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U.S. Hospital Bed Supply Shrinks While Hospital Workforce Grows

*Dartmouth Atlas Report Prompts Call for Reforms
Some Mississippi Cities Have Twice the Beds of Some California Towns*

Lebanon, N.H. (April 2, 2009)—The supply of hospital beds and doctors varies widely from region to region across the United States, and the variations have nothing to do with the level of care patients want or need, according to a new report from the Dartmouth Atlas Project.

The “Hospital and Physician Capacity Update” report released today analyzes current hospital and physician capacity as well as trends over a 10-year period (1996-2006), which uncovered irrational distribution of valuable and expensive health care resources. The report found the same wide and persistent variations of acute care hospitals in 2006 that existed in 1996, and generally in the same places.

One example that illustrates the large variations: San Mateo and San Luis Obispo—both in California—had 1.45 beds per 1,000 residents in 2006, while Mississippi’s Jackson and Gulfport both had triple that number, 4.44 beds per thousand.

The distribution of hospital capacity fails to reflect the regional need for hospital care, either for beds or for hospital staff. As the health reform debate heats up, the report’s lead author, David Goodman, M.D., M.S., professor of pediatrics and community & family medicine at The Dartmouth Institute for Health Policy and Clinical Practice, said it is important to understand the disconnect between the supply of hospital beds and patient needs.

“Simply put, a built bed is a filled bed,” says Goodman. “While high hospital and physician capacity drives costs upwards, there are many regions that do well with many fewer beds and physicians per capita. Health systems in these lower capacity regions show that efficiency is a partner, not a competitor, of quality.”

The report analyzed the country based on 306 Hospital Referral Regions. Looking at the number of doctors, there was little substitution regionally in the primary care and specialist workforce—regions that have a high supply of one tended to have a high supply of the other. One reason, research has shown, is that doctors tend to settle in more affluent communities and close to the teaching hospitals where they trained, not where they are most needed.

For example, well-to-do communities such as San Francisco have 117 primary care doctors per 100,000 residents; Washington, D.C. has 102; and White Plains, in the New York City suburbs, has 101.4. But smaller Texas communities have far fewer doctors—Odessa has 43.9, McAllen has 45.1 and El Paso has 47.2 physicians per 100,000 residents.

There is similar variation in nursing capacity. There were a number of places with more than 5.5 registered nurses per thousand residents, such as Gulfport (5.58) but cities like San Luis Obispo had only 1.94 RNs per thousand residents.

Overall, U.S. hospital bed supply decreased by nearly 13 percent over the 10-year period, as care continued to shift to outpatient settings. Despite this trend, hospitals beefed up staff by more than 6 percent, plus a 14-percent increase of registered nurses (RNs), reflecting the continuing importance of the hospital for health care delivery, including outpatient services such as outpatient surgery, diagnostic tests and physician visits.

Changes in bed supply from 1996-2006 were marked by extremes. Very sharp declines were reported in Newark, New Jersey (-36.6 percent), while the number of beds in McAllen, Texas grew by 40.2 percent in the same time period.

To reach capacity that meets patient needs, Goodman recommends three steps to better manage capacity growth:

1. Hospital capacity: Congress should require the Centers for Medicare and Medicaid Services (CMS) to leverage its capital payment policies to limit hospital growth in regions which may already have too many beds.

2. Physician workforce: Form a national workforce commission in order to better direct training funds for the health workforce toward high need clinicians, such as primary care practitioners. Such a commission would be comprised of clinical professionals, public health practitioners, purchasers and patients.

3. Market-oriented reform of delivery systems: Fostering the growth of more organized systems of care and payment reform that encourages team-based collaboration in the care of populations. Through Accountable Care Organizations (see www.dartmouthatlas.org for more information), the current volume-based delivery system would gradually be replaced by partial capitation, bundled payments, or share savings.

The findings in the report are based on data from the Centers for Medicare & Medicaid Services, the American Hospital Association and the American Medical Association.

About the Dartmouth Atlas Project

For more than 20 years, the Dartmouth Atlas Project has documented glaring variations in how medical resources are distributed and used in the United States. The project, principally funded by The Robert Wood Johnson Foundation, provides comprehensive information and analysis about national, regional and local markets, as well as individual hospitals and their affiliated physicians. These reports, used by policymakers, the media, health care analysts and others, have radically changed our understanding of the efficiency and effectiveness of our health care system. For more information, visit www.dartmouthatlas.org.

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