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MAY 5 1975

The Honorable David E. Satterfield III
Chairman, Subcommittee on Hospitals
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

On April 22, 1975, your staff requested certain information we had gathered on the [adequacy of medical staffing in selected Veterans Administration hospitals.] Specifically, you were interested in

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---the budget process for estimating and requesting medical staff for the hospitals;

---the difficulties the agency has in recruiting professional medical staff, particularly physicians; and

---hospital officials' views on the adequacy of hospital staffing for direct medical care.

As discussed with the Committee staff, we had done some limited work in these areas at 15 hospitals. Our purpose was to obtain first-hand information on staffing problems from those who carry out the day-to-day medical system.

In the budget process area, we developed information on the number of medical personnel (1) requested by all the Veterans Administration's hospitals, (2) as revised by its central office, and (3) actually included in its budget submission.

In the adequacy of staffing area, we interviewed various hospital officials--such as directors, chiefs of services, and physicians--to obtain their views on how well the hospitals were staffed and what were the causes of any shortages.

According to hospital officials that reported staffing shortages, the shortages were caused by budgetary constraints, recruitment difficulties, and increased workload.

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In the recruitment area, a number of hospitals had trouble attracting qualified professional personnel, especially physicians. Factors hindering recruitment included lower income than the private sector, remoteness of some hospitals, restrictive nature of the practice (almost exclusively older male patients), lack of opportunity for professional growth, restrictions against outside employment, and lack of prestige.

Each of the three areas is discussed in detail in the enclosure to this report.

As your office requested, because of the Subcommittee's desire to use this material during your current hearings, we did not obtain formal agency comments on the report.

We plan no further distribution unless you agree or publicly announce its contents.

Sincerely yours,

Comptroller General
of the United States

Enclosure

ADEQUACY OF MEDICAL STAFFING AT VETERANS ADMINISTRATION HOSPITALS

The Veterans Administration (VA) has the single largest medical system in the hospital and associated medical fields. Its fiscal year 1976 budget totaled about $3.7 billion to provide for inpatient care at VA and non-VA facilities for over 1.3 million veterans and for over 14.7 million outpatient visits by veterans.

VA shares with the private sector the problems of recruiting and retaining qualified professional staff; that is, competing in a highly restrictive marketplace for scarce health manpower resources. Surveys made by the House Committee on Veterans' Affairs on VA's medical activities showed that, according to many hospital officials, staffing was one of the most pressing problems. Staffing problems cited were (1) inadequate professional staffing caused by either funding limitations or ceilings established by VA's central office and (2) the inability to recruit sufficient professional staff. The Committee's 1973 survey showed that 122 of 167 hospitals reported staffing shortages as a problem.

The purpose of our review was to obtain first-hand information on the staffing problem from those who carry out the day-to-day medical delivery system--hospital directors, chiefs of services, physicians, etc. Our review covered 15 general hospitals in the United States (see p. 12).

STAFFING REQUESTS MADE AS PART OF THE BUDGET PROCESS

Early in each calendar year, hospital directors meet with central office representatives to review each hospital's budget for the fiscal year beginning on July 1 of the following year. The budget review includes the estimated fiscal year workload and staff requirements, showing the additional staff required to improve the hospital's quality of care (staff improvements); to handle the estimated increased workload; and to support new activities, such as specialized medical services and new wards. The agreed-upon hospital budgets are compiled by the central office and serve as a basis for preparing a preliminary budget, which is submitted to the VA Administrator for review and eventual submission to the Office of Management and Budget for review and approval.

Based on the budget approved by the Office of Management and Budget, the central office sends each hospital its target allowance, establishing

the funds for the oncoming fiscal year. The hospital directors, on the basis of the target allowance, prepare the annual budget plan and establish personnel ceilings for the various hospital departments. To the extent that the target allowance does not support the total number of personnel requested to provide improved quality care, the hospital may report to the central office its "staffing deficiencies"--positions that could not be provided.

According to central office officials, for fiscal year 1974, the Office of Management and Budget made no funds available for staff improvements. However, later in that fiscal year, because of inadequate nursing personnel for night and weekend coverage, the Congress provided funds solely for upgrading nursing and related staff.

For fiscal year 1975, the hospitals requested about 15,080 additional positions to operate the health care delivery system. About 9,510 of these were for staffing improvement for direct medical care for existing programs. Central office officials evaluated these requests on the basis of VA staffing criteria and lowered the requests to 8,625 additional positions, of which 4,980 were for staffing improvement.

The final fiscal year 1975 budget submission allowed for an increase of 8,184 positions for medical care. The majority of the positions were earmarked for activating new facilities, supporting specialized medical programs, increasing VA's centralized training program, and upgrading certain VA hospitals to meet standards of educational capability for affiliation with medical schools and other related programs, but not otherwise for staff improvement. A total of 560 positions were allocated for staff improvement; however, 200 of these were for protective service personnel. Only the remaining 360 positions were for improving direct patient-care staffing at various VA hospitals.

The Congress augmented the fiscal year 1975 increase of 8,184 positions for medical care by authorizing the hiring of another 1,000 nurses.

The fiscal year 1976 budget submission requests an increase of 9,448 positions for medical care, of which 5,006 are for improved hospital staffing in areas where additional staffing is essential to maintain a high standard of care.

Although the central office has recognized a need to provide additional positions for staff improvement, not until the fiscal year 1976 budget submission did VA request a substantial number of additional positions for existing programs to meet critical patient-care needs. If approved by the Congress, the additional positions requested for fiscal year 1976 will

help alleviate the problem of staffing shortages caused by budgetary constraints; however, they will have little or no effect on staffing shortages caused by recruitment difficulties.

RECRUITING PROFESSIONAL STAFF

Each VA hospital recruits its own professional staff. Central office officials believe that this decentralized recruitment is effective because VA medical facilities, due to their location, size, affiliation with medical schools, and other factors, have different needs. However, although the central office does not actively participate in staff recruitment, it (1) puts out brochures on medical career opportunities in VA's medical fields, (2) has established a nationwide college recruitment liaison program, and (3) when deemed necessary, allocates funds for nationwide publicity.

The central office receives information from various hospitals regarding employment vacancies. With this information, it prepares a monthly recruitment bulletin which lists all the vacancies reported. We were told that hospitals are not required to report their vacancies and generally do so only when the vacancies have existed for a long time. Although the instructions covering this reporting encourage mutual assistance among hospitals, there is no provision for informing the central office if there are extra applicants in one locality and vacancies in another.

Recruiting physicians

Many VA hospitals have experienced difficulties in attracting qualified professional staff, especially physicians. VA has recognized the need to make its hospitals more attractive to physicians and has conducted programs to this effect. The Department of Medicine and Surgery is involved in the education and training of medical specialists to maintain a flow of qualified physician specialists and thus insure quality care. Also, VA has been involved in a program leading to affiliating its hospitals with medical schools, enabling it to participate in the training of health manpower.

VA established a career residency program for resident physicians to receive training in VA hospitals in specialities for which physicians are in short supply. Under this program, the resident, while receiving training, received pay about equal to that of a full-time VA physician (excess stipend). In consideration for the training received and the excess stipend paid, the resident agreed to work for VA for a prescribed period (obligated service). This program has been phased out because many residents who completed their training would "buy out" their obligated

service by repaying 90 percent of the excess stipend received. We understand that career residency appointments are now available only in dentistry.

On July 1, 1972, VA started a 1-year pilot program at its hospital in Beckley, West Virginia, whereby it extended visiting privileges to private physicians in the community. Under this plan, the visiting physician would be authorized to directly admit to the hospital eligible veterans who were his private patients at no cost to them. The physician would be compensated by VA for all his services to the veterans.

The program, however, was not very successful because relatively few of the physicians' private patients were veterans and most of the veterans who used the services of the hospital did not have private physicians. An explanation given for this lack of success was the setting of the hospital, which is surrounded by counties with a low ratio of physicians to population and economic deprivation. However, the pilot program was apparently successful in enhancing the hospital's image in the community and improving the relationship between VA and community physicians. Patients admitted under this plan were pleased that their physician was able to continue treating them in the VA hospital, and the hospital availed itself of specialized services not available from its staff.

Through discussions with hospital officials, chiefs of service, and staff members and with some persons outside VA, we attempted to (1) evaluate the magnitude of the recruitment problem and its effect on VA's professional staff and (2) obtain views on how recruitment could be improved.

Factors mentioned by hospital officials as affecting a hospital's ability to recruit staff included (1) degree of affiliation with a medical school, (2) financial considerations, (3) location of the hospital, (4) economic conditions in the area, (5) restrictive nature of a VA physician's practice, and (6) VA policies.

The purpose of a VA hospital-medical school affiliation is to provide education and training of physician graduates in the VA hospital. The medical school, through the hospital director and staff, supervises the training programs. The hospital staff members generally hold faculty appointments in the medical school.

According to hospital officials, affiliated VA hospitals generally have less difficulty attracting physicians than nonaffiliated hospitals.

The hospital-medical school affiliation offers the physician (1) an academic environment, which many physicians seek, (2) additional income from a faculty appointment, and (3) more opportunities for training and research. These incentives generally outweigh the most frequently given reasons for VA's lack of attractiveness to physicians. Therefore, the reasons discussed below apply principally to nonaffiliated hospitals:

1. Financial considerations--The maximum salary of a staff physician in 1974 was $36,000 (chief grade, step 10).[1] About 2,700 out of about 8,000 physicians presently in the VA system are in this category. The consensus among hospital officials and staff physicians was that physicians' salaries were generally not comparable to the potential earnings in the private sector. Information on net income of private practitioners is limited; however, in November 1973, a Medical Economics survey showed the median net income for private practitioners for calendar year 1972 to be $40,730.

2. Geographical location--Certain locations, because of their proximity to cultural centers, metropolitan cities, and resort areas, are more desirable. For example, at the VA hospitals in Fayetteville, Arkansas; San Francisco, California; and Reno, Nevada, location was mentioned as a favorable factor; conversely, for the hospitals in Muskogee, Oklahoma, and Grand Island, Nebraska, remoteness of location was mentioned as an unfavorable factor.

3. Restrictive nature of practice--The VA patient population is composed almost exclusively of male patients, of which a great majority are old. The young physicians may feel that this tends to limit the scope of their practice, since they have little opportunity to treat women and children.

4. Lack of opportunity for professional growth--Officials at nonaffiliated VA hospitals believe their hospitals do not offer sufficient training, research, and other opportunities for professional growth.

5. Restrictions against outside employment as a means to supplement income and broaden the scope of practice.

Recruiting registered nurses and nursing staff

Recruiting registered nurses was not as critical a problem as recruiting physicians. VA salaries for nurses are generally competitive with those

[1] The salary is limited by 5 U.S.C. 5308 to the rate for level V of the executive salary.

in the private sector. In the case of registered nurses, the problem appears to be more one of turnover (retention) than recruitment. Reasons given for nurses leaving VA were primarily personal. One reason mentioned which involves VA's policy was VA's rotating tour of duty system which requires nursing personnel to alternate work shifts. The Veterans Health Care Expansion Act of 1973, which provides pay differential for nurses working between 6 p.m. and 6 a.m. and additional pay for Federal holidays and Sundays, may change the attitude of some nurses toward working night shifts and holidays. However, our review was performed before we could measure the impact of this law.

Recruiting technologists, technicians, and other paramedical professionals

Some hospitals we visited were having difficulty recruiting and retaining technicians, technologists, and other paramedical professionals. The reason given was lower salaries than those available in the private sector. During our review, for example, the San Francisco VA hospital was having trouble attracting medical technologists and technicians because the salaries offered were considerably lower (about $1,500 to $2,400) than those offered in the private sector in the San Francisco area.

POSSIBLE EFFECT OF VA'S RECRUITMENT DIFFICULTIES ON VA HOSPITALS' STAFFS

VA hospitals' recruiting problems could have prevented VA from employing the quality of staff it seeks. Officials said an advertisement for a physician position could bring replies from about 40 applicants; these responses, however, generally come from foreign-educated physicians.

Hospitals had on their staffs a number of foreign-educated physicians. Some of them were not U.S. citizens (38 U.S.C. 4114 authorizes hiring aliens when qualified U.S. citizens are not available). Although we do not question the qualifications of foreign-educated physicians--in fact, many were board certified[1]--some hospital officials and staff physicians and a dean of a medical school believe that some foreign physicians may have a language problem which may create a communication gap between them and their patient or their patient's family.

Some hospitals have employed physicians who had retired from private practice. Employing these physicians filled the immediate need; however, in our opinion, it did not help VA's long-range staffing problem since these physicians may elect to retire shortly from Federal service.

Difficulties in recruiting certain paramedical personnel may have resulted

[1]Physicians who have met certain residency requirements and have passed examinations given by governing bodies (boards) of various medical specialities.

in hospitals not being able to employ the quality of staff they desired. For example, officials at the Dallas VA hospital said support services could be improved, blaming poor service and delays partly upon staff inefficiency. San Francisco VA hospital officials attributed the problem to being unable to attract qualified technologists and technicians at the level of VA salaries, which were lower than those of the private sector.

The Chief of the Pathology Service, Livermore VA hospital, said his problem was not quantity, but quality of staff. The salary offered technologists was not competitive with salaries offered by other hospitals in the area.

POSSIBLE EFFECT OF STAFFING SHORTAGES ON PATIENT CARE AND STAFF MORALE

Although we did not attempt to evaluate the quality of care at the various hospitals we visited, we asked hospital officials and staff members what impact reported staff shortages could have on the quality of care or the staff morale.

Most hospitals which reported staff shortages stated that the quality of care would improve with more professional staff. Some officials and staff members cited instances in which (1) the quality of care could have suffered because of inadequate staff, (2) hospital coverage during night shifts, weekends, and emergencies was not adequate, and (3) staff shortages had affected staff morale.

The San Francisco hospital reported a staff deficiency of 10 positions in the Clinical Pathology Service for fiscal year 1974. Officials of the Service stated that it could no longer guarantee good patient care because of a low personnel ceiling and increased workload and that this situation had created a staff morale problem. According to the Assistant Chief of the Service, because of this situation, the laboratory could no longer offer adequate coverage during the evening and night shifts. In fact, no technologist would be available for duty in the hospital from 11:00 p.m. to 7:00 a.m., and with the exception of emergency blood banking, all emergency laboratory tests would have to be performed at a non-VA hospital on a fee basis. The Clinical Pathology Advisory Committee believed that curtailing the laboratory service was not professionally acceptable and that the inability to obtain prompt emergency laboratory results could endanger patients.

During October 1973, the Chief of the Medical Service and other physicians expressed their concern to the hospital director regarding the inadequate coverage by the Clinical Pathology Laboratory and cited some examples of patients' lives being endangered because of the inadequate laboratory coverage.

Hospital officials admitted that the Clinical Pathology Service was understaffed but attributed some of the problems to poor management. The hospital director informed us that steps had been taken to correct the situation.

A staff shortage in the Nursing Service, Oklahoma City VA hospital apparently had an impact on patient care and staff morale. The Chief of the Nursing Service, staff nurses, and nonprofessional nurses commented that because of understaffing some nurses have had to neglect certain patient needs. For example, patients' vital signs were not being checked when required, beds were not always changed daily, patients had to wait for their pain medication, charting was sometimes neglected, and patients were not being taken out of bed and put in chairs as instructed. Emergency needs were being met by voluntary coverage of nurses beyond normal tour hours. According to an acting supervisor in the Surgery Intensive Care Unit, at least one nurse voluntarily stayed over because of lack of replacements for evening and night shifts and nurses had occasionally been required to work on a holiday or on their day off due to the staff shortage.

Officials and staff members at the Reno VA hospital said the Nursing Service was understaffed and coverage during evenings and nights was limited. However, the Chief of the Nursing Service

---stated that, even though the Service was understaffed, the patients were receiving quality care without delays but

---admitted that the staff was overworked and morale was low, especially among the younger nurses, who felt that they were not able to devote sufficient time to knowing the patients and their problems and teaching them to care for themselves.

According to the Chief of Medical Services, Muskogee VA hospital, five additional physicians were needed for the Service to provide the desired level of patient care. The shortage of physicians had resulted in the present staff being overworked. As a result, patient care had sometimes been delayed and the patients and their families had not been adequately counseled on the patients' prognosis and required treatment.

ADEQUACY OF VA PROFESSIONAL STAFF

The expanding role of the VA medical system and the congressional desire to provide high quality medical care to veterans requires VA to (1) constantly appraise its staffing needs, (2) conduct an aggressive program to attract, recruit, and maintain a sufficient number of qualified medical personnel, and (3) provide for future staffing needs.

VA has not established detailed guidelines to measure the adequacy of staffing at its hospitals. Certain general staffing guidelines were published in September 1970; however, they are very broad and have to be adapted to fit situations peculiar to each hospital and type of patient.

In the absence of such detailed guidelines, we asked hospital directors, chiefs of staff, and chiefs of services, and staff members about the adequacy of staffing and current staffing needs at their hospitals. We also discussed the possible effect staffing shortages could have on the quality of care patients receive and reviewed the hospital requests for staffing as part of the hospital budget process. Most hospitals we visited reported staffing shortages ranging from minor to serious. Officials and staff members at these hospitals attributed the problem to staffing ceilings and budgetary limitations established by the central office and the difficulties some hospitals experienced in attracting qualified personnel.

Although opinions among hospitals and their officials varied as to what was adequate staffing, all hospitals reporting staffing shortages cited budgetary constraints or recruitment difficulties as causal factors.

The following are examples of hospital officials' comments regarding their staffing needs.

Oklahoma City VA hospital--463 beds

The hospital director cited a need for about 126 additional positions, of which 99 were medical, as a basic requirement to provide adequate staffing for current and increased workloads. The medical positions were as follows:

Physicians	16
Dentist	1
Psychologists	2
Social worker	1
Social worker associates	2
Registered nurses	25
Licensed practical nurses and nurses aids	30
Pharmacist	1
Dental assistant	1
Technologists and technicians	20
Total	99

The hospital reported that, with current salary levels, it could not recruit any of the physicians needed, although funding was available for 10 of the 16 positions. No funds were available for any of the other positions listed.

Grand Island VA hospital--156 beds

According to the hospital director, this hospital needs 29 additional medical positions: 23 for present needs and 6 to cope with an expected increase of outpatients.

The hospital director stated that, because of the shortage of physicians, the Chief of Staff had been acting Chief of Medical Service and Admitting Officer. The needed medical positions were as follows:

	Current needs	Anticipated needs
Physicians	[a]4	2
Registered nurses	11	-
Licensed practical nurses	4	-
Pharmacists	1	1
Nuclear medicine technician	1	-
Inhalation therapists	2	-
Social worker	-	1
Laboratory technician	-	1
X-ray technician	-	1
Total	23	6

[a]Only the position for one physician had been funded.

Muskogee VA hospital--245 beds

The hospital director, after consulting with other hospital officials, gave us a list of funded vacancies and staff needs for which funds were not available. According to him, these personnel are essential to maintain modern quality care.

Vacancies funded:

Physicians	6
Registered nurses	2

Needs--not funded:

Physicians	5
Registered nurses	9
Radiology technologists	3
Total	25

He added that the funded physician positions were not filled because of difficulties in recruiting qualified physicians.

Oteen VA hospital--537 beds

According to statements made by the chiefs of the medical, surgical, radiology, laboratory, and nursing services, about 22 additional medical-type positions were needed to improve the quality of patient care. The hospital director, however, believed that the hospital actually needed the following 33 positions.

Physicians	2
Pharmacists	1
Registered nurses	8
Licensed practical nurses and nurses aids	12
Technicians and other paramedical positions	10
Total	33

The director said these additional positions would enable the hospital to improve the quality of patient care--particularly on the evening and night shifts and on weekends and holidays. He attributed the staff shortages to personnel ceilings and budgetary limitations imposed by the central office.

San Francisco VA hospital--352 beds

The chiefs of services reported to the hospital director a need for about 107 medical and support positions. The director, however, believed that only the following 30 positions, which were reported to the central office as staff deficiencies (medical and support), were needed to maintain and improve the quality of care.

Physicians	6
Pharmacists	2
Registered nurses	10
Technologists and technicians	8
Clerk technicians	4
Total	30

The Chief of the Nursing Service had requested from the director 36 positions, of which only 10 were reported as staff deficiencies to the central office. She told us that she still needed the 36 positions. She

said that the authorized staff would normally be adequate to handle the existing workload; however, a larger staff was needed because turnover was so high that the staff had to spend considerable time supervising and observing new employees.

During the fiscal year 1974 budget plan period, the Clinical Pathology Department requested 10 additional positions. The hospital director reported the 10 positions, including 6 technologists, to the central office as staff deficiencies. In addition to these reported deficiencies, the department was not able to fill existing vacancies because VA salaries for medical technologists were about $1,500 to $2,400 a year lower than salaries offered in the local private sector.

SCOPE OF REVIEW

We reviewed and discussed with VA officials budget submissions as they pertain to requests for staff improvements. We discussed the adequacy of medical staffing and recruitment and retention problems with various hospital officials to obtain their views on how well the hospitals were staffed and what were the causes of any shortages.

We made our review at VA's central office, Washington, D.C., and at the following 15 VA general hospitals:

Hospital	Number of beds
Atlanta, Georgia (note a)	550
Big Spring, Texas	225
Dallas, Texas (note a)	764
Dublin, Georgia	461
Fayetteville, Arkansas	230
Grand Island, Nebraska	156
Kerrville, Texas	310
Livermore, California	175
Mountain Home, Tennessee	500
Muskogee, Oklahoma	245
Oklahoma City, Oklahoma (note a)	463
Oteen, North Carolina	537
Reno, Nevada (note a)	177
San Francisco, California (note a)	352
Temple, Texas	715

Note: Survey work was also performed at Palo Alto,[a] Martinez, and Fresno, California.

[a]Hospital affiliated with a medical school.