

LIFT Texas Task Force
A Principled Approach to Health & Human Services

Hospital Issues

17 March 2000

The Shortage of Hospital Personnel

Wayne B. Sorensen, Ph.D., FACHE

Southwest Texas State University

Thesis statement:

“There is no shortage of hospital personnel.”

Position:

There is no shortage of hospital personnel. This is an acceptable position unless one assumes that the Texas hospital is attempting to respond to demands from its stakeholders and customers to provide services that it cannot provide with high quality and safety, at the charges it is permitted to make, at the rate of payment it is permitted to receive, and under the regulatory environment (including unfunded mandates) it must operate within. **THERE IS MALDISTRIBUTION OF HOSPITAL PERSONNEL; THERE ARE SUPPLY PROBLEMS, BUT A SHORTAGE. . . ?**

1. Who are these “hospital personnel?”
 1. Providers, such as:
 1. Hospitalists.
 2. Staff physicians and surgeons.
 3. Non-staff specialists and sub-specialists.
 4. Nurses.
 5. Nurse practitioners.
 6. Nurse anesthetists, and so forth.
 7. Allied health science personnel.
 8. Ancillary health service providers (such as food service personnel).
 9. And so forth.
 2. Non providers, such as:
 1. Administrators.
 2. Managers.
 3. Board members.
 4. Clerical personnel.
 5. Housekeeping personnel.
 6. Maintenance personnel.
 7. Buildings and grounds personnel.
 8. Laundry workers.
 9. Patient transporters.
 10. Volunteers.

11. Contract for service personnel.
 12. And so forth.
2. There seem to be enough of these folks around if we could just stick them here or there where they are “needed.” That brings me to where they “are,” rather than where they are “needed.”
1. Review of physician locations in Texas. These are human beings who have chosen, for whatever reason, to concentrate in metropolitan areas. For example:
 1. *Go to the TDH table.*
 2. To serve the estimated 19,995,428 Texans (1999 figure), there were 28,595 physicians, in Texas, providing direct patient care (not counting 1,826 physician “feds,” residents, or fellows). But, are these physicians evenly scattered across Texas in order to provide a ratio of 699 people per doctor? Nope.
 3. *QUESTION: please give me a county and I will describe the doctor ratio as of 2 November 1999.*
 2. Review of nurses locations in Texas. Again, these are human beings who have chosen, for whatever reason, to concentrate in metropolitan areas. For example:
 1. *Go to the TDH table.*
 2. To serve the estimated 19,995,428 Texans (1999 figure), there were 118,929 registered nurses, in Texas, in practice. In addition, there were 46,112 registered nurses with out-of-state employment addresses and 5,836 “feds.” But, are these nurses evenly scattered across Texas in order to provide a ratio of 168 people per nurse? Nope.
 3. *QUESTION: please give me a county and I will describe the nurse ratio as of 2 November 1999.*
 3. What about the 63,295 LVNs . . . ?
 4. What about the 1,893 PAs . . . ?
 5. What about the 7,284 primary care dentists . . . ?
 6. What about the 5,901 respiratory care practitioners . . . ?
 7. What about the 14,782 social workers . . . ?
3. Not all of these people work in hospitals, but some do. Why is there a maldistribution? There are many reasons, such as:
1. Voluntary separations; those people who leave for THEIR own reasons.
 2. Involuntary separations; those people who are TOLD to leave. (Do we see the effects of the BBA here? HCFA decisions and regulations?)
 3. Unattractive worksites.
 4. Inadequate pay/benefits.
 5. Unappealing community.
 6. Inadequate training for job skill demands.
 7. Intrusive demands by government agencies.
 8. And, so forth.
4. What can be done to change the status of hospital personnel from one of maldistribution to one

of effective distribution?

1. Anytime we incur costs to the public, such as through taxation, there should be a cost-effective equation determined, with a focus on outcome, such as: is the “best” use being made of those dollars going into GME programs when we have an oversupply of physicians in metropolitan areas and an under-supply in rural areas (assuming that there is a common breakout of specialists, PAs, and nurse practitioners going into metropolitan and rural areas, even though there is not such a breakout)?
 2. There is always the approach to health services supply that can be compared to the drug abuse problem in the United States Could we change the demands made by stakeholders and consumers to something much less, and assume that the problem of supply is similarly reduced? Could we, for example, change the expectation of pregnant women (and their families) from one where they must have a hospital-based delivery with an obstetrician, in order to have a high quality, safe experience, to one involving a mid-wife? to one with a mid-wife and in a non-hospital setting? Wouldn't costs decrease? Wouldn't the supply of personnel more closely match the effective use of dollars compared to outcome?
5. Comment for discussion: “Just increasing the supply of physicians (and other maldistributed health services personnel) is not the answer to the apparent problem of a shortage of hospital personnel.”
1. Rationale: We already have an oversupply of physicians (mostly in the sub-specialties), according to the American Association of Medical Colleges in an issue paper dated 3 March 1997. That report concluded that many medically underserved communities will continue to have inadequate numbers of physicians for the foreseeable future.
 2. And, in a 1995 Report, the Council on Graduate Medical Education suggested that since 1970, the increasing supply of physician specialists has made the maldistribution of physicians even worse! and that access to physician services in rural communities is worse currently (1995) than it was in 1970, even though there are many more physicians working in practice than there were in 1970.