LONG VIEW
THRIVE BY DESIGN

# Five Forces Driving Anesthesia Stipend

## Why the Old Model of Anesthesia Management Requires a Reset

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## An Outdated Model Living Beyond Its Utility

**Key Learnings**

- **There are FIVE forces at play that drive anesthesia stipends today**. The forces are – i) growing aggregate demand for anesthesia, ii) workforce shortage, iii) lack of a shared safety stock framework, iv) altered preferences of the MD/CRNA workforce and v) governance gaps between administration and surgeons. Demand for anesthesia services continues to grow as surgical and procedural volume expands across hospitals, ASCs, and interventional suites. At the same time, the clinician workforce is constrained, scheduling expectations are changing, and hospitals lack a shared framework for determining how to have enough but not too much anesthesia capacity held in reserve. Add to this the governance tension between surgeons seeking reliable access and administrators protecting thin margins, and the result is predictable. The stipend becomes the place where all these pressures accumulate.
- **Re-Contracting anesthesia services is NOT a sustainable solution**. Many health systems negotiate harder, revise PSA terms, or attempt to limit stipend growth in the next renewal cycle. These steps can buy temporary relief but rarely change the underlying problem – an outdated operating model which is attempting to match variable demand with constrained workforce supply based on yesterday's models.
- **A "reset" of the perioperative operating model itself is needed to provide sustainable relief**. Instead of asking how to negotiate a smaller payment model, leading systems are asking a different question: what anesthesia coverage model is needed for the market we are in? That means aligning surgeon access, staffing models, and anesthesia coverage with real demand by site and time of day, while building a shared safety stock framework that both administrators and surgeons trust. When the operating model leads the thinking, the contract simply reflects the model that works for a given health system.

## A Rising Tide of Anesthesia Demand

Over the past two decades, the demand for anesthesia services has changed not only in sheer volume but also into new settings. Demographically, the United States is moving towards what one anesthesia analyst has called "the gray zone of care," one where population aging and chronic disease steadily increase the need for surgical and interventional procedures that require anesthesia support. The surgical workforce literature anticipated this turn based on age-specific utilization rates and Census forecasts, where the per capita workload in surgical fields was expected to increase by 14–47% as the population aged, with the greatest growth in specialties serving older adults. That forecast is now visible in contemporary data. A 2024 national survey of US households found that one in nine Americans reported undergoing at least one surgical procedure in the preceding year, underscoring how routine operative care has become prevalent at a population level. Global analyses points in the same direction. The Lancet Commission on Global Surgery estimates that roughly 5,000 procedures per 100,000 population per year are a

reasonable benchmark for meeting surgical and anesthesia needs, and many high-income systems are clustered at or above that level as surgical access has expanded.

The growth in non-operating room anesthesia (NORA) makes the rising tide trend even more concrete. According to National Anesthesia Clinical Outcomes Registry (NACOR), national registry data show that NORA cases rose from 28.3 percent of all anesthesia cases in 2010 to 35.9 percent in 2014. Institutional analyses documented NORA volumes growing by more than 157 percent over a single decade at one large academic center. Looking ahead, the American Hospital Association and the ASA now project that NORA is projected to account for a growing share of anesthesia cases and could approach or exceed half of total volume in the coming decade, surpassing traditional OR work for the first time. Combined with the continued growth of ASC volumes, this means that most anesthesia demand will soon originate *outside* the traditional hospital OR, fundamentally changing who competes for anesthesia provider time and on what terms.

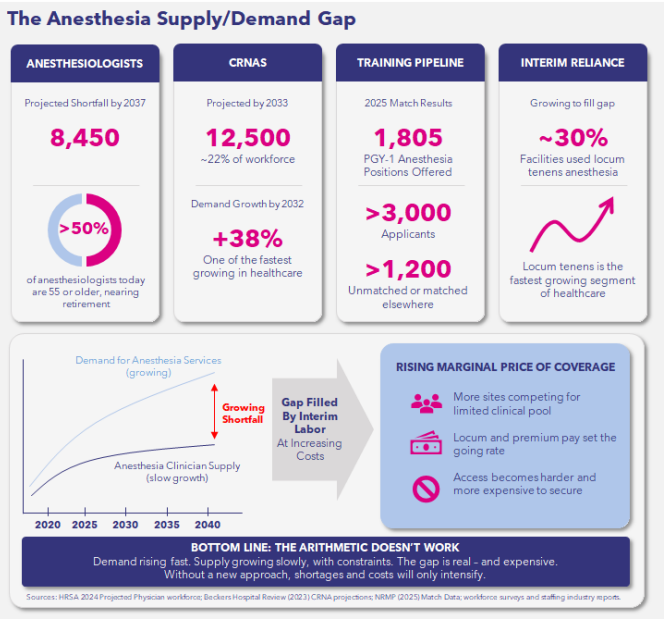
In addition to sheer volume, the "site of care" has also shifted. MedPAC reports that per-beneficiary ASC procedure volume for Medicare grew modestly at about 0.6 percent annually from 2018 to 2022, followed by a sharper 5.7 percent increase in 2023 as more procedures shifted to ambulatory settings. JAMA Surgery data show that ambulatory surgery center activity now accounts for a rapidly rising share of the more than 70 million procedures performed annually in the United States, while large academic and community hospitals have seen non-OR anesthesia demand grow in GI, cardiovascular, and interventional suites.

Lastly, Market analysts estimate the US anesthesiology services market at roughly $18 to $19 billion in 2024, with projections approaching $28 billion over the next decade, driven by rising procedural volume and outpatient growth.

Taken together, these figures describe a simple reality, the total number of anesthesia-relevant encounters, per capita and in aggregate, has risen substantially, and that growth has been dispersed across a widening array of sites drawing on the same finite pool of anesthesia clinicians.

## A Structural Squeeze on Anesthesia Supply

As aggregate demand has been rising steadily, the supply of anesthesia clinicians has not kept pace. The American Society of Anesthesiologists now describes "a growing imbalance in the supply versus demand for anesthesia care providers," warning that "the labor supply-demand imbalance for anesthesia clinicians has reached critical levels, with major implications for safe and effective patient care."




The underlying arithmetic is unforgiving. The Health Resources and Services Administration projects that by 2037 the United States will be short roughly 8,450 anesthesiologists, even as more than half of those in practice today are

already over the age of 55 and moving toward retirement. On the CRNA side, Becker's, summarizing workforce projections, reports that by 2033 the country could face a deficit of about 12,500 nurse anesthetists, or roughly 22 percent of the current workforce, while demand is projected to grow by 38 percent over the same period, making it one of the fastest-growing roles in health care. Training pipelines remain tight. In the 2025 Match, 1,805 PGY-1 anesthesiology positions were offered for more than 3,000 applicants who ranked the specialty, reflecting strong demand relative to available training capacity. The gap is being met with interim labor. Workforce surveys suggest that roughly 30 percent of healthcare facilities relied on locum tenens anesthesia providers or CRNAs in the prior year, and staffing industry data show locum tenens as the fastest-growing segment of healthcare staffing as systems struggle to maintain access in the face of chronic shortages. In effect, more and more sites are competing for anesthesia coverage, but the clinician pool is expanding only marginally and at considerable cost, with locum and premium pay increasingly setting the marginal price of an anesthesia hour.

## The Safety Stock Dilemma: Too Little, Too Much and No Formula

Anesthesia capacity in a hospital functions like safety stock in a high-value production line. Too little, and cases are delayed or cancelled because there is no anesthesiologist or CRNA available, surgeons lose operating time, and high-margin procedures migrate to competitors. Too much, and funded anesthesia time sits idle in under-utilized rooms incurring cost with no offsetting revenue, especially when coverage is supported through multi-million-dollar stipends. Yet most leadership teams lack a disciplined way to answer three apparently simple questions: How much excess anesthesia capacity is truly needed to protect surgical margin and safety? At what point does additional "insurance" become waste? And how should that balance differ by day of week, time of day, and service line?

The stakes on both sides of that trade-off are high. Surgical services are among the strongest contributors to hospital economics. One well-known analysis found that transplant surgery generated roughly $276 of hospital margin per operating-room hour, and thoracic surgery about $234 per hour, far outstripping many other service lines and underscoring why executives are so wary of losing cases. At the same time, overall financial resilience is limited. A recent KFF review of hospital finances estimated aggregate operating margins at about 5 percent in 2023, still below pre-pandemic levels, and reported that roughly two in five hospitals ran negative margins, with roughly two in five hospitals operating at a loss, including about half of low-volume, Medicare-dependent, and sole community hospitals. In that environment, a few percentage points of avoidable idle capacity in the OR can make the difference between a barely positive and a negative bottom line.

On the ground, the cost of undershooting safety stock is already visible. Reports from clinical and industry publications describe operating rooms cutting up to a quarter of scheduled capacity on some days due to anesthesia staffing shortages, forcing case delays, cancellations, and surgeon frustration. When access becomes unreliable, surgeons do not just complain, they begin to move cases to ASCs or competing hospitals where they perceive anesthesia and OR time to be more secure. Faced with this, and with no shared quantitative framework to balance risk and waste, many leadership teams default to overshooting on safety – they purchase more anesthesia coverage than their ORs can consistently use, "just to be safe," and absorb the resulting stipend as the implicit price of uncertainty.

## A Workforce That No Longer Fits the Old Template

Workforce expectations add a third layer of strain, on top of rising anesthesia demand across more sites and the absence of a clear framework for how much capacity hospitals must hold in reserve. The current generation of anesthesiologists and CRNAs is not a fungible pool of full-time clinicians willing to cover any room at any hour; it is a mosaic of professionals with stronger preferences for predictable schedules, fewer nights and weekends, and more control over where and how they practice. In markets where options abound, including hospital ORs, ASCs, and office-based practices, those preferences matter.

The problem is that most hospital coverage models and PSAs were written for an earlier era. They still assume that if the hospital commits to a certain number of rooms and hours on paper, the workforce can simply be slotted into match. In reality, the sites that offer the most attractive schedules and case mixes, often ASCs or high-volume daytime services, are the first to be filled, while nights, weekends, and low volume locations increasingly depend on locums, premium pay, or expanded stipends to stay staffed. Workforce observers now argue that "flexibility around scheduling" and models that give anesthesiologists and CRNAs "greater control over how they structure their time through self-scheduling, varied shift options, and flexible FTE arrangements" have become central to recruitment and

retention. The result is a growing mismatch, an anesthesia workforce that is more fragmented and preference driven, layered onto coverage expectations that were built for a more uniform, "anytime, anywhere" labor market. That friction does not just make staffing harder; it directly raises the effective price of every hour of coverage the hospital wants to guarantee.

## A Conversation That Never Quite Happens

Just as the supply and demand sides of anesthesia are out of balance, the way hospital leaders and surgeons talk to each other is also misaligned. Administrators look at anesthesia as a large and growing fixed cost and feel pressure to rationalize it to protect thin margins. Surgeons look at anesthesia as a simple on or off constraint. From their perspective, either there is an anesthesiologist available when they have a list, or there is not. When there is not, they lose income, disappoint patients, and damage referral relationships. In many markets they also have a real option of moving their cases to another hospital or to an ASC that can offer them more reliable access.

The result is a structural gap in how the two sides experience "safety stock." When administration talks about trimming coverage, surgeons hear a threat to their ability to operate and to their own economic security. When surgeons insist on more rooms and more coverage "just in case," administrators see costs that they cannot pass on to payers. Because surgical services generate some of the strongest margins in the hospital, executives are acutely aware that alienating high volume surgeons could mean losing some of their best business, not just for the OR but for downstream admissions and ancillary services as well. Case studies of OR access show how quickly this becomes real. As profitable elective cases have migrated to ASCs, some hospitals have responded by blocking almost all available OR time for elective surgeons in an effort to recapture volume, only to find that urgent and emergent cases are squeezed out, and surgeons still feel they cannot get the time they want.

In this environment, it is not surprising that stipends often become the path of least resistance. Without a shared, trusted framework for looking at risk, capacity, and access together, hard conversations about changing coverage patterns are easily interpreted as one side trying to win at the other's expense. Administrators fear losing surgeons and volume. Surgeons suspect cost cutting at the expense of their patients and practices. Both sides retreat into familiar positions of "we cannot cut" versus "we cannot keep paying this" mentality. It is easier, at least in the short term, to keep writing a larger check than to confront the underlying design problem.

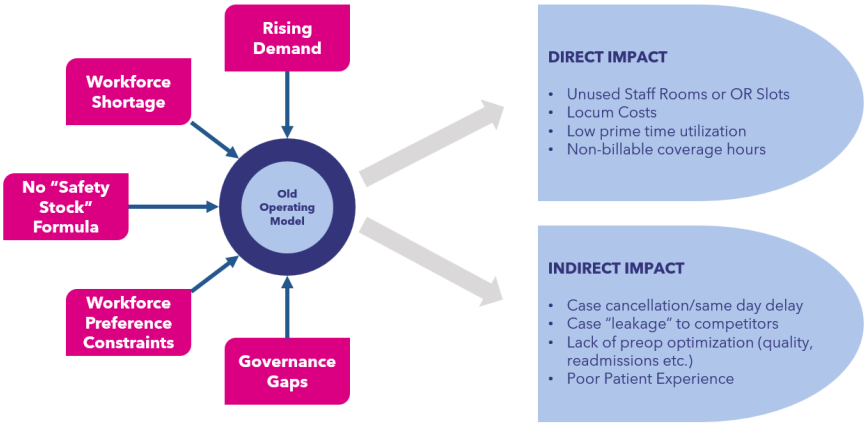
## Where All the Pressures Show Up: The Stipend Line

Thus far, we have described the five forces and their dynamics:

1. Growing aggregate demand for anesthesia
2. Shortage and structural constraints on the workforce
3. Lack of a shared safety stock framework
4. Altered preferences of the workforce
5. Governance gap between administration and surgeons

When these five forces are not managed explicitly, the system converges on an unpopular outcome, the anesthesia stipend.

# 5 Forces Driving Stipends




The scale of this shift is no longer anecdotal. A study of nonacademic hospitals in California found that the share of hospitals making direct payments to anesthesia groups rose from 52 percent in 2002 to 69 percent in 2014, and that the median payment, adjusted for inflation, more than tripled, from about 242,000 dollars to 765,000 dollars over that period. Similar patterns are emerging outside the hospital. VMG Health reports that anesthesia groups serving ASCs, facing tighter reimbursement and higher labor costs, are now "requesting additional compensation" to maintain coverage, and that many centers are confronting anesthesia subsidies for the first time. Industry analysts suggest that the share of ASCs expecting to pay anesthesia stipends increased from 28 percent in 2024 to 44 percent in 2025, and that roughly two thirds of ASC leaders now list anesthesia coverage among their top financial challenges.

In this sense, the stipend line on the income statement is not just a price for anesthesia services. It is a composite signal that the operating model, the workforce, and the governance of perioperative access have not yet been brought into alignment with the new reality. Until those underlying forces are addressed directly, there is every reason to expect that line to keep rising.

## From Bigger Checks to a Different Question

If stipends are where all these pressures show up, the natural temptation is to treat them as a contracting problem. Many hospitals respond by bargaining harder on the dollar amount, tweaking PSA terms, or changing the payment formula. Those steps can buy time, but they do not change the underlying reality. The coverage footprint stays the same. The workforce constraints stay the same. The OR scheduling patterns and safety stock habits stay the same. The communication gap between administration and surgeons stays the same. In that situation, a lower stipend this year is often followed by a higher one a few years later.

A more durable approach starts with a different premise. The question is not "How do we get this number down in the next negotiation," but "what operating model do we want to be paying for instead" and "How do we bring our anesthesia partners and surgeons into that design." Consultants who work in this space are increasingly explicit on this point. Surgical Directions, for example, has shown how poor OR utilization and unmanaged non OR anesthesia locations can drive a minimum stipend request of 4 million dollars, and how redesigning surgeon access, block use, and NORA coordination can both increase throughput and materially reduce the required subsidy. SullivanCotter describes working with large systems to map actual coverage needs across all anesthetizing locations, modeling the right mix of anesthesiologists and CRNAs, and then renegotiating PSAs around a new care team and scheduling model, rather than simply pricing the old one.

In practice, this means transforming the operating model and allowing the model to lead contractual changes. It means right sizing coverage to real demand AND supply constraints by site and time of day, rethinking staffing models in light of workforce preferences, and building a shared safety stock framework with surgeons so that tradeoffs are explicit rather than implicit. Only then does a contractual change stand a chance of producing sustainable results. Until

that happens, stipends will continue to serve as a telltale sign that the operating model isn't quite right for the given market conditions.

## The Long View

Over the long run, the forces reshaping anesthesia will not ease. Populations will continue to age, surgical and procedural demand will keep rising, and anesthesia professionals will remain in short supply. Health systems that succeed in this environment will be those that accept these facts early and respond *strategically* by redesigning their perioperative operating model, not just their contracts. They will learn to size anesthesia "safety stock" with care, align coverage with where and when demand truly occurs, and build genuine partnership with surgeons and anesthesia groups around shared data and shared risk. In doing so, they will treat the stipend not as a permanent tax on the income statement, but as a signal that guided them toward a more resilient and sustainable way of delivering surgical care.

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