

2. BABY BOOMERS AND THE HEALTH SYSTEM: “IT’S THE WORKFORCE, STUPID!”

by Jeff Goldsmith, Ph.D.



Baby boomers represent more than one-fourth of the U.S. population, so tracking their movements really should not be all that difficult. Yet this notoriously contrary generation has already faked out the health system. Preparing for the boomers, and assisted by what J.D. Kleinke has called the “twaddle echo factor” (a chorus of groupthink emanating from industry think tanks and “experts”) (Kleinke 2001), hospitals are in the process of adding thousands of new beds for the baby boom—capacity that may not be needed in some slowly growing communities for 10 or 15 more years.

Hospitals have read the demand side of the baby boomers wrong; it is not going to arrive in a phalanx of wheelchairs. Baby boomers currently range in age from 40 to 60. (I defy the reader to find a single boomer who thinks of himself or herself as elderly!) Pretending to be 35 will continue for some time to be the main driver of healthcare demand for this population. This drive ignited the explosive demand growth in

sports medicine, cosmetic surgery, and diagnostic procedures such as colonoscopies that began during the 1990s. Because many hospitals did not view supporting these services as their core business, much of it escaped into “physician space” across the street.

Despite the wide prevalence of obesity, baby boomers as a generation are healthier than their parents or grandparents, and are likely to continue or even accelerate the 25-year-long trend of declining morbidity among people over age 65, which Kenneth Manton and others have documented (Manton and Gu 2001). Many boomers will be healthier at age 85 than their grandparents were at 65, and, as a result, will remain in the labor force far longer.

At the same time, technology continues to reshape the demand for hospital care. Within the decade, most cardiac, cancer, and GI diagnoses will be made by enhanced imaging technologies. Major joint replacement, spinal

About the Author

Jeff Goldsmith, Ph.D., is president of Health Futures, Inc., which specializes in forecasting future trends in health-care technology, delivery, and financing. He also lectures in the M.B.A. program at the Wharton School of the University of Pennsylvania in Philadelphia. His interests include biotechnology and information technology, international health systems, and the future of health services. Dr. Goldsmith is a director of Essent Healthcare, a privately held, investor-owned hospital company, and he advises small technology firms on strategy. He lives at Ricochet Farm in Charlottesville, Virginia.

fusion, and a significant fraction of heart care will rarely require more than an overnight hospital stay. There will be far fewer strokes and heart attacks, thanks to the wide usage of beta blockers, statin drugs, and over-the-counter anti-inflammatories. Inpatient services will become predominantly ER-driven, linked to acute infections and accidents.

A Workforce Tsunami

While they wait for years for baby boom health services demand to crest, however, hospitals are going to be experiencing a human resource crisis of unprecedented magnitude. As those who live near the ocean realize, the first thing that happens in a tsunami is that the water recedes a long way. To extend our metaphor, when the water recedes, a good chunk of today’s healthcare workforce will be carried out with it.

The current U.S. healthcare system is powered by baby boomers.

Most baby boom caregivers will have moved out of direct care provision before the wave of boomer-driven healthcare demand arrives on hospital doorsteps. How the health system copes with the temporal mismatch between health services demand and supply of professionals, technicians, and managers from this generation will determine not only its future economic health, but also, and more crucially, whether it can meet the demands of an aging population when they do arrive.

The average age of registered nurses in the United States is 47 (U.S. HHS 2006). Some 38 percent of physicians are over 50 (Merritt, Hawkins and Associates 2004). The entire senior management cadre of most hospitals and health systems are older boomers. Though their retirement plans are difficult to pin down and may depend on the fickle stock market's performance, baby boom caregivers and managers are already looking for less stressful work than manning hospital ORs, ICUs, and ERs and being on call 24 hours a day.

Healthcare provision is not uniquely vulnerable to the generational transition. The U.S. Department of Labor expects 10 million more jobs than workers by 2010, with the shortage tilted toward the skilled positions (U.S. Department of Labor 2005–2006). School districts are vulnerable to baby boom retirement, as is the federal civil service system, particularly high-stress jobs such as air traffic controller.

The looming talent shortage will surprise hospital management, who have been conditioned to think of workforce shortages as cyclical. This human resources crisis is not cyclical, but rather is due to secular changes in workforce composition. Incremental

productivity improvements will not be sufficient to close the gap. Moreover, simply throwing dollars at the problem, through recruitment bonuses and large pay raises, will run up against Medicare and private insurance payment limits, damaging hospital financial performance.

Implications for Hospital Leaders

Although human resource policy has not been viewed traditionally as a major strategic issue, the issue is rapidly becoming strategic, and will require a strategic response and appropriate focus by senior managements and boards.

Increased focus on retention.

Retention, not recruitment, of skilled workers becomes the central issue. Today's healthcare management grew up in an era of plentiful supply of health professionals and technicians. The huge surge of baby boomers into the workforce lulled management into a "spare parts" mindset, where workers who left could be easily replaced. High vacancy rates in clinical services have led to reliance on mandatory overtime, temporary staffing agencies, and overseas recruitment—which has the unfortunate effect of removing skilled workers from nations with far more pressing health needs than our own—rather than a searching examination of the burn rate of experienced workers.

Because most hospital accounting systems have not treated human resources as a capital expense, the high cost of turnover is not fully appreciated by senior management. The cost of replacing an experienced OR or ICU nurse, including recruitment, training, and the productivity decrement as newly hired persons master the hospital's information technology (IT) systems and protocols of care, can easily run into the low six

figures per nurse (Atencio, Cohen, and Gorenberg 2003).

Job redesign for older workers.

Slowing the exodus of boomers from the healthcare workforce will require redesigning work roles to better integrate work with leisure and family obligations. Older workers will be seeking to work less than full time, or to work what seem today to be odd work schedules—six months on and six months off, for example—while retaining health benefits and pension coverage. These accommodations seem like a small price for hospitals to pay to retain these workers' knowledge and commitment.

Older workers will also be asking for the opportunity to learn new skills or even to return to school and can be assisted in doing this by a creative sabbatical policy. Finally, for workers in their sixties and seventies, new work roles similar to emeritus professorships in universities, as well as mentor and project consulting roles (again, with access to benefits where needed), will help facilitate both intellectual growth and the transmittal of important cultural knowledge to younger workers.

Real clinical transformation.

Healthcare IT is not just about improved efficiency and error reduction, it is also about redesigning jobs to reduce stress and turnover. Hospitals are in the midst of an historic (and expensive) process: replacing costly and inefficient paper- and telephone-based care management systems with modern, digital clinical software. All too often, however, the essential redesign of clinical roles and relationships is being neglected. Vendors have encouraged hospital managements and boards to believe that "clinical transformation" comes in the box when they buy an enterprise IT system.

Clinical transformation does not come "in the box." This essential and difficult task should precede vendor selection and frame precisely what you ask the vendor to do. This often-neglected task is unambiguously the responsibility of hospital management. By eliminating repetitive clerical tasks and improving scheduling and documentation processes, the redesign of clinical work flow, assisted by intelligent clinical IT, can maximize scarce professional time spent in direct patient care. In turn, this will increase clinical workforce morale and commitment and reduce costly turnover.

Virtual clinical care. Healthcare IT will enable continuous patient monitoring by telepresence technology. The ability to coordinate nursing and physician care will

also dramatically improve with the advent of clinical software that enables remote monitoring and management of patients. Seen first with so-called nighthawk radiology, the advent of broadband has enabled clinicians to evaluate, asynchronously and remotely, streams of digital clinical information, and use that information to guide the care process.

Combining live audio and video feeds, an electronic patient record, and clinical decision support, telepresence monitoring of patients by physicians is being rapidly adopted in hospital ICUs. Remote monitoring will spread to other parts of the hospital that care for unstable but not acutely ill patients (cardiac telemetry, 23-hour observation

units in ERs, perioperative monitoring of surgical patients), dramatically improving both quality of care and clinical worker productivity. The clinical team will become increasingly virtual, enabling a surprising number of caregivers to work from home. Vital clinical care decisions will not have to wait for physicians to answer their beepers or commute into the hospital, reducing stress both on the physicians involved and on the onsite care team.

Dramatic improvements in clinical workforce productivity will be required for hospitals to weather the workforce transition that has already begun. The era of plentiful clinical and technical workers in the American healthcare system is at an end.

References

- Atencio, B.L., J. Cohen, and B. Gorenberg. 2003. "Nurse Retention: Is It Worth It?" *Nursing Economics* 21 (6): 262-68.
- Kleinke, J.D. 2001. *Oxymorons: The Myth of a U.S. Healthcare System*. San Francisco: Jossey-Bass, 11.
- Manton, K.G., and X. Gu. 2001. "Changes in Prevalence of Chronic Disability in the United States Black and Non-Black Population Above Age 65 from 1982-1999." *Proceedings of the National Academy of Science (US)* 98 (11): 6354-59.
- Merritt, Hawkins and Associates. 2004. *2004 Survey of Physicians 50 to 65 Years Old*. [Online information; retrieved 10/7/06.] www.merrithawkins.com
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. 2006. *Preliminary Findings: 2004 National Sample Survey of Registered Nurses*. [Online information; retrieved 10/7/06.] <http://bhpr.hrsa.gov/healthworkforce/reports/rnpopulation/preliminaryfindings.htm>
- U.S. Department of Labor, Bureau of Labor Statistics. 2005-2006. *Occupational Outlook Quarterly*. [Online information; retrieved 10/6/06.] www.bls.gov/opub/ooq/2005/winter/art05.pdf