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Driving the Economy: Health Care in New Hampshire (2008)

September 2008

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About this paper

This paper is one of a series published by the NH Center for Public Policy Studies on the broad topic of health-care finance and insuring the New Hampshire workforce. The Concord-based Endowment for Health has sponsored this work.

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Executive Summary

The cost of personal health care is rising in New Hampshire. In the Granite State, personal health care—which includes visits to doctors, hospitalizations, medicine, and so on—consumes 18 percent of our economy, or 18 cents of every dollar. In 2007, that amounted to \$10.16 billion. Twenty years ago, spending on personal health care was less than 10 percent of New Hampshire's economy. Twenty years from now, health care spending is projected to reach nearly 22 to 25 percent of economic activity.

Perhaps most striking in this analysis is the degree to which healthcare plays an even larger role in the economic landscape in New Hampshire. Hospitals are often the single largest employer in the labor market areas across New Hampshire. More generally, the health and social services industries account for a significant share of economic activity – as measured by wages – particularly in rural areas of the state.

While public policy has focused on declines in rural manufacturing and forest based industries, health care has increased in importance. Contrary to popular perception, health care can be an important export-based industry in rural areas. And the health care system is expanding. Since 2000, hospitals alone have invested \$1.2 billion in the healthcare infrastructure of New Hampshire. New Hampshire hospitals in this decade are building at nearly three times the rate as in the prior two decades, implying that hospital costs and the role in local economies will also continue to increase rapidly.

Just as health care takes up an ever increasing share of the state's gross domestic product, private health care premiums are taking up an increasing share of wages. In New Hampshire, health insurance premiums for families and couples are higher than the national average, while premiums for single people are roughly the same. The cost of the average family health insurance plan in New Hampshire increased from \$7,525 in 2000 to \$12,686 in 2006. The cost of a family policy grew from 10.2 percent of mean family income in 2000 to 15 percent in 2006.

The increasing importance of health care to the economy and the growing lack of affordability of premiums create a policy conundrum. Health care reform may be failing because, in order to control health care costs, one must also control growth in one of New Hampshire's primary economic engines. Health care plays a critical role in the economy, so any policy debate about managing health care costs must address the fact that health care is now one of the primary drivers of the state's economy. The New Hampshire Department of Employment Security projects that by the year 2016 one out of every nine jobs in New Hampshire will be in the health care sector. For many reasons, both political and practical, one cannot address the issue of health care costs without addressing the issue of economic development, particularly in our rural communities where health care is replacing manufacturing and forest resources as one of the most critical industries.

Other major findings include:

- **Health care spending in New Hampshire increased dramatically.** Spending on hospitals increased by almost one half (\$1.4 billion) from 2000 to 2007, while spending on physician services rose by more than one third (\$600 million) from 2000 to 2007. Pharmaceutical spending has doubled from 2000 to 2007.

- **Public sources pay for about half of our personal health care.** In 2007, about half of the money to pay for personal health care came from private sources (primarily out-of-pocket payments and health insurance) and half came from public tax sources (primarily Medicare and Medicaid).
- **New Hampshire employers continue to play a large role in insurance coverage in the state.** Full-time workers are much more likely to be covered (63 percent) than part-time workers (7 percent). New Hampshire employees pay an average of 27 percent of the cost of coverage, and the contribution they make to their insurance premiums is rising faster than the cost of insurance to their employer.

Aggregate Health Care Dollars and Relation to Income

Total Health Expenditure as Percentage of Gross Domestic Product

In 2007, New Hampshire's Gross Domestic Product (GDP), the most comprehensive measure of the state's overall economy, was \$56.07 billion and total health expenditure was \$10.16 billion, or 18 percent of GDP.¹ Said another way, 18 cents of every dollar of New Hampshire economic activity is estimated to go towards health care expenditures.

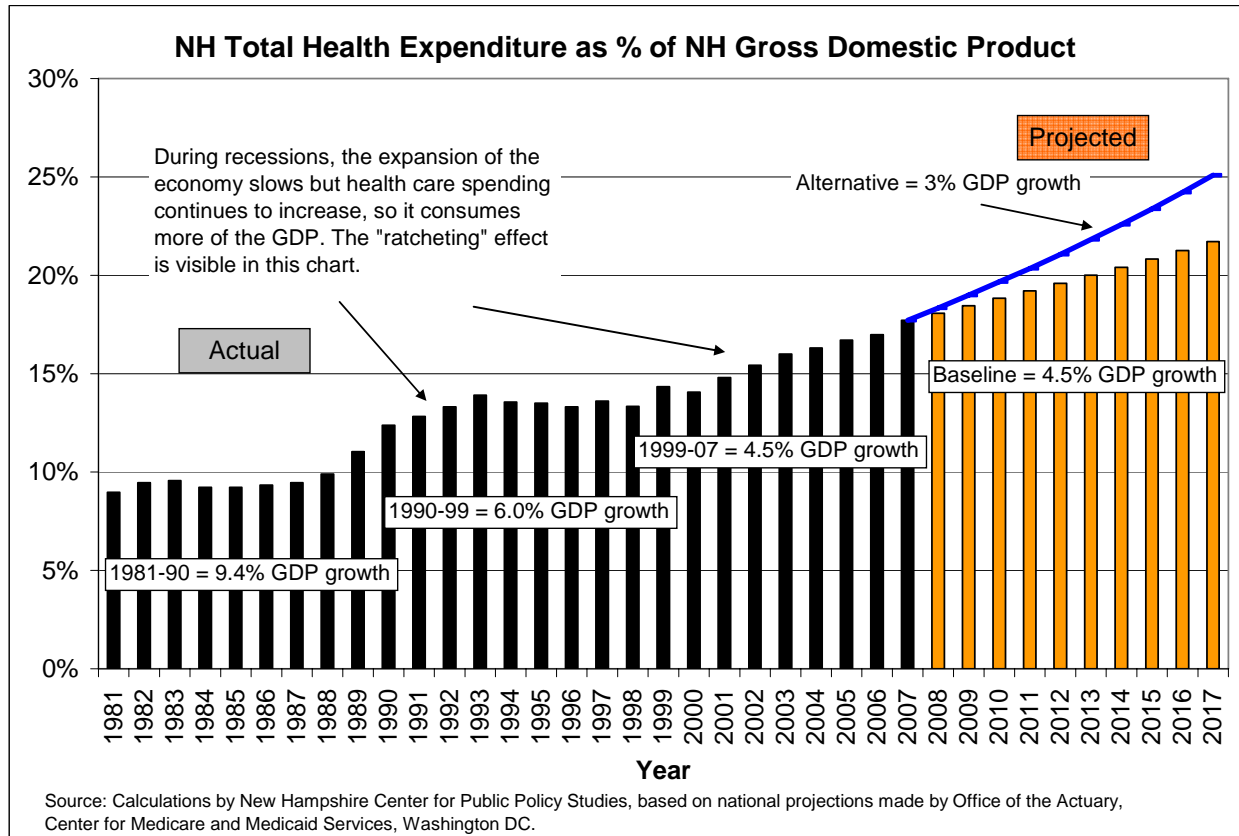
Figure 1 displays the percentage of the state's overall economy that is accounted for by health care. Until 1989 health care remained under 10 percent of the overall economy. With the onset of the 1989 recession health care spending continued to rise, even as the overall economy slowed. As a result, health care's share of the economy expanded to about 13 percent in 1992. The rapid expansion of the state's economy coupled with more tightly managed health care through the expansion of health maintenance organizations (HMOs) resulted in health care's share of the economy declining slightly through 1997. The economic slowdown that started in 2000, coupled with a loosening of managed care controls, again resulted in health care expanding rather rapidly as a percent of the overall GDP. Health care expenditures rose from 14.1 percent of GDP in 2000 to 18 percent of GDP in 2007.

We project health care spending to continue to expand as a portion of the overall economy. In 2017 we expect the GDP to reach \$89 billion and total health expenditure to be \$19.34 billion. That will be 22 percent of the GDP. This is similar to what is assumed to happen nationally.

The share of health care expenditures, relative to the overall economy, will grow even faster if the economic growth slows. That is because health care expenditures will continue to rise, even as the expansion of the economy decelerates. Figure 1 also shows an alternative estimate of New Hampshire total health expenditures as a percent of GDP. The alternative assumes slower economic growth, while health care expenditures continue to increase at historical rates. In that alternative scenario, by the year 2017 New Hampshire's GDP will reach \$77 billion and total health expenditure will be \$19.34 billion, or 25 percent of the GDP.

¹ Most figures in this section are taken from or based on 2004 national and state Health Expenditure Accounts prepared by the Office of the Actuary, Center for Medicare and Medicaid Services (CMS), US Department of Health and Human Services. http://www.cms.hhs.gov/nationalhealthexpenddata/01_overview.asp
We have projected New Hampshire expenditures for years 2005-2017 using the CMS national projections through 2017. Although the New Hampshire 'history' from 2005 to 2007 is estimated from the national projection, the result is consistent with other measures of New Hampshire health expenditures, such as hospital revenues from the NH Hospital Association.

Figure 1



Total Health Expenditure by Type of Service or Product

Spending on “personal health care” includes payments for all the services and products that are purchased for the health care of individuals. It includes hospitals, nursing homes, drugs, wheelchairs, care from physicians, surgeons, other medical specialists, and alternative health providers, prescription and over the counter medicines, medical equipment, etc.

“Total health expenditure” is greater than spending on personal health. While it includes all spending on personal health care, it also includes spending on health care research, health facility construction and equipment, general health education, public health services such as restaurant inspections, epidemiology investigations, smoking cessation, or cancer prevention. Importantly, it also includes that portion of health insurance premiums that never pays claims (the administrative and claims processing costs and profits of the insurers themselves). National data show that in 2004 total health spending was 20 percent greater than spending on personal health care.

Personal Health Care Spending in 2007

Total health expenditure in New Hampshire totals \$10.16 billion in 2007. Of that, *personal health care spending* amounts to about \$8.5 billion, more than doubling from only \$4.23 billion ten years earlier. For the past ten years, personal health care spending has been increasing at an average compound annual rate of 7 percent.

Figure 2 displays the portion of this 2007 personal health care spending that is attributable to different services. Hospital services constitute about 36 percent of the total, while physician and clinic services make up about one quarter of the total.

Figure 2

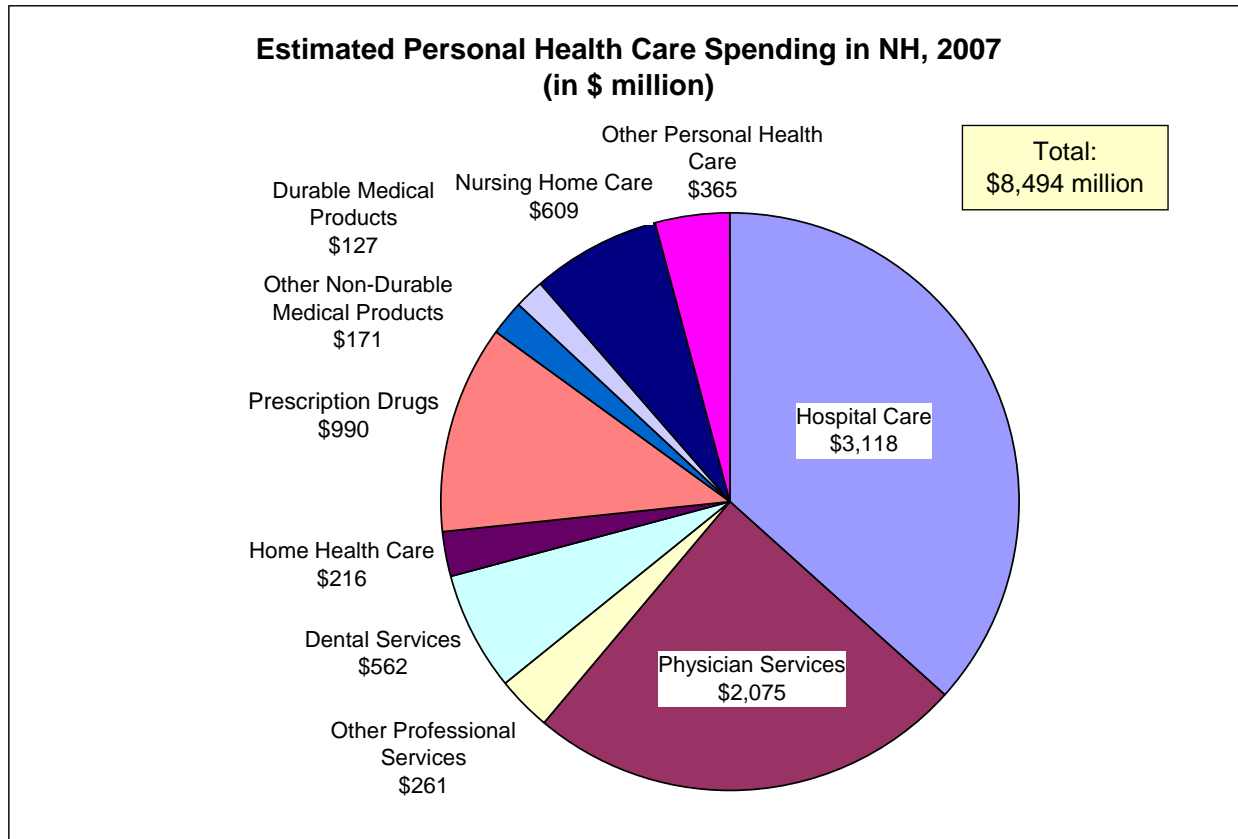


Table 1 contains the 2000, estimated 2007, and projected 2017 spending by service type.

Table 1

Personal Health Care Spending in New Hampshire (\$ in millions)					
	2000	Est. 2007	Avg Ann increase 2000-2007	2017	Avg Ann increase 2007-2017
Hospital Care	\$1,748	\$3,118	8.6%	\$6,022	6.8%
Physician Services	\$1,405	\$2,075	5.7%	\$3,685	5.9%
Other Professional Services	\$177	\$261	5.7%	\$445	5.5%
Dental Services	\$280	\$562	10.5%	\$985	5.8%
Home Health Care	\$149	\$216	5.4%	\$446	7.5%
Prescription Drugs	\$499	\$990	10.3%	\$2,207	8.3%
Non-Durable Medical Products	\$144	\$171	2.5%	\$248	3.8%
Durable Medical Products	\$94	\$127	4.4%	\$190	4.1%
Nursing Home Care	\$431	\$609	5.1%	\$1,022	5.3%
Other Personal Health Care	\$226	\$365	7.1%	\$960	10.2%
Total	\$5,153	\$8,494	7.4%	\$16,210	6.7%

Spending in New Hampshire hospitals increased by \$1.4 billion from 2000 to 2007, and was responsible for most (41 percent) of the \$3.3 billion increase in total spending from 2000 to 2007. Spending in hospitals is expected to double in the next ten years. The second largest contributor to spending was physician services, accounting for 20 percent of the increase between 2000 and 2007.

Spending on prescription drugs increased by 10 percent per year between 2000 and 2007 and we project it to increase by another 8 percent per year in the next ten years. This has been one of the most rapidly growing components of health care spending.

Projected spending in the year 2017 is \$16.2 billion, an increase of \$8.2 billion over 2007. This represents a projected future annual increase from 2007 of about 7 percent per year.

Personal health care spending per capita has increased from \$4,170 in 2000 to \$6,456 in 2007 and we project it to be about \$11,043 in 2017.

How Do We Pay for Health Care?²

The Growing Role for Public Payers

The spending on personal health care comes from various sources. Some health care is purchased directly by consumers with their own resources. Other services are purchased by commercial insurance carriers on behalf of insured individuals and those costs are passed on in premiums to the purchasers of insurance, both employers and individuals. Yet other costs are paid by public programs such as Medicare, Medicaid, and the Veterans Administration.

As shown in Figure 3, 54 percent of the money to pay for personal health care in 2007 comes from private sources (primarily out-of-pocket and health insurance). Slightly less than half comes from public, tax supported sources (primarily Medicare and Medicaid). A similar distribution is also true in New Hampshire, although exact figures are not available.

Some claims paid by health insurance are, in fact, derived from public tax sources. The health insurance premiums of public employees, including school teachers, firefighters, police, state employees, and federal employees, are paid primarily by public funds. Payments for their personal health services by their insurance carriers are here categorized as a private source rather than a public source. When that is taken into consideration, it is fair to conclude that about half of all personal health care costs are actually paid for by public taxation.

² Data in this section are taken from various tables of the Insurance Component of the Medical Expenditure Panel Survey (MEPS) of the Agency for Health Care Research and Quality, U.S. Department of Health and Human Services. The tables may be obtained from http://www.meps.ahrq.gov/Data_Pub/IC_Tables.htm.

Figure 3

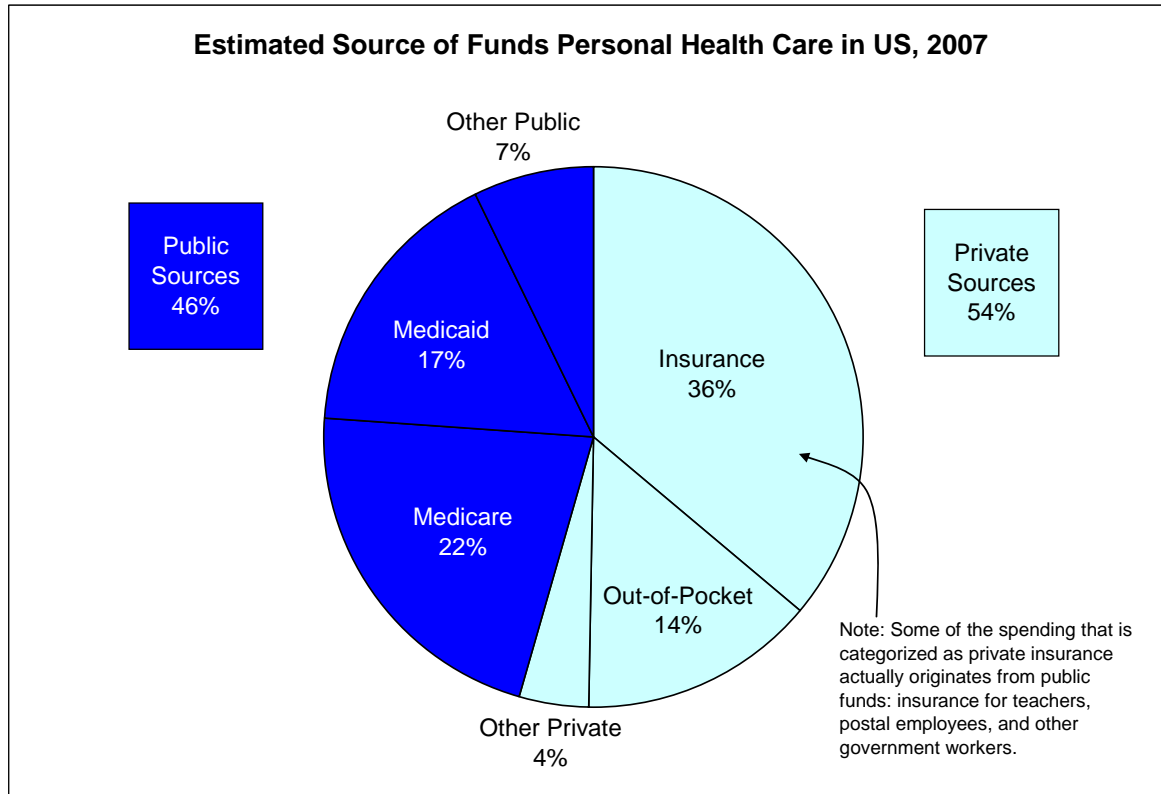
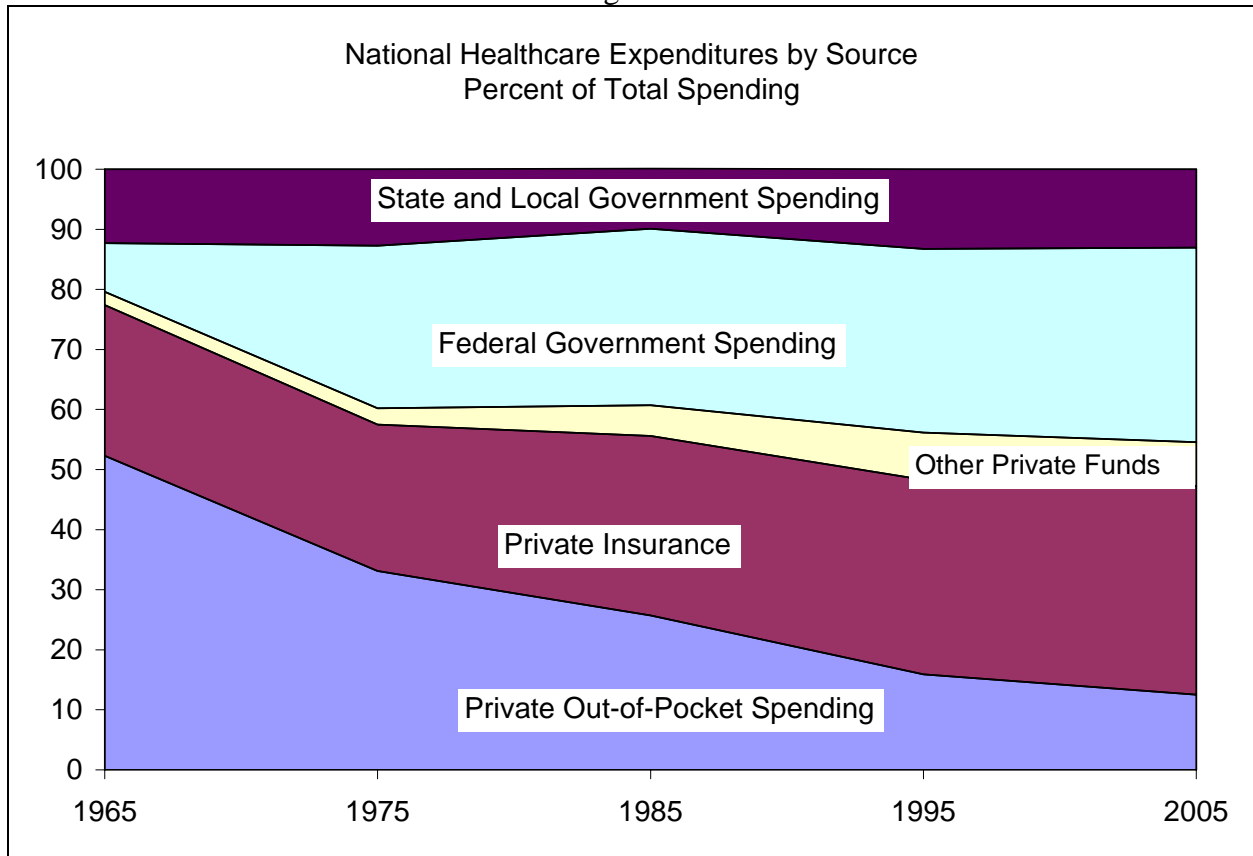


Figure 4 shows the trend in National Health Care Expenditures over time and for selected years. In 1965 a little more than half of US health care expenditures were paid for by private citizens out of their own pockets. Private insurance covered about one quarter of health care expenditures in that year. The state and local governments accounted for a little more than ten percent of US health care expenditures, while the federal government was responsible for less than ten percent of health care expenditures.

By the year 2005 the responsibility for payment of health care expenditures had shifted. The most significant change resulted from the Medicare and Medicaid federal programs that were signed into law on July 30, 1965. By 2005 less than 13 percent of health care expenditures were covered by private out-of-pocket spending. One third of health care expenditures were covered by private insurance, while another third was the responsibility of the federal government. Interestingly, the state and local share of US health care expenditures has not changed much in the last forty years.

Figure 4

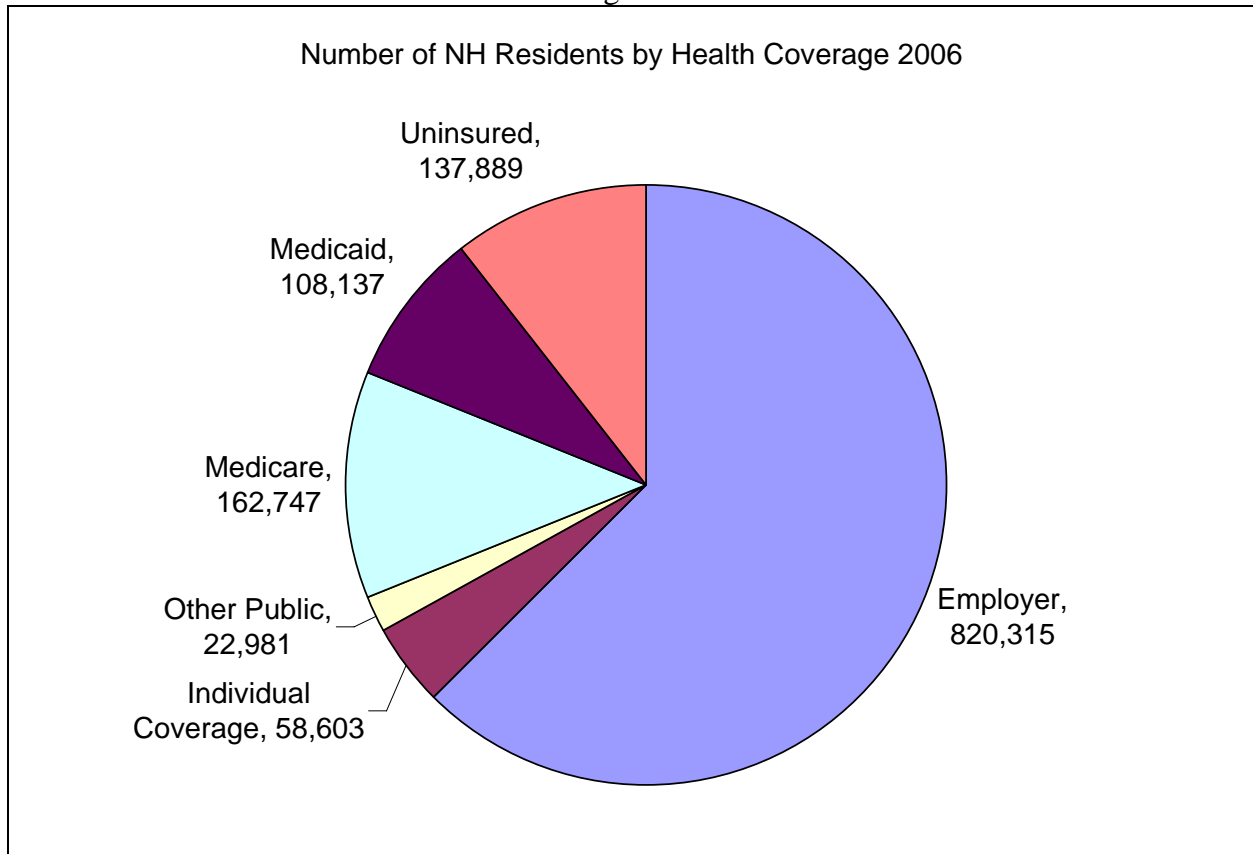


Employer Sponsored Health Insurance

Even with the increasing importance of public payers in the health care system, the majority of New Hampshire residents obtain health insurance through the employer of one of their immediate family. Figure 5 shows that 820,000 of New Hampshire 1.3 million residents are covered by employer sponsored health insurance. This estimate includes employees as well as members of their immediate families. The status of employer sponsored health insurance is therefore critically important in understanding the operation of the state’s health care system. Opinion polls show that health insurance is among the issues of greatest concern to the public in terms of both cost and access.

In many respects the current situation in New Hampshire mirrors the national situation. However, there are important differences as well.

Figure 5



Employers Provided Health Insurance to 271,000 Employees

In 2006, of the estimated 562,000 private sector employees of New Hampshire employers, the employers provided health insurance to approximately 271,000 employees. There were multiple reasons why 291,000 employees were not covered by an employer-sponsored health insurance plan: (1) their employer did not offer any insurance at all; (2) they did not meet the eligibility criteria of their employer's plan (usually period of service or hours worked); (3) although eligible, they chose not to enroll (usually because they had insurance through a spouse, parent, or Medicare).

Of those who obtained health insurance from their employer, some obtained single coverage, some obtained 2-person coverage, and others obtained full family coverage.

Figure 6 shows both the percent of New Hampshire employees who obtained each type of health insurance as well as the reasons the remaining employees did not obtain such insurance. Figure 7 displays the same information for the nation as whole. Nationally, 53 percent of all workers were enrolled in their employer's health insurance plan while in New Hampshire it was 48 percent. The 2006 Medical Expenditure Panel Survey (MEPS) indicates that a greater percentage of workers in New Hampshire are ineligible for their employer's health insurance benefit than is the case nationally.

Figure 6

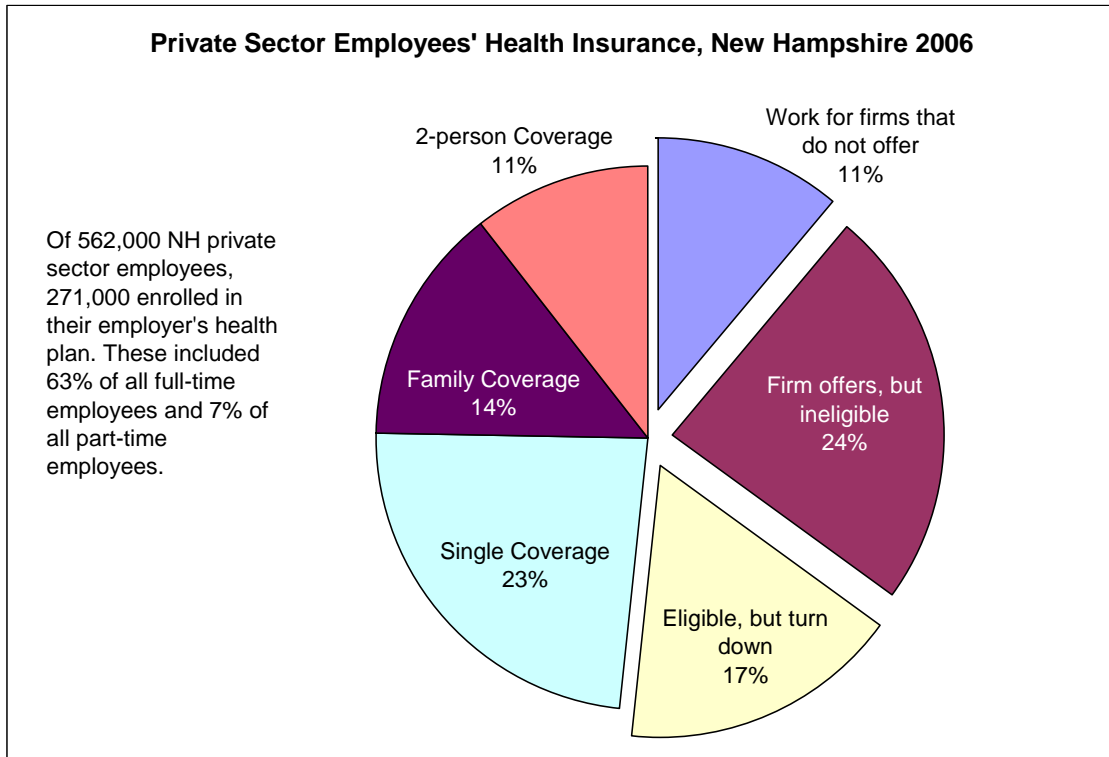
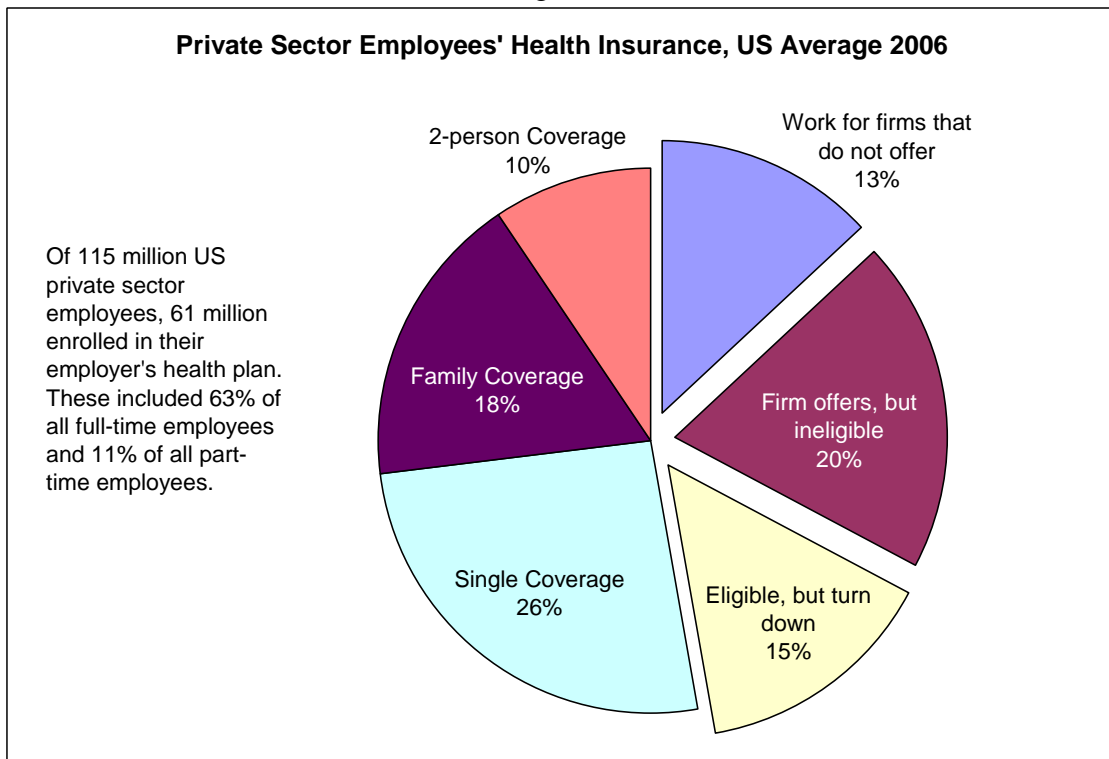


Figure 7



Full-time and Part-time Employment

Whether an individual is employed full-time or part-time is very strongly related to the probability that he or she will be enrolled in an employer-sponsored health insurance plan. In New Hampshire in 2006, 63 percent of full time employees were enrolled in an employer-sponsored health plan. Among part-time employees, about 7 percent were so enrolled. The difference between full-time and part-time employment can be seen in Figures 8 and 9. A similar pattern exists nationally.

Figure 8

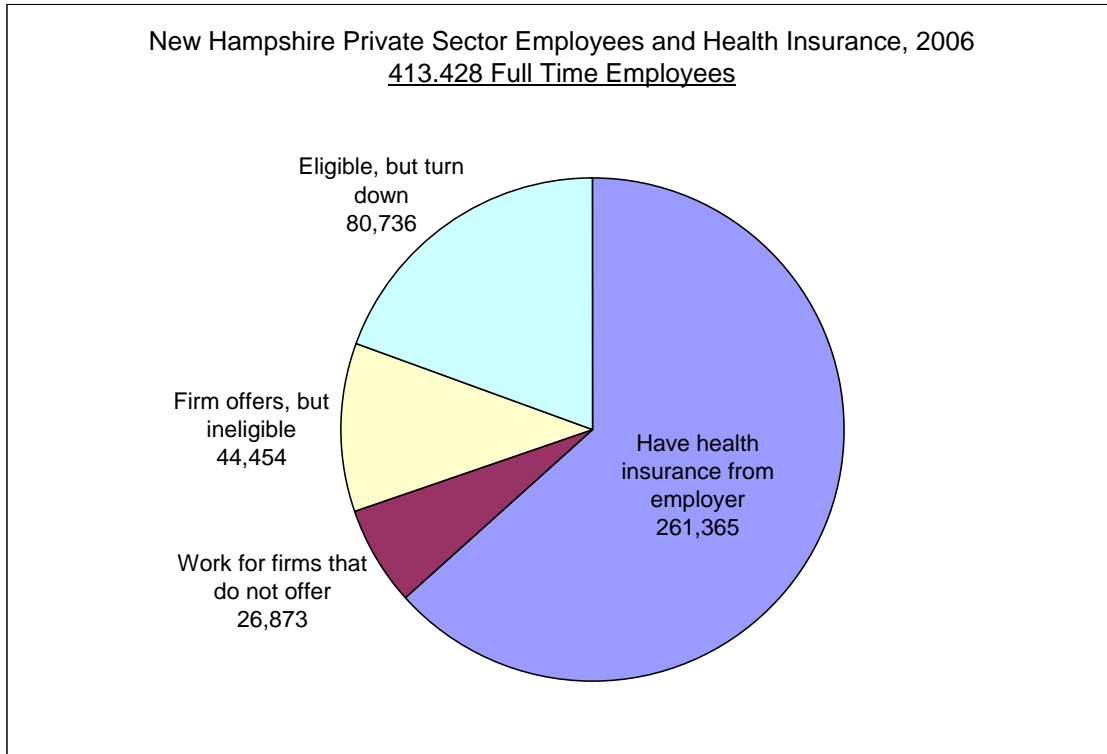
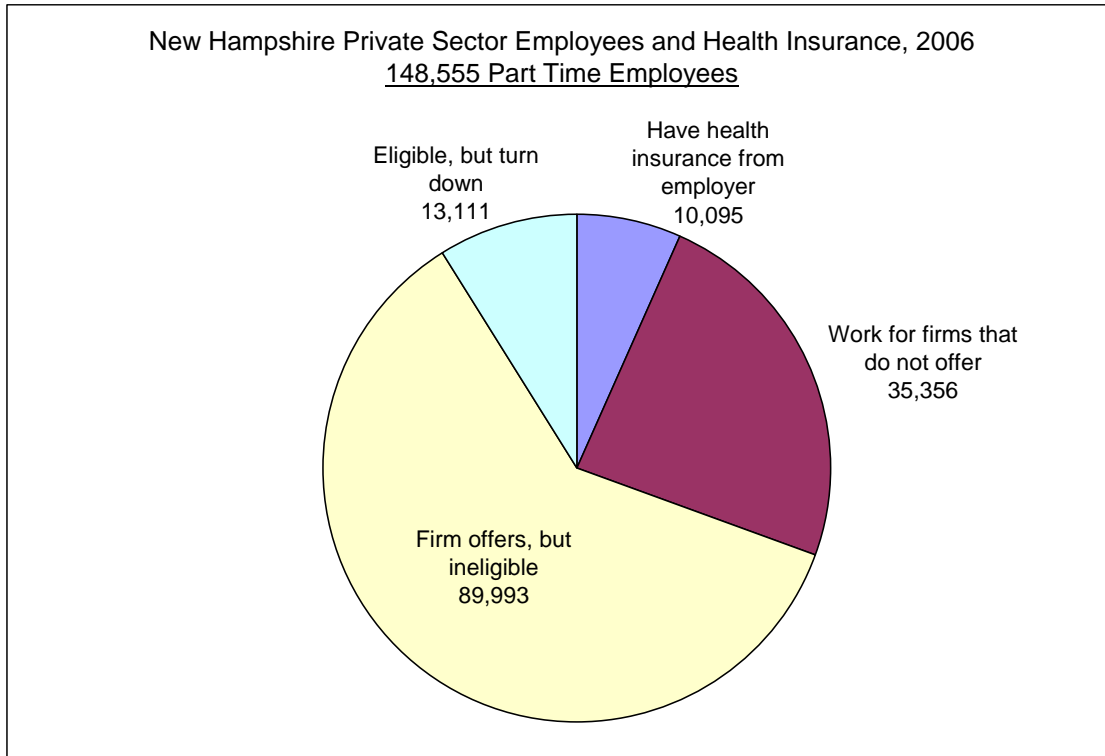


Figure 9



Annual Health Insurance Premiums

The average annual premium borne by employers and employees for single coverage is considerably less than that for employees who are covered by a family plan. The premium for 2-person coverage is typically about double that of single coverage.

In 2006, the average annual premium for single person coverage in New Hampshire was \$4,622 and was 13 percent higher than the national average. The average premium for family coverage in New Hampshire was over \$12,686, about 11 percent more than the national average. The premium for 2-person coverage in New Hampshire, about \$8,817, was 10 percent more than the national average.

Table 2

Average Annual Health Insurance Premium						
	New Hampshire			United States		
	2000	2006	Annual increase	2000	2006	Annual increase
1-Person coverage	\$2,790	\$4,622	8.77%	\$2,655	\$4,118	7.59%
Family coverage	\$7,525	\$12,686	9.09%	\$6,772	\$11,381	9.04%
2-person coverage	n/a	\$8,817	-	n/a	\$7,988	-

As shown in Table 2, the compound average rate of increase in premiums for single coverage and family coverage in New Hampshire for the past six years (2000-2006) has been just about 10 percent per year.

Some caution must be used in interpreting these data and other similar data from the MEPS survey. Because they are derived from a survey of only a sample of employers, there is an inherent sampling error that must be taken into consideration. Small differences may be nothing more than the effect of the specific employer sample. To account for this, we have calculated 95 percent confidence intervals for each annual premium. The confidence intervals for the national averages are very small because the national sample is quite large. For the state of New Hampshire, however, the confidence intervals are considerably larger.

Figures 10, 11, and 12 show average annual premiums for 1-person, family, and 2-person coverage in New Hampshire and nationally for recent years. After taking into account the 95 percent confidence intervals, New Hampshire rates for 1-person coverage are close to the national average while rates for family and 2-person plans are clearly above the comparable national averages.

Figure 10

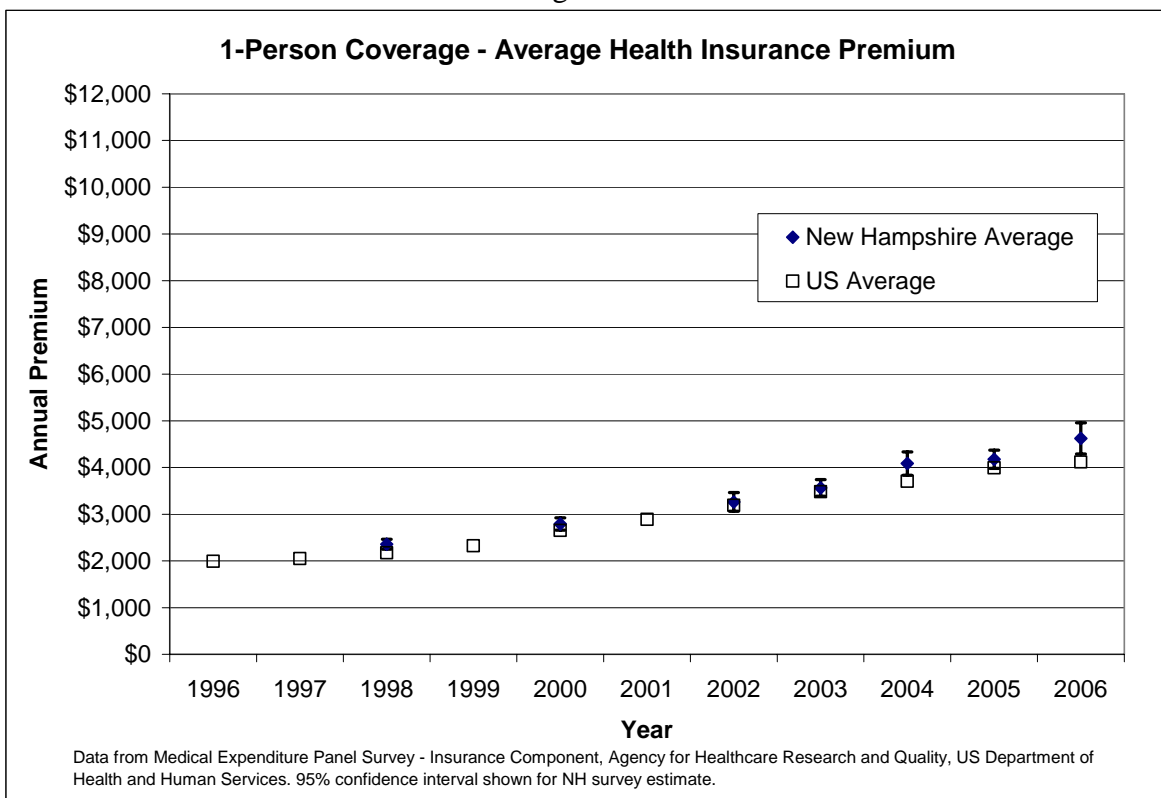


Figure 11

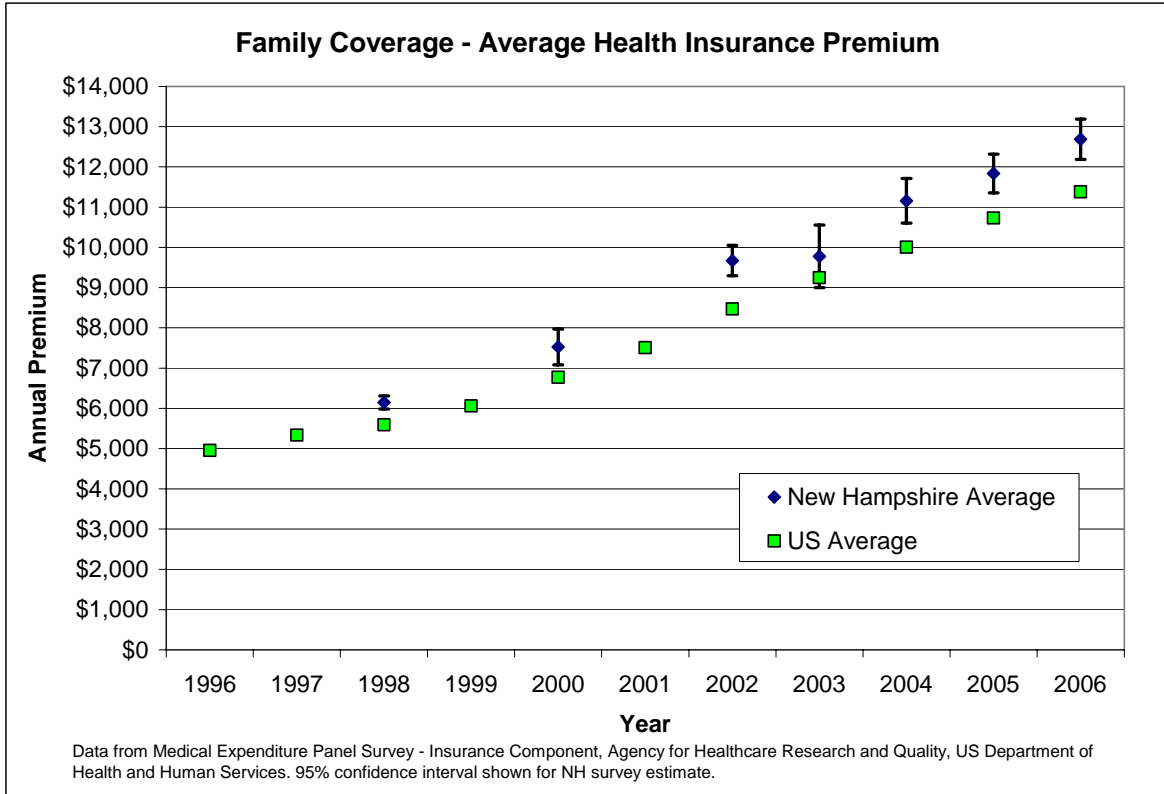


Figure 12

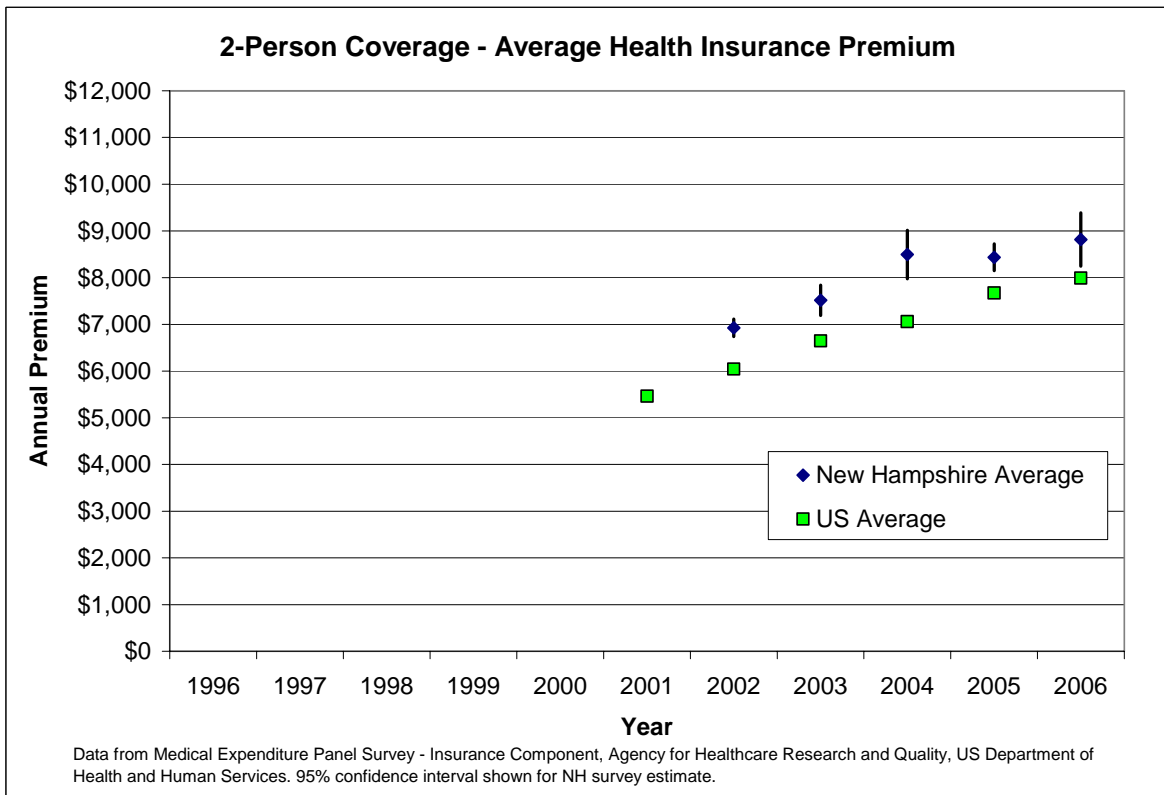


Table 3 shows that overall health care costs in New Hampshire, on a per capita basis, are very close to the national average. It is possible that the average benefits of insurance coverage in New Hampshire are greater than the national average (lower average deductibles or co-payments, for example) or some other differences in policy types could account for the higher average premiums in our state. An examination of the MEPS data for the most recent years available showed that average deductibles in New Hampshire were 15 percent below the national average, average co-payments were about 10 percent below the national average, and that coinsurance payments were about the same as the national average.

Table 3

Per Capita Spending on Personal Health Care, 2004, Source: statehealthfacts.org		
	NH	US
Hospital Care	\$1,941	\$1,931
Physician & Clinical Services	\$1,354	\$1,341
Other Professional Services	\$176	\$179
Drugs and Other Medical Nondurables	\$741	\$757
Nursing Home Care	\$422	\$392
Dental Services	\$363	\$277
Home Health Care	\$130	\$145
Medical Durables	\$90	\$79
Other Personal Health Care	\$215	\$181
Total	\$5,432	\$5,282

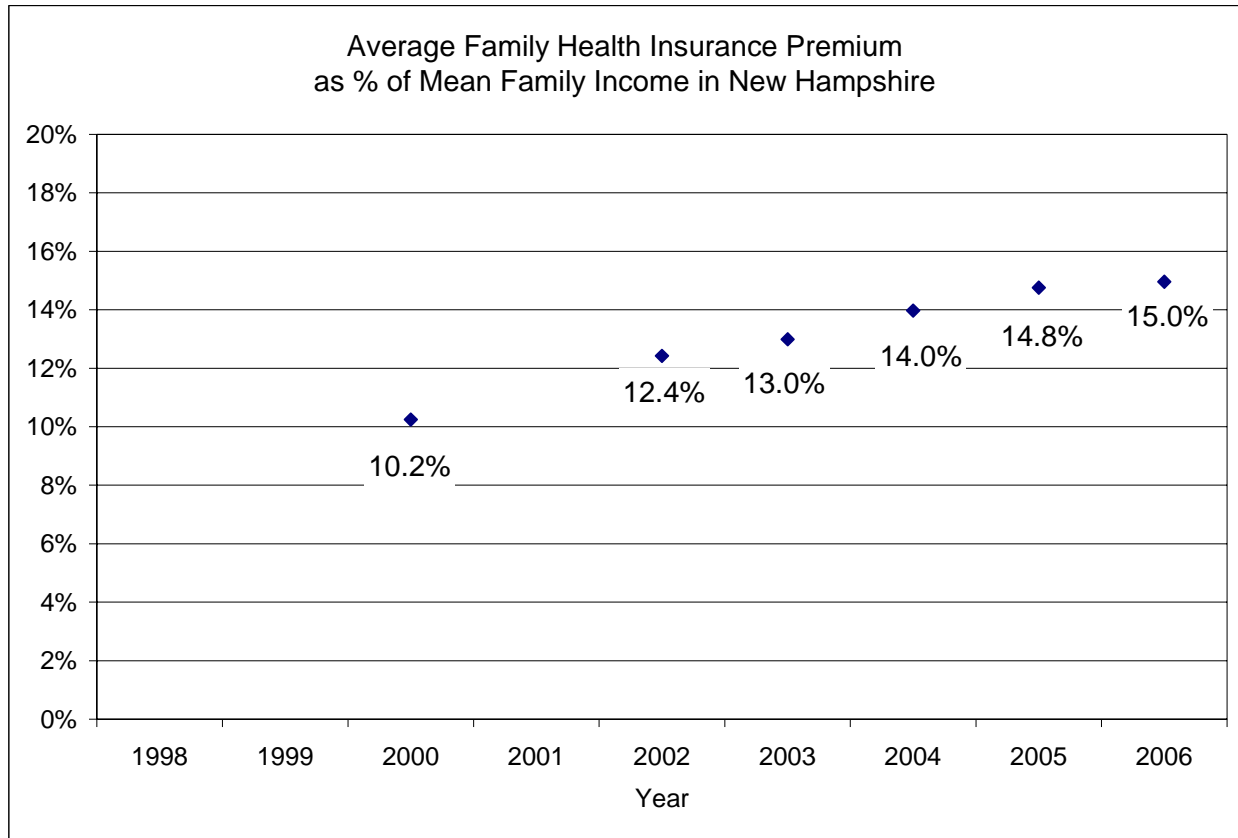
The average premium of a family health insurance policy can be compared to the state's mean family income to ascertain, on average, what percent of income would have to be paid to purchase such a policy. Both sets of data are available for some recent years.³ Family income has not been keeping up with increases in health insurance costs. As shown in Table 4 and Figure 13, the cost of a family policy in New Hampshire has grown from 10.2 percent of mean family income in 2000 to 15 percent in 2006.

Table 4

New Hampshire Annual Health Insurance Premium for Family Coverage as Percent of Mean Family Income								
	1998	2000	2001	2002	2003	2004	2005	2006
Family Coverage Premium	\$6,146	\$7,525		\$9,672	\$9,776	\$11,156	\$11,835	\$12,686
Mean Family Income		\$73,465	\$72,655	\$77,874	\$75,229	\$79,840	\$80,187	\$84,795
% of Family Income		10.2%		12.4%	13.0%	14.0%	14.8%	15.0%

³ Mean family income from the American Community Survey, US Bureau of the Census, <http://www.census.gov/acs/www/Products/index.htm>, June 17, 2008

Figure 13



Employee Share of Premiums

With very few exceptions, most employers require that their employees pay some portion of the premiums for health insurance. There are many different ways by which employers structure these co-premium payments. For example, some require a higher co-premium for family coverage than those covering only the employee.

Table 5

Average Annual Employee Contribution to Health Insurance						
	New Hampshire			United States		
	2000	2006	Annual increase	2000	2006	Annual increase
Single coverage	\$470	\$1,004	13.50%	\$450	\$788	9.80%
Family coverage	\$1,752	\$3,318	11.23%	\$1,614	\$2,890	10.20%
2-person coverage	n/a	\$2,913	-	n/a	\$1,903	-

As shown in Table 5, the average employee contribution to health insurance is higher in New Hampshire than nationally and has been growing at a faster rate as well. Also, as shown in Table 6, for both single and family coverage New Hampshire employers require their employees to pay a slightly larger portion of the insurance premiums than do employers nationally.

Table 6

Average Annual Employee Contribution to Health Insurance as % of Premium (2006)		
	New Hampshire	US
Single coverage	22%	19%
Family coverage	26%	25%
2-person coverage	33%	24%

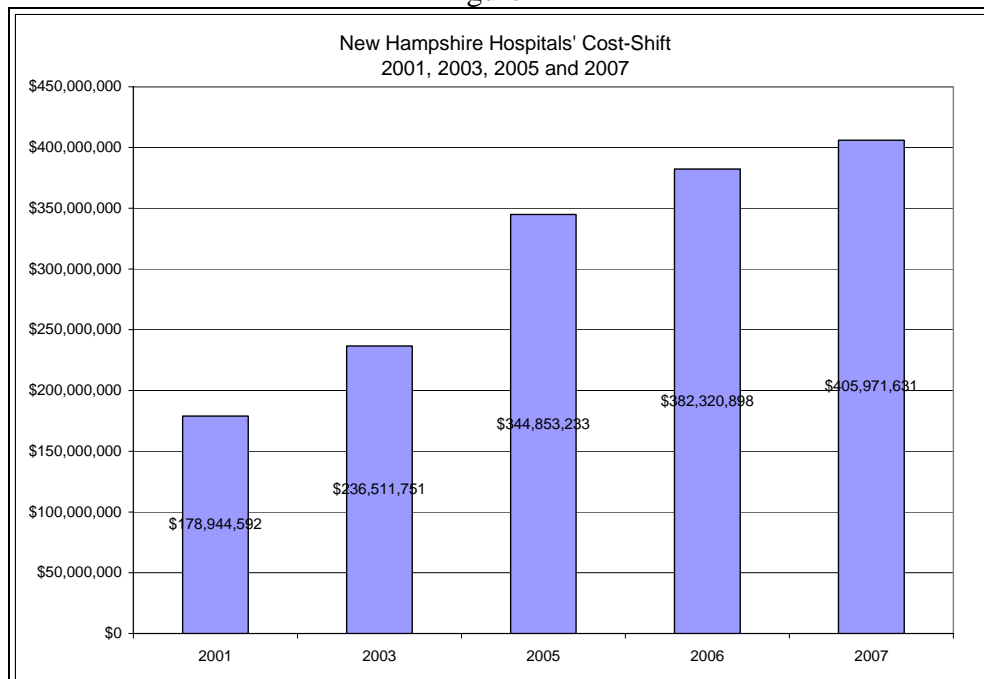
Cost Shifting and Operating Margins

The increase in health insurance premiums is due not only to rising health care costs, but also due to increases in the level of cost-shifting by healthcare providers and increasing operating margins for both health care providers and state insurance companies.

Healthcare providers seek to recover revenue when payment received for services from any payer is inadequate to cover costs. In November 2004 the Center published “A Framework for Thinking About Cost-Shifting in Health Care.” That report describes the concept of cost-shifting, which occurs when government payers (Medicare and Medicaid) and charity populations do not pay the full cost of service. Health care providers then shift those costs on to private payers, specifically those populations covered under employer sponsored health insurance.

The cost-shifting phenomenon has grown considerably since the Center began conducting its work on cost-shifting in 2001. Our analysis of the 2001 finances of 26 New Hampshire hospitals showed that the hospitals had to shift approximately \$179 million to meet operating costs. By 2007, the magnitude of the cost shift had grown considerably. The amount cost-shifted by New Hampshire hospitals grew by approximately 15% per year to \$406 million in 2007. Figure 14 shows these changes graphically.

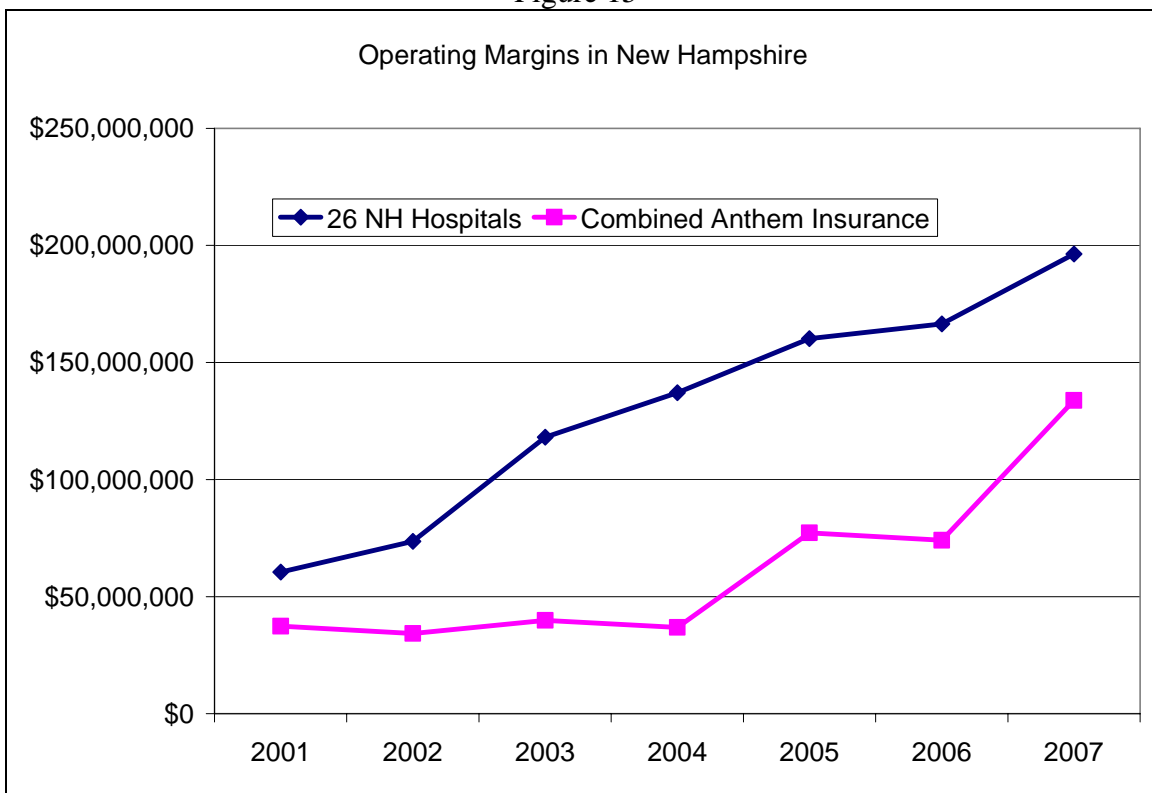
Figure 14



In addition, operating margins for both hospitals and insurance companies doing business in New Hampshire have grown. In 2001, the hospital industry experienced net operating income of \$60 million. Between 2001 and 2007, net operating income grew by 225% or an average of 22% per year. Similar increases have been seen in the insurance market. In 2001 Anthem – which includes Anthem Health Plans of New Hampshire, Inc., and Matthew Thornton Health Plan, Inc. – had a net operating income of \$37 million. By 2007 Anthem’s net operating margin increased to \$134 million, an average increase of 24% per year.

Figure 15 below illustrates the operating margins for Anthem and for New Hampshire’s 26 operating hospitals for the period 2001 to 2007. The largest single year increase in Anthem net income occurred from 2006 to 2007, when net income increased from \$74 million in 2006 to \$134 million in 2007. Examination of Anthem Health Plans of New Hampshire, Inc. financial statements shows a \$70 million investment gain in that year. In late 2007 Anthem was also awarded the New Hampshire State Employee Account that will add about 39,000 self-funded members to the Anthem insurance rolls in 2008.

Figure 15⁴



⁴ The source for the data used in Figures 14 and 15 are the New Hampshire Hospital Association and the National Association of Insurance Commissioners (<http://www.naic.org/cis/>)

Economics of Health Care⁵

Hospital Economics

As shown in Table 1 New Hampshire hospitals are the largest recipients of personal health care spending in New Hampshire, amounting to over \$3 billion in 2007. Spending on New Hampshire hospital care alone increased by over \$1 billion from 2000 to 2007. Hospitals have also been a significant source of growth for the New Hampshire economy. Employment in New Hampshire hospitals rose by twenty-five percent in the same period, from 22,000 jobs in hospitals in 2002 to 27,000 jobs in 2007.

Increasingly, health care is garnering a larger share of local economic activity. One measure of this development is shown in the number of jobs in New Hampshire hospitals. Within most labor market areas in New Hampshire, hospitals are one of the largest employers in the local labor market area. Concord Hospital, with 2,960 employees, is the largest employer in the City of Concord. Dartmouth Hitchcock Medical Center/Hitchcock Clinic, with about 5,816 employees, is the largest employer in Lebanon. Even in Manchester, Elliott Hospital with 2,821 employees and Catholic Medical Center with 1,700 employees rank first and second respectively among the employers in New Hampshire's largest city. Southern NH Medical Center and St. Joseph Hospital & Trauma Center, each with more than 1,000 employees, rank as the third and fourth largest employers in New Hampshire's second largest city, Nashua.

Hospital Infrastructure Expansion

A recent study from the Department of Employment Security used an economic multiplier model to estimate the impact of hospital expansion projects on the New Hampshire economy. The study evaluated hospital construction projects for medical facilities planning to expand or invest capital funds toward improvements submitted in the certificate of need (CON) applications to the State from 2004 to 2006. The study concluded that the \$200 million in hospital expansion projects in that period would have a total economic impact (including multiplier impacts) on the state of 15,600 additional jobs and almost \$1 billion in economic growth by the year 2015.⁶

More recent data on CON applications shows acceleration in construction projects undertaken by New Hampshire's hospitals. Since the year 2000 New Hampshire hospitals have undertaken more than one billion dollars in planned construction projects. Projects approved in 2007 and through May in 2008 are double the dollar value of all of the hospital projects approved in the 2004 to 2006 period examined in the above referenced study.

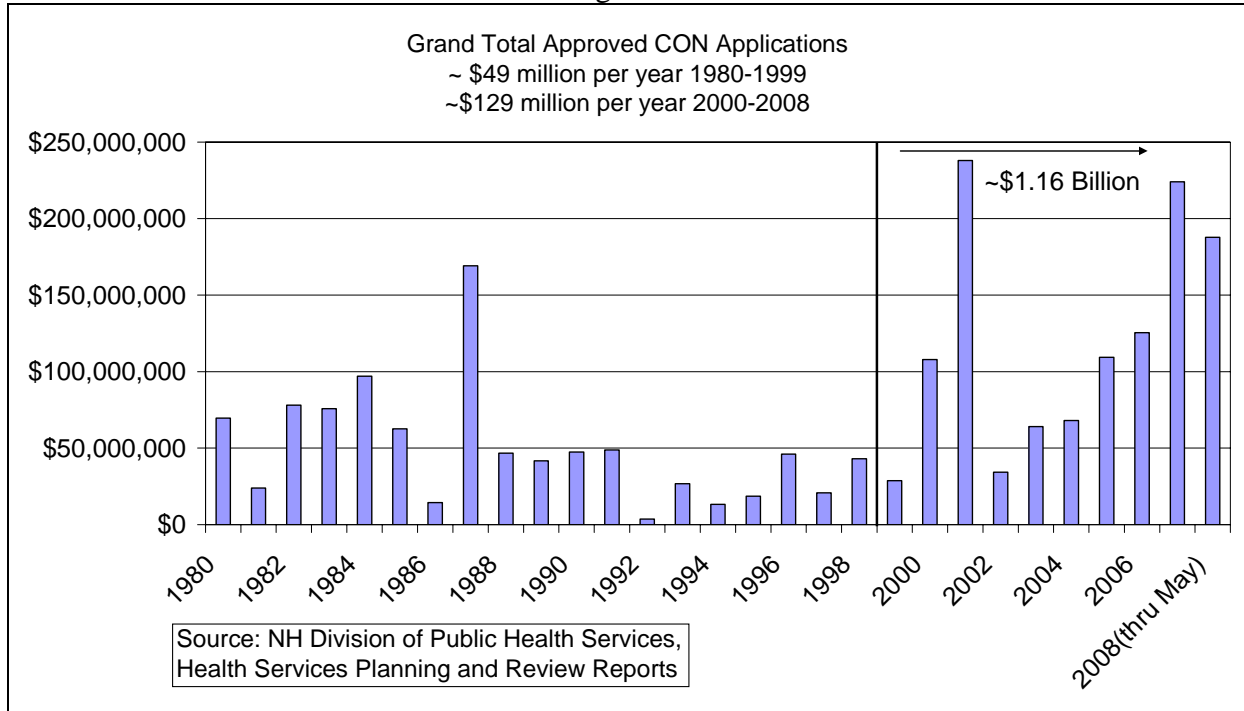
In the 1980's and 1990's New Hampshire hospitals announced construction projects averaging about \$49 million per year in expansions. In the current decade, the average annual expansion among all New Hampshire hospitals is almost triple that amount, at \$129 million per year (Figure 16). This implies much larger increases in jobs and greater economic impact than accounted for in the Department of Employment Security study. In addition, accelerated hospital expansions and construction projects in this decade represent significant financial commitments

⁵ Data in this section are taken from various sources, including the Department of Health and Human Services Planning and Review Board, and the New Hampshire Department of Employment Security.

⁶ *Hospital Construction Projects in New Hampshire*, Anita Josten, New Hampshire Department of Employment Security, January 2007.

that will have to be recovered by hospitals through charges and fees to their patients. Because of these construction projects, New Hampshire hospital costs will likely continue to escalate in the future.

Figure 16



Health Care and Social Assistance Jobs⁷

Health Care and Social Assistance industries are defined by the North American Industrial Classification System (NAICS). The Health Care and Social Assistance sector comprises establishments providing health care and social assistance for individuals. The sector includes both health care and social assistance because it is sometimes difficult to distinguish between the boundaries of these two activities. The industries in this sector are arranged on a continuum starting with those establishments providing medical care exclusively, continuing with those providing health care and social assistance, and finally finishing with those providing only social assistance. The services provided by establishments in this sector are delivered by trained professionals. All industries in the sector share this commonality of process, namely, labor inputs of health practitioners or social workers with the requisite expertise. Many of the industries in the sector are defined based on the educational degree held by the practitioners included in the industry. Table 7 shows the major industry categories in this sector.

⁷ Data in this part of the report is taken from the New Hampshire Department of Employment Security.

Table 7

NAICS Sector 62 - Health Care and Social Assistance consists of:
<u>NAICS 621000 - Ambulatory Health Care Services</u>
NAICS 621100 - Offices of Physicians
NAICS 621200 - Offices of Dentists
NAICS 621300 - Offices of Other Health Practitioners
NAICS 621400 - Outpatient Care Centers
NAICS 621500 - Medical and Diagnostic Laboratories
NAICS 621600 - Home Health Care Services
NAICS 621900 - Other Ambulatory Health Care Services
<u>NAICS 622000 - Hospitals</u>
NAICS 622100 - General Medical and Surgical Hospitals
NAICS 622200 - Psychiatric and Substance Abuse Hospitals
NAICS 622300 - Specialty (except Psychiatric and Substance Abuse) Hospitals
NAICS 623000 - Nursing and Residential Care Facilities
<u>NAICS 623100 - Nursing Care Facilities</u>
NAICS 623200 - Residential Mental Retardation, Mental Health and Substance Abuse Facilities
NAICS 623300 - Community Care Facilities for the Elderly
NAICS 623900 - Other Residential Care Facilities
<u>NAICS 624000 - Social Assistance</u>
NAICS 624100 - Individual and Family Services
NAICS 624200 - Community Food and Housing, and Emergency and Other Relief Services
NAICS 624300 - Vocational Rehabilitation Services
NAICS 624400 - Child Day Care Services

Health Care and Social Assistance Concentration

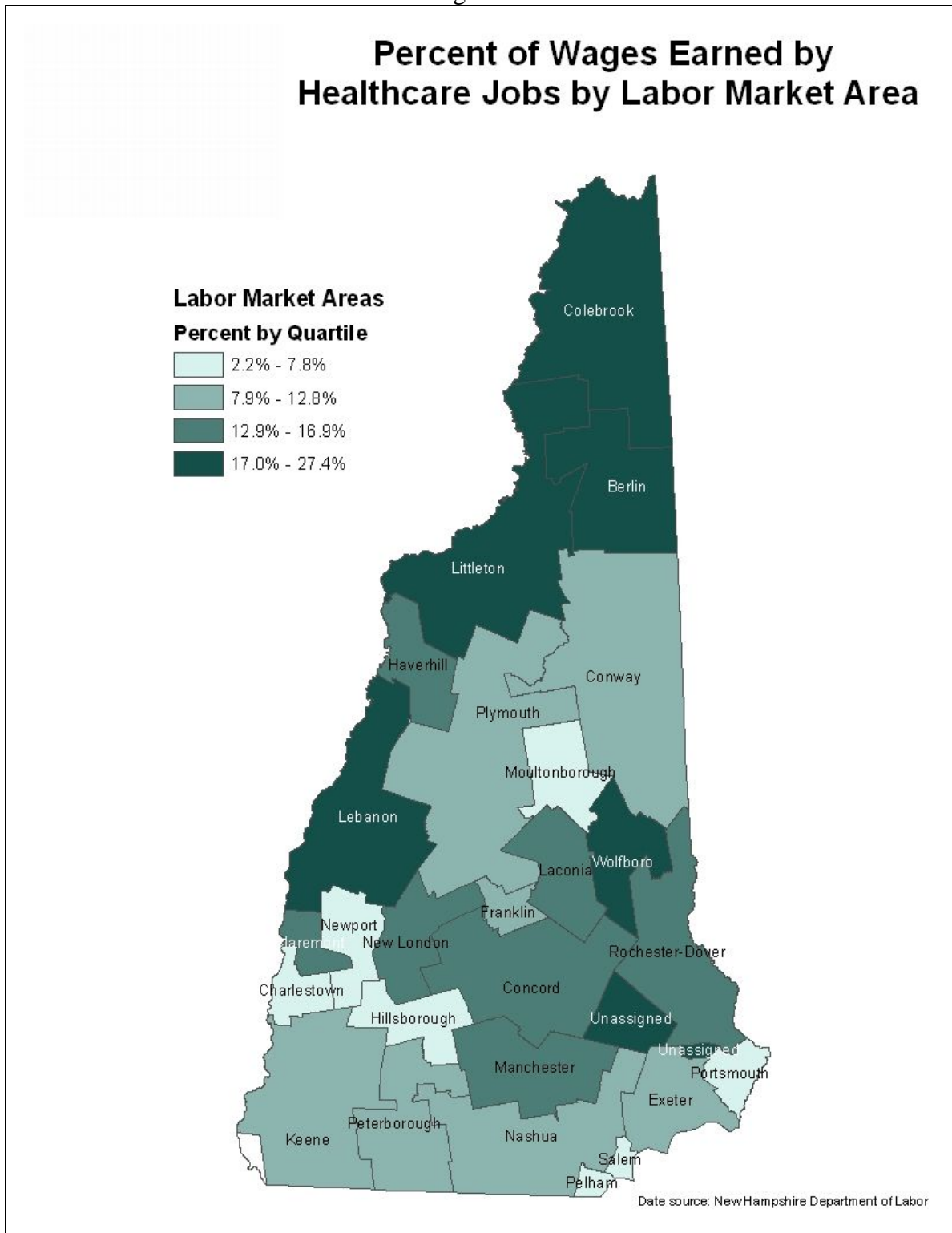
It is perhaps surprising that some of the labor markets with the greatest reliance on health care and social assistance related employment and wages are in New Hampshire's northern rural areas. Table 8 and the map of New Hampshire's labor market areas in Figure 17 show the concentration of health care and social assistance industry wages as a percent of all wages paid in each labor market area of New Hampshire in the year 2006. Health care and social assistance accounts for 27 percent of all private and government wages paid in the Lebanon, NH-VT labor market area, probably due to the dominance of Dartmouth- Hitchcock Medical Center in that area. But the health care industry accounts for more than 17 percent of the salaries paid in the Colebrook, Wolfeboro, Littleton and Berlin labor market areas, well above the state average of 12 percent. Clearly health care and social assistance has become an important part of the economic fabric of rural New Hampshire.

Table 8

New Hampshire Health Care and Social Assistance as a Percent of Total		
Labor Market Area	Employment	Total Wages
Lebanon, NH-VT MicroNECTA, NH Portion	23.6%	27.5%
Colebrook, NH-VT LMA, NH Portion	17.1%	20.5%
Wolfeboro, NH LMA	17.3%	18.1%
Littleton, NH-VT LMA, NH Portion	14.2%	17.5%
Berlin, NH MicroNECTA	15.9%	17.3%
Claremont, NH - MicroNECTA	16.0%	16.9%
Concord, NH - Micro-NECTA	15.5%	15.8%
New London, NH LMA	13.1%	15.2%
Laconia, NH - MicroNECTA	14.4%	15.0%
Haverhill, NH LMA	11.2%	14.5%
Rochester-Dover, NH-ME MetroNECTA, NH Portion	11.9%	13.4%
Manchester, NH MetroNECTA	13.2%	13.0%
Exeter, NH area, NH Portion, Haverhill-North Andover-Amesbury MA-NH NECTA Div	12.3%	12.8%
Conway, NH-ME LMA, NH Portion	11.1%	12.7%
Peterborough, NH LMA	13.1%	12.2%
Keene, NH - MicroNECTA	12.2%	11.3%
Franklin, NH MicroNECTA	10.7%	11.0%
Plymouth, NH LMA	8.7%	10.6%
Unassigned Town, Newmarket, NH	11.6%	9.0%
Nashua, NH-MA NECTA Div, NH Portion	10.3%	8.3%
Portsmouth, NH-ME MetroNECTA, NH Portion	10.1%	7.8%
Newport, NH LMA	8.7%	6.2%
Salem Town, NH Portion, Lawrence-Methuen-Salem, MA-NH NECTA Div	6.6%	5.8%
Hillsborough, NH LMA	7.6%	5.8%
Unassigned Town, Deerfield, NH	8.1%	5.0%
Charlestown, NH LMA	4.8%	3.6%
Unassigned Town, Northwood, NH	3.8%	2.7%
Pelham, Town, NH Portion, Lowell-Billerica-Chelmsford MA-NH NECTA Div	4.4%	2.6%
Moultonborough, NH LMA	2.5%	2.5%
Unassigned LMA	3.5%	1.6%
Hinsdale Town, NH Portion, Brattleboro, VT-NH LMA	0.0%	0.0%
Unassigned Town, Nottingham, NH	0.0%	0.0%
State of New Hampshire - Average Annual 2006	12.3%	11.8%

In the table above Labor Market Areas (LMA) are shown as published by the New Hampshire Department of Employment Security. A New England City and Town Area or NECTA is a geographic and statistical entity defined by the U. S. Office of Management and Budget for use in describing aspects of the New England region of the United States. A NECTA is a region associated with a core urban area with a population of at least 10,000, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting and employment.

Figure 17



Health Care and Social Assistance Employment Growth

The labor market areas in the previous section were defined in 2004, so the historical record of changes in employment by labor market area is relatively short. However, annual employment data as defined by the NAICS is available from the year 1990 forward. Table 9 shows the annual percent change in jobs by New Hampshire counties over the historical period 1990 to 2006.

Coos County, New Hampshire's northernmost and most rural county, is distinguished by little change in total employment in the historical period, but a significant increase in Health Care and Social Assistance (shown as NAICS 62) jobs⁸. Manufacturing and forest based jobs have been shrinking in Coos County, and those occupations have been replaced by jobs in health care and social assistance.

Table 9

Annual Percent Change in Jobs 1990-2006		
New Hampshire	NAICS 62	All sectors
Belknap County	2.4%	1.7%
Carroll County	2.5%	1.8%
Cheshire County	1.2%	1.2%
Coos County	2.7%	0.0%
Grafton County	3.5%	1.6%
Hillsborough County	2.7%	1.2%
Merrimack County	3.9%	1.9%
Rockingham County	3.5%	2.4%
Strafford County	3.9%	1.1%
Sullivan County	1.2%	0.1%

Table 10 displays the average weekly wage for the years 1990 and 2006 for health care and social assistance (NAICS 62) jobs and total jobs, and shows the average annual growth in that time period.

Table 10

Average Weekly Wages 1990 to 2006						
	NAICS 62		All sectors		Average Annual Change 1990 to 2006	
	1990	2006	1990	2006	NAICS 62	All sectors
New Hampshire						
Belknap County	\$394.01	\$742.99	\$370.42	\$657.93	4.0%	3.7%
Carroll County	\$291.10	\$635.97	\$306.88	\$575.59	5.0%	4.0%
Cheshire County	\$374.76	\$674.94	\$400.86	\$723.95	3.7%	3.8%
Coos County	\$347.20	\$652.21	\$372.44	\$572.86	4.0%	2.7%
Grafton County	\$492.54	\$1,016.97	\$399.27	\$803.40	4.6%	4.5%
Hillsborough County	\$449.84	\$784.57	\$482.18	\$897.24	3.5%	4.0%
Merrimack County	\$404.44	\$743.67	\$424.74	\$739.28	3.9%	3.5%
Rockingham County	\$395.57	\$749.85	\$428.83	\$842.13	4.1%	4.3%
Strafford County	\$369.29	\$815.09	\$400.19	\$723.22	5.1%	3.8%
Sullivan County	\$374.15	\$599.55	\$364.14	\$642.61	3.0%	3.6%

⁸ The US Department of Agriculture, Economic Research Service ("ERS"), published in 2004 a set of county-level typology codes that captures differences in economic and social characteristics. By this definition Hillsborough, Rockingham and Strafford counties are metropolitan counties, and all other counties in New Hampshire are non-metropolitan counties. Coos and Grafton counties are considered the most rural counties in New Hampshire, according to the ERS urban influence code definition.

Although health care and social assistance wages in Coos County increased faster than the average wage for the total jobs in the county, health care and social assistance jobs in rural areas pay less than similar jobs in urban areas of New Hampshire, such as Hillsborough and Rockingham Counties.

The rise in the importance of health care and social assistance to the overall economy in rural areas is illustrated in Table 11. In New Hampshire's Coos County all of the wages paid in health care and social assistance wages have increased from 9.6 percent of total wages paid in that region in 1990, to 18.1 percent of the total wages paid in the region in the year 2006. This represents a near doubling in the importance of health care and social assistance to the overall economic activity in Coos County, the largest such increase of any county in New Hampshire.

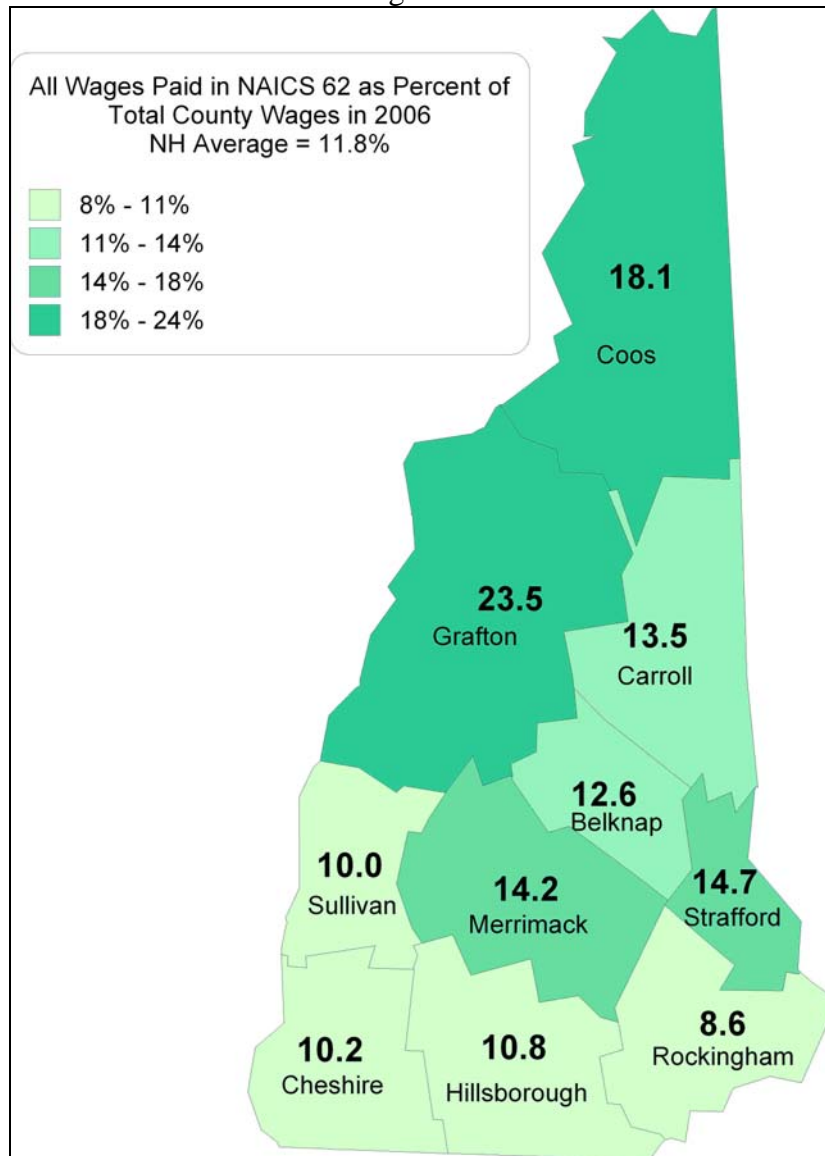
Table 11

All Wages Paid in NAICS 62 as Percent of Total County Wages, 1990 and 2006		
New Hampshire	1990	2006
Belknap County	10.8	12.6
Carroll County	10.5	13.5
Cheshire County	10.2	10.2
Coos County	9.6	18.1
Grafton County	17.2	23.5
Hillsborough County	9.0	10.8
Merrimack County	9.8	14.2
Rockingham County	7.6	8.6
Strafford County	7.8	14.7
Sullivan County	9.3	10.0

Figure 18 illustrates the data from Table 11, showing the portion of wages paid in the healthcare and social assistance as a percent of all wages paid by county in New Hampshire in the year 2006.

The most recent state employment forecast from the New Hampshire Department of Employment Security notes that health care and social assistance employment is on track to nearly match retail trade as the sector employing the most workers. At a growth rate of 30.9 percent over the ten-year projection period, employment will increase by 24,161 jobs by 2016, bringing total employment to 102,411. The health care and social assistance industry will employ one out of every nine workers in New Hampshire by the year 2016. Nationally, this industry sector is also expected to employ one out of every nine workers.

Figure 18



The Importance of Health Care in Rural Economies

The economic issues facing rural New Hampshire, and especially the North Country and Coos County, have commanded significant policy attention. In all of these discussions, the role of the health care industry is seldom mentioned. Because almost all of the difficulties facing rural regions have been in the manufacturing and forest resource industries, these industry sectors have drawn most of the attention. In addition, health care is viewed as a “local” industry, in contrast to the manufacturing and forest industries that export products to other regions and thus earn income for the rural area. When health care is part of the discussion, it is in the context of concerns over the cutback in rural social services and the ways in which residents of rural areas will receive adequate health care services.

Rural New Hampshire has become increasingly dependent on the health care and social assistance industry, as demonstrated by health care jobs and wages increasing faster in rural New Hampshire than for total employment in those areas. It is clear that manufacturing and forest resource industries in rural New Hampshire are being replaced by a reliance on the health care and social assistance industries, as manufacturing and forest resource based opportunities fade in importance.

Average wages paid in health care and social assistance in rural New Hampshire are significantly less than for similar jobs in the rest of New Hampshire, and less than the manufacturing wages and jobs they have replaced. The health care industry has provided jobs and income growth, but the replacement economic growth has not measured up to the jobs and wages lost.

However, there are some positive aspects to an increasing reliance on health care in rural areas. Jobs in manufacturing and forest resource industries were important to rural areas because they were tied to export based industries – that is, industries that brought dollars into the rural region. While most perceive health care and social assistance to be a ‘local’ industry, we know that almost half of health care spending is financed by public spending, in particular by reimbursement from government payers like Medicare and Medicaid. This means that health care in rural areas can be considered an “export” based industry, because health care brings in public monies (Medicare and Medicaid dollars) from outside the region.

Occupational skill levels for jobs in the health care industry are higher than average. Health care jobs require significant training, not only for health care practitioners and technical occupations, (doctors, nurses and dentists), but also for health care support occupations, (physical therapist assistants, transcriptionists and medical assistants). As such, an expansion of health care and social assistance jobs in rural areas can potentially raise the overall level of educational attainment and workforce training in rural areas, thereby improving the quality of the local labor force.

Health care can also be a technology driver in rural areas. For example, telemedicine is a rapidly developing application of clinical medicine where medical information is transferred via telephone, the Internet or other networks for the purpose of consulting, and sometimes remote medical procedures or examinations. Telemedicine expansions in rural areas could help drive the demand for broadband access in rural areas, and that demand could have important secondary effects for local economic development outside of the health care industry sector.

Health care related activity is becoming an increasingly important economic base for New Hampshire’s North Country. And, because slightly less than half of personal health care expenditures comes from public, tax supported sources (primarily Medicare and Medicaid), health care in rural areas actually imports wealth into the area. Healthcare can therefore be considered an export based industry in rural areas. Healthcare jobs require high levels of training, and also can drive technological advances in the region. This critical economic role will only grow over the next 20 years. It is clear that an aging society will demand more and more health care, and the rural areas of New Hampshire are likely to be among the areas with the highest proportions of elderly.

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