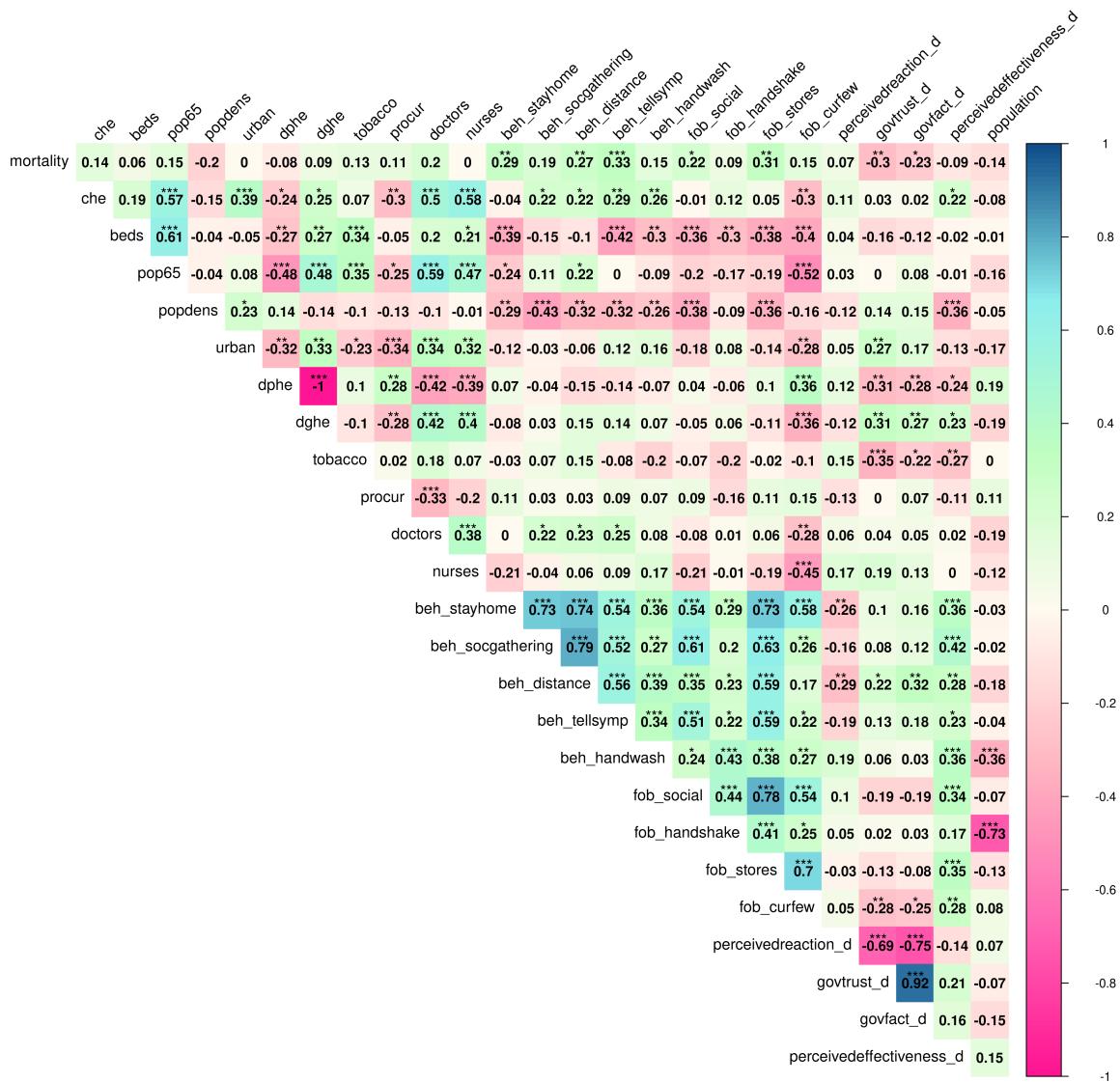


Figure 4: Correlogram of numeric variables. (*, **, and *** mean that correlation is different from 0 at 0.1, 0.05, and 0.01 levels respectively)

Figure 5: *mortality* vs each numerical variable

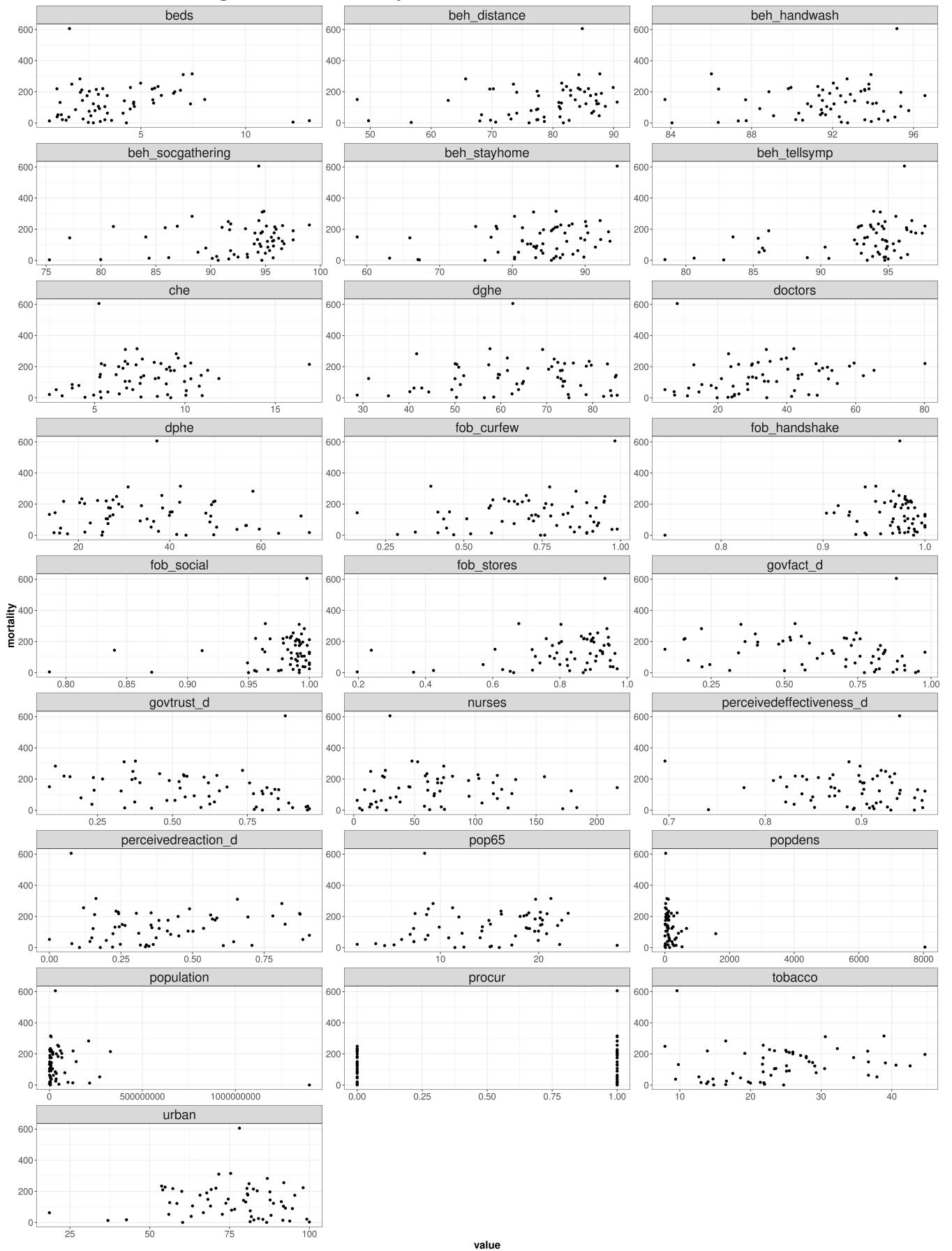


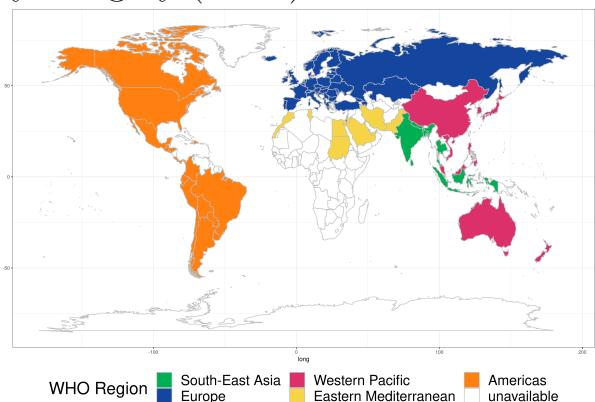
Table 4: Descriptive Statistics (n=96)

variable	mean	sd	min	Q1	median	Q3	max
mortality	118.11	101.07	0.39	30.93	105.14	184.11	605.68
che	7.00	2.52	2.34	5.28	6.88	8.66	16.89
pop65	12.20	6.67	1.16	6.43	12.11	18.75	28.00
popdens	268.42	856.98	3.30	46.36	100.05	220.68	8044.53
urban	68.47	20.49	17.31	57.00	71.19	83.75	100.00
dphe	39.80	16.24	11.96	26.60	39.48	49.72	77.27
dghe	57.86	18.33	14.87	45.25	59.59	73.16	88.04
doctors	27.95	17.93	0.60	12.66	26.29	40.52	80.13
nurses	58.15	46.94	2.80	19.03	51.52	74.27	216.70
beh_stayhome	82.68	8.71	48.36	79.06	84.24	88.50	95.72
beh_socgathering	91.26	5.79	70.30	88.16	93.19	95.55	99.30
beh_distance	76.33	9.91	47.87	69.79	77.60	84.31	92.07
beh_tellsymp	92.31	4.67	78.45	90.60	93.77	95.01	99.29
beh_handwash	91.49	3.29	80.60	90.18	91.97	93.75	97.92
fob_social	0.98	0.03	0.79	0.98	0.99	0.99	1.00
fob_handshake	0.96	0.04	0.66	0.96	0.97	0.98	1.00
fob_stores	0.81	0.14	0.20	0.78	0.86	0.90	0.97
fob_curfew	0.75	0.18	0.16	0.65	0.78	0.89	1.00
perceivedreaction_d	0.40	0.24	0.00	0.21	0.37	0.56	0.95
govtrust_d	0.54	0.25	0.04	0.37	0.52	0.77	0.96
govfact_d	0.60	0.24	0.09	0.40	0.65	0.80	0.98
perceivedeffectiveness_d	0.87	0.07	0.62	0.84	0.89	0.92	1.00
population (mln.)	69.54	201.818	0.361	5.658	12.161	53.932	1397.715

Table 5: *region*: Nº of observations by category (n=96)

region	Nº of obs.
1 Africa	7
2 Americas	18
3 Eastern Mediterranean	13
4 Europe	43
5 South-East Asia	6
6 Western Pacific	9

Figure 6: *region*: Countries available by category (n=96)



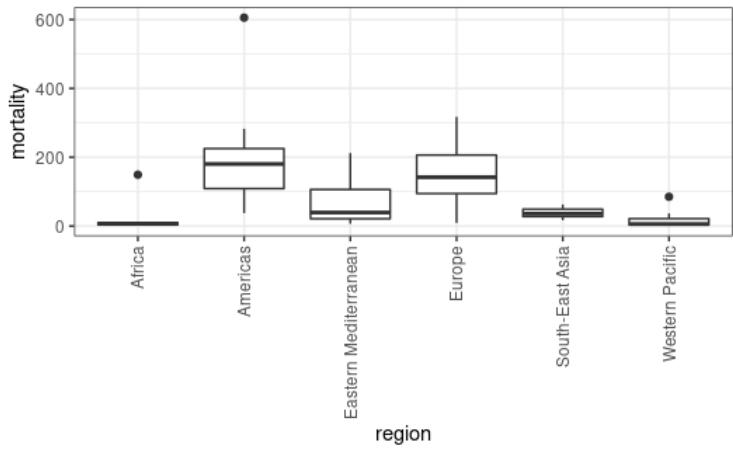


Figure 7: *mortality* distributions by WHO Region (n=96)

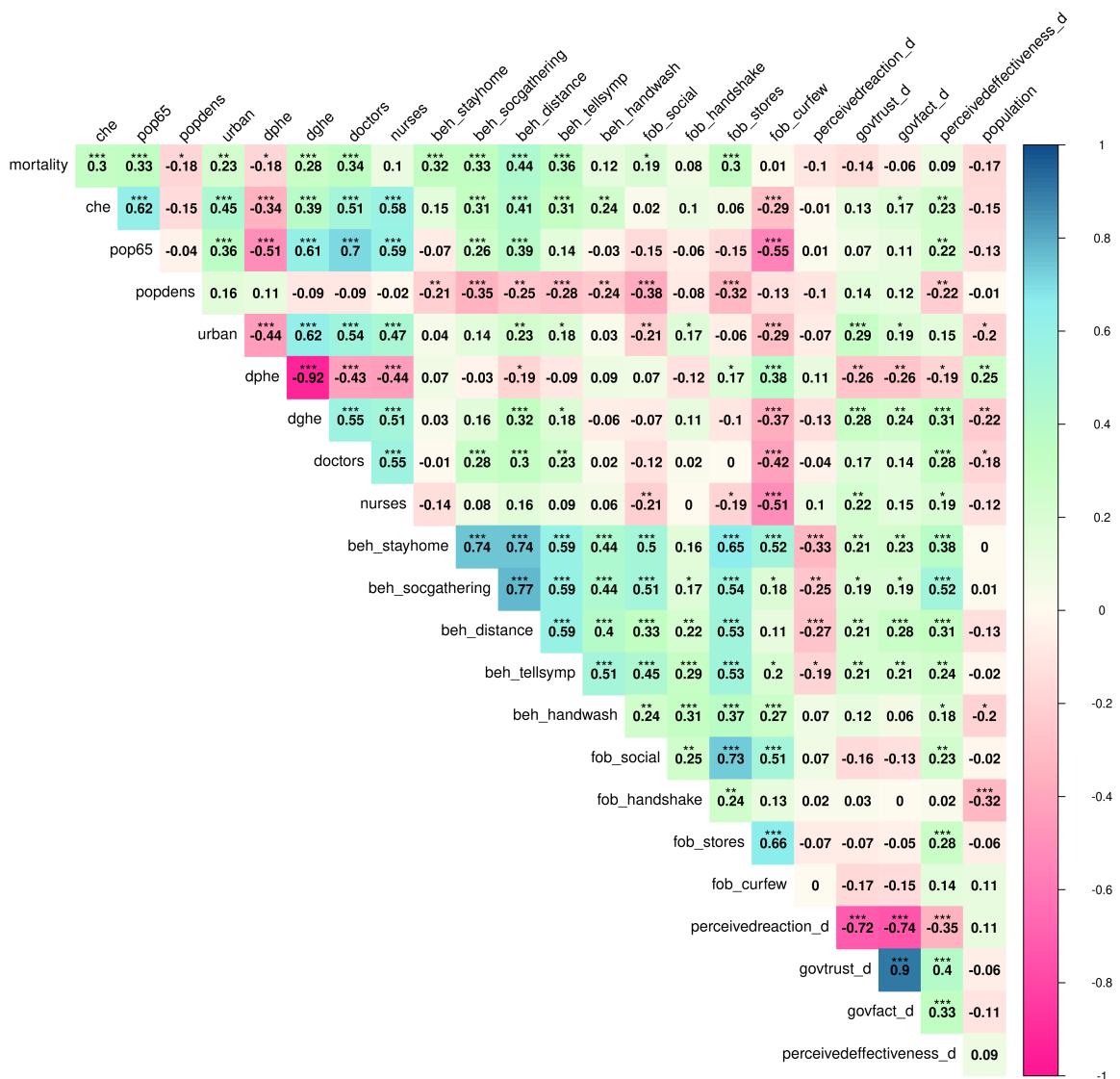
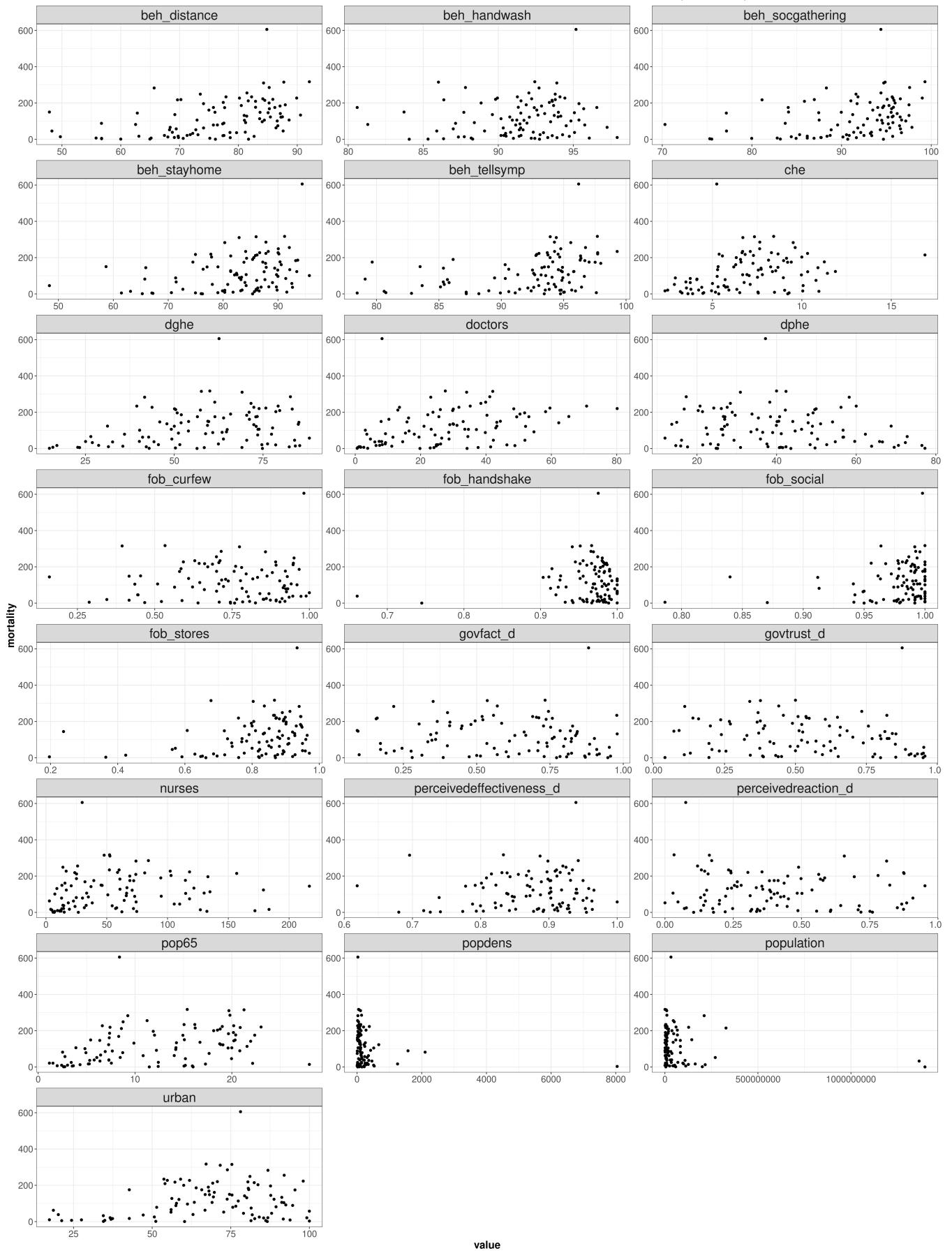


Figure 8: Correlogram of numeric variables (n=96). (*, **, and *** mean that correlation is different from 0 at 0.1, 0.05, and 0.01 levels respectively)

Figure 9: mortality vs each numerical variable (n=96)



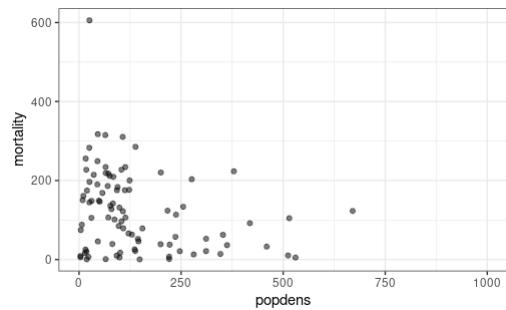


Figure 10: *mortality* vs. population density (over a limited range of density) (n=96)

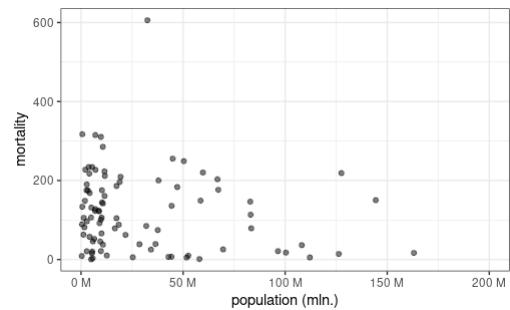


Figure 11: *mortality* vs. population (over a limited range of population) (n=96)

Appendix B

Relevant R code is available here: <https://ddtsvetkova.github.io/che-covid19/code.html>