CITIZENS RESEARCH COUNCIL OF MICHIGAN

"***The right to criticize government is also an obligation to know what you're talking about.***"
Lent Upson, First Director of the Citizens Research Council

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The State Can Benefit From Mandatory Staffing Ratios for Nurses, But Hospital Concerns Must be Addressed

In a Nutshell

- Michigan has a shortage of licensed nurses available who are actively working in health care, with the problem stemming from poor retention rather than a lack of newly trained nurses.
- Nurses report that working conditions are central to their decision to leave the profession.
- Mandatory nurse-patient ratios have been shown to improve nurse retention and satisfaction, as well as patient outcomes, but there are some potential drawbacks.

While shortages in every health care profession are important for public health, nurses are the largest segment of the health care workforce. Recent surveys and data point to a growing retention problem for Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) in particular, but the problem extends to a variety of nursing occupations and the entire health care workforce.

The health care worker shortage remains a problem in many parts of the country, and Michigan is no exception. A 2023 report from the Michigan Health Council found that a wide range of health occupations are expected to experience workforce shortages in the next 10 years. The U.S. Department of Health and Human Services (HHS) identifies Health Professional Shortage Areas (HPSAs), which are defined as geographic areas, populations, or facilities with a shortage of primary, dental, or mental health care providers. As of December 2023, Michigan had 288 primary care HPSA designations impacting a population of over three million people.

Designated Health Professional Shortage Areas in Michigan, December 2023			
Type of Health Profession	Total Designations	Population of Designated HPSAs	Percent of Need Met
Primary Care	288	3,594,485	50.93
Dental Care	250	1,560,302	26.62
Mental Health Care	264	6,010,177	36.06

Source: Designated Health Professional Shortage Areas Statistics, First Quarter of Fiscal Year 2024 Designated HPSA Quarterly Summary. Bureau of Health Workforce - Health Resources and Services Administration (HRSA)- U.S. Department of Health & Human Services

The nature of the shortage, including causes and proposed policy solutions, varies widely depending on the geographic region and the specific type of health care profession. Health occupations are markedly different in educational and employment requirements, salary and benefits, and work environments, and the particular factors contributing to the workforce shortage among different occupations reflect these variations.

The Decline of the Nursing Workforce

The declining number of nurses working in Michigan has received significant attention in Michigan and across the country. Michigan hospitals are currently trying to fill more than 8,500 nursing jobs. While many refer to the problem as a "shortage," according to state data compiled by the Michigan Public Health Institute (MPHI), there are over 170,000 registered nurses (RNs) with active Michigan licenses, but just over 100,000 are currently working as RNs in Michigan. While the COVID-19 pandemic exacerbated the problem, the issue has been relevant for many years.

In response to the decline, the state has made efforts to increase the number of nurses being trained, but the source of the workforce decline does not appear to be driven by a lack of new nurses entering the workforce. Nursing program enrollments have been increasing every year for two decades and the number of registered nurses in the state continues to grow.

Many studies on nursing retention and turnover point to poor working conditions as a significant contributor to staffing declines. Among RNs who reported a change in employment in the MPHI's 2023 survey of Michigan nurses, most reported that they were seeking a less stressful position (44.8 percent), wanted a better schedule (43.4 percent), or were unhappy with the work culture (32.5 percent). Only 5.4 percent of nurses leaving cited retirement as the reason. In addition, a 2023 study from the University of Michigan that surveyed nurses across Michigan found that nearly 40 percent of nurses plan to leave the profession within the year, and 60 percent of the nurses surveyed pointed to inadequate staffing and resources to deliver adequate patient care as a factor in their departure.

While increasing the number of nurses being trained in Michigan may help alleviate the problem, tailoring a policy response that targets the source of the issue – which is that nurses report feeling overworked and appear to be burning out at high rates – is much more likely to put the state on a sustainable path to a sufficient nursing workforce. The state has recently taken steps to acknowledge this by establishing other professional health licenses designed to take some of the burden off nurses, but there are other policy options with the potential to make a larger impact.

The Case for Policy Action

Hospitals and nurses operate like other competitive industries and workforces. In most industries, a declining workforce is addressed by market incentives, and only becomes a problem for the industry if it impacts their profit margins. In order to achieve the goal of providing quality care to patients, hospitals need to comply with state and federal regulations, limit legal liability, and compete with other providers in their area. With respect to nurses, this means that they need to employ enough nurses to deliver the level of care necessary to maintain licensure and avoid lawsuits, but exceeding that level of nurse staffing only serves the interests of the facility if it serves to increase its profit margins.

Given the nature of work performed by nurses, adding nurses to a shift is unlikely to proportionally increase a hospital's profits. Nurses are typically salaried or hourly and perform a set of tasks that are proportional to the number of patients. If a hospital can safely meet the basic needs of patients with a given number of nurses, adding an additional nurse would not allow the hospital to bill for additional services, it would simply decrease the individual workload on the nurses. This creates a financial incentive for hospitals to get more work out of the nurses they have rather than scaling up the number of nurses.

Hospitals and other facilities have so far seemed content to accept the existing level of turnover and dropout. In fact, some hospitals are seeking nurses outside of Michigan, even internationally, instead of focusing on improving the quality of working conditions. This is not to say that hospitals are acting nefariously. They are responding to the regulatory and economic frameworks that are in place. If an individual hospital wanted to increase nurse staffing to a level that would make the job more attractive to nurses and aid in retention, they would be voluntarily jeopardizing their profits because other hospitals are not required to play by the same rules.

Nurses can respond to their working conditions using tools available to workforces generally – they can unionize and strike, or seek out alternative professions. So far, the nurses are choosing the latter option. Both hospitals and nurses share a common goal of providing quality of care, but individual hospitals and nurses are not motivated to solve the nursing workforce decline statewide.

This is exactly the type of situation in which there is a viable role for government. The larger public interest in the sustainability of the nursing workforce cannot be solved by hospitals or nurses directly. If the specific goal is to increase and maintain the number of nurses in Michigan, the state is the only actor that has the appropriate motivation to effectuate that. Individual hospitals acting alone cannot improve conditions dramatically enough to solve the lack of working nurses statewide. While it is certainly possible that hospitals may act when the economic situation becomes dire, it is appropriate for the state to step in before that point.

Mandatory Staffing Ratios

Mandating minimum staffing ratios for health care professionals, particularly nurses, has been discussed for decades as a potential policy solution to the shortage problem. Four states (California, Massachusetts, New York, and Oregon) have passed laws that mandate some level of staffing ratio for nurses. Other states include requirements for public reporting systems for staffing ratios and nurse-led staffing committees.

Michigan first introduced staffing ratio legislation in the early 2000s, and some version of nurse staffing legislation has been introduced every year since. Late last year, the House Health Policy Committee took testimony on House Bills 4550, 4551, and 4552 which propose to:

Require hospitals to implement specified minimum ratios of direct care registered professional nurses (RNs) to patients in different hospital units;

- Provide administrative fines and sanctions for violations;
- Require records to be kept, provide for notice, and a complaint process; and
- Create a fund through which fines imposed for violation of the bills can be used to support their administration.

Several groups and organizations submitted testimony regarding this legislation, and there remains a sharp divide between those for and against mandated staffing ratios. Essentially, hospitals and for-profit entities oppose the legislation, claiming that staffing ratios lead to inflexibility that could be detrimental to patients. They also argue that this legislation could put hospitals at risk of closure for failing to meet the ratios, which ultimately does not serve the populations who rely on these hospitals. Most of the support for this legislation comes from the nurses themselves and other policy and academic researchers who have studied the impact of nursing staff ratios.

Existing Research on Staffing Ratios

Several studies have assessed the impact of California's staffing ratio law, which was first implemented in 2004. This research consistently found a positive impact on job retention, job satisfaction, and/or patient outcomes.

A 2010 study compared California to Pennsylvania and New Jersey which did not have mandated staffing ratios and assessed nurse workloads and patient outcomes. The study found that California hospital nurses cared for fewer patients on average, and these lower ratios were associated with lower mortality rates among patients and higher job satisfaction among nurses. Another study found that the implementation of staffing ratios for RNs and licensed practical nurses (LPNs) was associated with a statistically significant reduction in occupational injury rates. Further, a recent longitudinal analysis that compared hospital nursing staff in California to other states before and after the Great Recession found that higher staff ratios may help protect hospitals in times of recession.

Several other studies support the results found in California. A study on New York hospitals showed that hospitals with higher nursing staff ratios were associated with higher odds of in-hospital mortality and 30-day

readmission, and longer lengths of stay for medical and surgical patients. A large-scale prospective study in Queensland, Australia, which implemented staffing ratios in 2016, found that hospitals with mandated ratios had better outcomes in mortality, length of stay, and readmissions, even after accounting for differences in demographics, comorbidities, and hospital size. What's more, the quasi-experimental study design allowed researchers to find causality in the impact of the staffing ratios.

Concerns About Mandatory Staffing Ratios

While hospitals fear that the cost of hiring more nurses would put an untenable economic strain on their resources, many of these studies found that staffing ratios helped reduce other costs. For example, the Queensland study found that the costs avoided due to fewer readmissions and shorter lengths of stays were more than twice the cost of the additional nurse staffing. The New York study also projected substantial savings due to shortened length of stays and fewer readmissions. Further, a study that used economic simulation to specifically address the cost-effectiveness of staffing ratios found that having a higher baseline roster of nurses led to improved patient outcomes and higher costs. However, having a lower baseline roster of nurses resulted in higher costs as well due to longer patient stays. The study also found that even a flexible model that allows shift-by-shift measurement of patient demand was not beneficial unless the baseline number of staff was sufficient.

Hospitals also have argued that the improved outcomes are insufficient to justify the increased cost. Some opponents of staffing ratios point to broader data to show that hospital quality is unaffected by staffing ratios. However, using broad data points like overall hospital quality, as opposed to specific patient outcomes, is less relevant – hospital quality encompasses a much wider range of contributing factors. Staffing ratios are designed to improve a very specific part of the overall hospital system, and research has shown that staffing ratios consistently succeed at these goals. Staffing ratios are not meant to solve large-scale issues about hospital quality all on their own.

There is a lack of evidence on the potential negative impact of mandatory staffing ratios on the flexibility of nurses and supervisors to adapt to changing needs of patients. Hospitals and some nurses argue that staffing nurses on a hospital floor is complicated, and managers need the discretion to respond to the varying needs of patients, which includes the number of nurses necessary on a given floor. With mandatory staffing ratio legislation, hospitals would be unable to pull nurses from one area that has less need to another higher need area, which could be detrimental for some patients. Hospital staff have a particular expertise on the day to day operations and their concerns about the implementation, should be considered when forming any potential legislation.

There may be an opportunity for Michigan to implement staffing ratios in a way that maintains the necessary flexibility for the hospital, but this will take more collaboration between stakeholders. There is sufficient evidence for mandatory staffing ratios to show that they have a positive impact on job satisfaction and patient outcomes, and little evidence to show that they create unmanageable economic distress for hospitals. Addressing the flexibility issue has not been adequately studied because no other state has drafted staffing legislation that attempts to incorporate these concerns about flexibility. Michigan has an opportunity to work with nurses and hospitals to incorporate some safeguards about staffing flexibility into any policy that sets minimum staffing ratios.

Conclusion

The state has a clear interest in educating and retaining nurses, but the existing regulatory and economic framework has left Michigan with a shortage of working nurses that is likely to get worse. While the problem is multifaceted, working conditions seem to be the primary reasons for nurses leaving the profession. Better staffing ratios have been shown to improve retention and satisfaction, but the market does not seem to be heading in that direction.

Based on a variety of research, it is likely that state-level mandatory staffing ratios would move Michigan toward increased retention rates for nurses and stem the shortage to some degree.

While hospitals are concerned about the economic impact of such mandates, there is evidence to suggest the second- and third-order effects of these policies will also benefit hospital bottom lines, particularly if everyone is required to meet these minimums. There is little data regarding the impact of restricted flexibility on patient outcomes, and therefore, any legislation should work to address this concern.

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