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The Leadership Shortage Behind the Physician Shortage

Everyone is counting the doctors. The shortage that will actually break health systems is the one in the C-suite, and almost no one is measuring it.

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EXECUTIVE SUMMARY

The bottleneck is not who treats the patient. It is who runs the building.

13.5k–86k
Projected U.S. physician shortfall by 2036 (AAMC)[1]

~5 yrs
Average tenure of a hospital CEO[5]

77% / 52%
Of the time the CMO / COO also turns over within a year of a CEO exit[5]

~213%
Of annual salary to replace a senior healthcare executive[7]

For twenty years the healthcare workforce conversation has had one number at its center: the doctor shortage. It is a real and serious problem. But it has crowded out a second shortage that is arriving faster, costs more per seat, and determines whether the clinical workforce can function at all. That is the shortage of leaders who can run complex, financially pressured, multi-site care organizations.

This paper makes a simple argument with hard consequences. The scarcest resource in American healthcare is not beds, capital, or even clinicians. It is the executive talent that decides whether an organization survives the next reimbursement cut, integrates the next acquisition, opens the next site of care, and keeps the clinicians it already has. When that talent is missing or churns, the damage does not stay in the executive suite. It flows straight to the bedside as canceled growth, deferred investment, staff turnover, and, in the hardest cases, closure.

The data assembled here points to five conclusions:

- **The leadership bench is thin and aging** at the same moment demand for healthcare managers is projected to grow **29% through 2033**, far faster than almost any other occupation.[2]
- **Turnover at the top is structural, not incidental.** Hospital CEO turnover has held near **16%** a year, and recent tracking shows it climbing again.[3,4]
- **One empty seat becomes several.** A CEO departure triggers a leadership cascade through the rest of the C-suite within twelve months.[5]
- **Vacancies are expensive and slow to fill,** commonly 60 to 120 days or more, with replacement costs that dwarf the salary itself.[7,8]
- **Leadership quality is measurable in outcomes.** The evidence links strong, stable, clinically fluent leadership to better performance, and its absence to worse.[9]

> *If you solve the physician shortage but cannot staff the leadership that deploys those physicians, you have not solved the problem. You have relocated it.*

SECTION 1

The shortage everyone is counting

Begin with the number that dominates every workforce headline. In its March 2024 projections, the Association of American Medical Colleges estimated that the United States will face a shortage of between 13,500 and 86,000 physicians by 2036.[1] The range is wide because it depends on policy choices still unmade, chiefly how many residency positions the country funds. Under current trajectories, the shortfall lands painfully high, and the association has been explicit that without new investment, future gaps will look closer to the 124,000 it projected in its earlier work.[1]

The drivers are demographic and difficult to reverse. The U.S. population is projected to grow about 8% by 2036, but the population aged 65 and older, which uses far more care, is projected to grow by roughly **34%**.[1] Demand rises steeply on one side. On the other, supply is aging out: **20%** of the clinical physician workforce is already 65 or older, and another **22%** is between 55 and 64.[1] More than two in five physicians are within roughly a decade of a plausible retirement. Primary care, the front door to the entire system, faces a projected shortfall of **20,200 to 40,400** physicians on its own.[1]

None of this is in dispute, and none of it should be minimized. The physician shortage is real, it is measured carefully, and it deserves the attention it gets. The problem is not that the industry is counting doctors. The problem is what the industry stops counting once it has.

> **THE FRAMING TRAP**
>
> Workforce strategy has become almost synonymous with clinical headcount: how many physicians, nurses, and technicians can we recruit and retain. That framing quietly assumes the organizational machine that deploys those clinicians is fixed and functioning. In a growing number of systems, it is neither.

Consider what a clinician actually needs in order to practice. A site of care that is open and solvent. A service line that has been designed, staffed, and resourced. A schedule, a payer contract, an EHR configuration, a supply chain, a compliance program, and a budget. Every one of those is the product of leadership decisions. A physician cannot see a single additional patient in a service line that no one built, a site that closed for lack of an operator, or a department whose director seat has sat empty for four months.

The clinical workforce is downstream of the leadership workforce. When we treat the first as the whole problem and the second as a given, we misdiagnose the system.

SECTION 2

The leadership shortage hiding in plain sight

If the physician shortage is the most-measured number in healthcare, the leadership shortage may be the least. There is no single headline figure for it, which is precisely why it is underestimated. Assemble the available evidence, though, and the shape is unmistakable: demand for healthcare leaders is surging, the sitting cohort is turning over and retiring, and the pipeline behind them is dangerously shallow.

Start with demand. The Bureau of Labor Statistics projects employment of medical and health services managers to grow **29%** from 2023 to 2033, adding roughly **160,600** jobs, with about **61,400** openings each year across the decade.[2] That is close to ten times the growth rate projected for the average U.S. occupation. Health systems are consolidating, diversifying into new sites and value-based models, and layering in technology and compliance demands that did not exist a decade ago. Every one of those shifts multiplies the number of leadership seats a system must fill, and raises the bar for who can fill them.

Now look at supply, and the picture inverts. At the top of the house, hospital CEO turnover has run near **16%** a year in recent reporting from the American College of Healthcare Executives, and historically has swung between 16% and 20%.[3] More recent tracking suggests the trend is turning back up: one firm counted **111 hospital CEO exits in 2025**, and the first quarter of 2026 ran roughly a third ahead of the prior year.[4] A one-in-six annual turnover rate at the very top of an organization is not a rounding error. It means the average system is running a permanent, rolling search for its most consequential role.

29%
Projected growth in healthcare management jobs, 2023–2033[2]

~16%
Annual hospital CEO turnover rate[3]

31%
Of nurse leaders expect to be in a different role within a year[6]

The pressure is not confined to the CEO office. In nursing leadership, a 2024 survey found that **31%** of nurse leaders expected to be in a different role within a year, whether moving organizations, leaving administration, or exiting nursing altogether.[6] Chief nursing officer searches have become some of the hardest in the market, precisely as the clinical nursing shortage makes strong nurse leadership more essential, not less.

And an aging leadership cohort compounds all of it: a substantial share of nurse executives expect to retire or shift to consulting by 2030.[10]

Behind the sitting leaders, the bench is not being built fast enough. Industry surveys of succession readiness are sobering: a minority of healthcare organizations report a formal succession plan, and a majority of HR leaders say they lack a structured pipeline for clinical leadership roles.[10] Meanwhile a large share of current executives, by some surveys a majority, expect to retire or change roles within three years.[7,10] High demand, high turnover, high retirement, thin pipeline. That is the anatomy of a shortage, whether or not anyone has printed a single number on the cover of a report.

> *The physician shortage has a number, a lobby, and a national strategy. The leadership shortage has none of the three, which is exactly why it is more dangerous.*

SECTION 3

The cascade: why one empty seat becomes five

Leadership turnover behaves differently from clinical turnover, and understanding the difference is the key to seeing its true cost. When a staff nurse leaves, the organization loses one unit of capacity and fills it from a labor pool. When a CEO leaves, the organization does not lose one seat. It destabilizes the entire executive team, and often the strategy those executives were carrying.

The evidence for this cascade is direct. ACHE's own research on the impact of hospital CEO turnover found that within one year of a CEO's departure, the chief medical officer also changed roughly **77%** of the time and the chief operating officer roughly **52%** of the time.[5] A single exit at the top routinely takes two more senior leaders with it inside twelve months. New chief executives bring their own teams, in-flight initiatives stall, and institutional knowledge walks out in waves rather than one at a time.

Exhibit A · The turnover cascade following a hospital CEO departure

TRIGGER	DOWNSTREAM EFFECT WITHIN ~12 MONTHS	CONSEQUENCE
CEO exit	CMO turns over ~77% of the time; COO ~52% of the time[5]	Executive team rebuilt, not repaired
Strategy reset	New leadership pauses or reverses in-flight initiatives	Growth projects and capital plans stall
Culture & morale	71–85% of departing CEOs saw staff morale, medical-staff and community relations suffer[5]	Clinician retention weakens
Oversight gaps	Interim periods create lapses in control and compliance	Elevated risk of error and closure[5]

The instability is not only about who leaves, but for how long anyone stays. The average tenure of a hospital CEO is roughly **five years**, well short of the seven-plus years common at large public companies in other industries.[5] Five years is often less time than it takes to design and fully realize a service-line expansion, a facility build, or a multi-site integration. Systems that turn their top leader over on that cycle are effectively resetting strategy before the last strategy could mature. Continuity, the quiet

precondition of every long-horizon investment in care, becomes the exception rather than the norm.

Departing executives see the damage clearly. In ACHE's research, between **71% and 85%** of hospital CEOs reported that community relations, medical-staff relations, organizational culture, and employee morale suffered as a result of their departure.[5] These are the exact conditions that determine whether clinicians stay. A leadership vacancy, in other words, is not a quiet gap at the top of an org chart. It is a shock that propagates downward into the working lives of the clinical staff the organization is fighting so hard to keep.

SECTION 4

What a leadership vacancy actually costs

Executives are trained to weigh the cost of a hire. Far fewer weigh the cost of a vacancy, which is usually larger and almost always hidden. The price of an empty leadership seat shows up in three places: the direct cost of replacement, the operational cost of the gap, and the strategic cost of the momentum lost while the seat is open.

The direct cost of replacement

Replacing a senior professional is not a fraction of their salary; it is a multiple of it. Widely cited estimates put the fully loaded cost of replacing a highly educated executive at around **213% of annual salary** once search, onboarding, ramp time, and lost productivity are counted.[7] On a $200,000 executive, that is roughly **$426,000**. A failed leadership hire, the one that does not survive the first year, can cost **50% to 200%** of that leader's salary again in severance, restarted search, and disruption.[7] At the whole-organization level the numbers are staggering. One widely referenced retention analysis estimated the average hospital lost about **$8.55 million** in a single year to turnover-related costs across its workforce.[8]

The operational cost of the gap

Leadership seats do not fill quickly. In healthcare, executive and director vacancies routinely last **60 to 120 days or longer**, and the most specialized roles far exceed that.[7] While the seat is open, the work does not pause. It gets absorbed by an interim, spread across an already-stretched team, or simply left undone. Budgets drift, overtime climbs, decisions queue, and the organization pays for the absence every single day in ways that never appear on a recruiting invoice.

~213%
Of salary to replace a senior executive (fully loaded)[7]

$8.55M
Average annual hospital turnover cost, all roles[8]

60–120+
Typical days a healthcare leadership seat sits open[7]

The strategic cost of lost momentum

This is the largest cost and the hardest to invoice. A leadership vacancy is a pause button on everything that leader was driving. The new service line does not open on schedule. The acquisition integration slips. The payer negotiation is handled by

someone holding the seat temporarily and without a mandate. Growth that was months from paying off is deferred into next year, or abandoned. In the most severe cases the research is blunt: CEO turnover and short tenures have been associated with an increased risk of hospital closure, as leadership gaps produce lapses in oversight and strategic drift at exactly the wrong moment.[5] The empty seat does not just cost what it costs to fill. It costs everything the organization could not do while it was empty.

> *The most expensive leadership decision is almost never the salary you pay a strong leader. It is the revenue, the retention, and the growth you lose during the months you had no leader at all.*

SECTION 5

The evidence that leaders move the needle

It would be easy to treat all of this as intuitive and move on. But the case for leadership as a strategic priority does not rest on intuition. There is a body of research linking the quality and character of leadership to measurable organizational performance, and it is worth taking seriously, because it reframes leadership spend from overhead into one of the highest-leverage investments a health system can make.

The most striking findings concern clinically fluent leadership. Research examining hospital performance has found a strong association between the ranked quality of a hospital and whether it is led by a physician, with physician-led hospitals showing lower in-hospital mortality for certain conditions and higher patient-satisfaction measures.[9] The mechanism is not mysterious. Leaders who can speak both the language of the clinician and the language of capital make better tradeoffs at the exact points where care quality and financial reality collide. The findings on pure financial metrics are more mixed, and honesty requires saying so: some analyses find no clear revenue or margin advantage.[9] But on the quality and workforce dimensions that increasingly determine reimbursement and reputation, the direction of the evidence is consistent.

WHY THE DYAD WORKS

The strongest operating model many systems have found is not physician-versus-administrator but physician-and-administrator. When a clinical leader and an operational leader share a mandate, the evidence points to improved clinical care, better operational performance, and stronger system-level decisions than either discipline achieves alone. The scarce, valuable profile is the leader who can hold both perspectives, or partner seamlessly with someone who holds the other.

The same logic runs through the succession research. Industry analyses suggest that organizations with strong succession strategies are meaningfully more likely to sustain quality outcomes and hit growth targets than those without one.[10] This is the positive mirror image of the cascade in Section 3. Where leadership is deep, stable, and deliberately developed, the organization compounds advantage. Where it is thin, reactive, and perpetually mid-search, the organization compounds disadvantage. Leadership is not a neutral line item that a strong clinical staff can paper over. It is the multiplier, up or down, on everything the clinical staff does.

Put the two halves of this paper together. Section 4 established what the absence of leadership costs. Section 5 establishes what its presence is worth. The gap between those two numbers, the cost of the empty seat versus the value of the right leader in it, is the return on getting leadership talent right. For most health systems it is the single highest-return decision available to them, and the one least likely to appear in a workforce plan.

SECTION 6

Why the gap is accelerating

A shortage that is merely large is a problem you can plan around. A shortage that is widening while the job itself gets harder is a different order of challenge, and that is the situation healthcare leadership is in. Three forces are pulling the supply of qualified leaders down and the bar for the job up at the same time.

The retirement wave is here, not coming

The generation that has run American health systems for two decades is exiting. That exit is concentrated at the senior level, where experience is deepest and hardest to replace, and it is landing at the same moment that BLS projects healthcare management demand growing **29%** through 2033.[2] Rising demand meeting accelerating retirement, with a thin pipeline in between, is the textbook setup for a sustained shortage rather than a temporary tight market.

The job is harder than the job used to be

The healthcare executive of 2026 must operate under conditions the executive of 2006 never faced. Value-based arrangements such as PACE, I-SNP, and post-acute risk reward an operator profile that fee-for-service never selected for. Behavioral health and substance-use platforms have drawn a wave of capital and now need operators who can run them at scale. Private equity ownership has raised the tempo and the accountability of leadership across whole segments of the industry. Artificial intelligence and digital tools are arriving faster than the leaders who know how to deploy them, making adoption a leadership challenge as much as a technical one. Each of these shifts narrows the pool of leaders who can actually do the modern job.

Exhibit B · Forces widening the leadership gap

FORCE	EFFECT ON SUPPLY OF QUALIFIED LEADERS	EFFECT ON THE JOB
Retirement wave	Removes the most experienced cohort	Erases institutional knowledge
Value-based & new sites of care	Fewer leaders with the right operating experience	Rewards a different operator profile
Behavioral health & PE capital	Demand outruns the pool that can run platforms at scale	Raises tempo and accountability
AI & digital adoption	Few leaders fluent in both care and technology	Makes adoption a leadership problem
Thin succession pipeline	Little internal bench to backfill[10]	Forces external, slower, costlier searches

The pipeline was never built to backfill this

For years, leadership development was something organizations did when there was slack. There is no slack now. With a minority of organizations reporting formal succession plans and a majority of HR leaders reporting no structured pipeline for clinical leadership roles, most systems are meeting an accelerating shortage with an infrastructure built for a calmer market.[10] The result is predictable: more searches, run externally, taking longer, costing more, and filling seats that a healthier pipeline would have filled from within. The gap is not just wide. Left alone, it widens.

SECTION 7

What the best organizations do differently

The organizations that will come through the next decade intact are not the ones with the deepest clinical rosters alone. They are the ones that treat leadership talent as the strategic asset it is, and manage it with the same rigor they apply to their balance sheet. Five practices separate them from the field.

1. Build the bench before the seat is empty

The single highest-return move is also the least urgent-feeling, which is why it is so often skipped. Organizations that identify and develop the next two levels of leadership before a vacancy occurs convert the cascade in Section 3 from a crisis into a transition. Succession planning is not an HR formality. It is the difference between promoting a prepared internal leader in weeks and running a four-month external search while the work goes undone.

2. Treat time-to-fill as a financial metric

If a leadership seat costs the organization real money every day it is open, then time-to-fill belongs on the same dashboard as days-in-A/R. The best systems measure it, own it, and resource against it, rather than treating each vacancy as an unfortunate surprise. A search started the week a resignation lands, not the month after, pays for itself many times over.

3. Recruit for the job as it is now, not as it was

Given the forces in Section 6, the leader who succeeded in a fee-for-service, single-site world is not automatically the leader who will succeed in a value-based, multi-site, capital-backed one. The organizations that win are deliberate about the operator profile the modern role demands, and they widen their search beyond the obvious internal-industry candidates to find it.

4. Invest in clinically fluent leadership

The evidence in Section 5 argues for deliberately developing physician executives and building genuine dyad partnerships rather than leaving clinical-operational fluency to chance. The leaders who can speak clinician and speak capital are the rarest and most valuable profile in the market, and the systems that grow their own, or recruit them intentionally, hold a durable advantage.

5. Use interim leadership as a bridge, not a band-aid

When a gap does open, strong interim leadership preserves momentum and buys time to run the permanent search properly, rather than making a rushed hire under pressure, the failed-hire scenario that costs 50% to 200% of salary all over again.[7] The point is not to avoid vacancies entirely, which is impossible. It is to make sure a vacancy never becomes a vacuum.

> *You cannot out-recruit a leadership shortage one emergency search at a time. You can only out-build it, by treating the bench as strategy and the empty seat as the risk it actually is.*

CONCLUSION

The real bottleneck

The physician shortage will remain a defining story of American healthcare, and it should. But it is not the whole story, and treated as the whole story it leads organizations to under-invest in the very capability that determines whether they can use the clinicians they fight so hard to recruit.

The argument of this paper is that the leadership shortage is the shortage behind the shortage. It is arriving faster than the industry admits, it costs more per seat than almost any clinical vacancy, it cascades when it strikes, and its presence or absence is measurable in the outcomes that increasingly decide reimbursement and survival. A system that fills every clinical role but cannot keep a stable, capable, clinically fluent leadership team in place has not solved its workforce problem. It has simply moved the failure point upstream, to the seat where the most damage is done.

The organizations that understand this will do something the rest will not. They will put leadership talent on the strategic agenda alongside capital, quality, and growth, because it is upstream of all three. They will build the bench before the seat is empty, measure the cost of the gap, and recruit for the job the future actually requires. In a decade defined by shortage, that is the decision with the highest return and the least competition, because so few are making it. The scarcest resource in healthcare is leadership. The organizations that treat it that way will be the ones still standing to use every clinician the country manages to train.

About the author

Lee Fossey is US Sector Head, Healthcare, at ISG-Americas, where he advises health systems, behavioral health and post-acute operators, private-equity sponsors, and their portfolios on the executive and physician-leadership talent that determines whether they scale or stall. His focus is the leadership layer of the healthcare workforce: the C-suite, clinical-executive, and multi-site operating talent that the industry counts least and needs most. From the boardroom to the bedside.

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Figures are drawn from the sources above as of publication. Ranges reflect the underlying studies. Where figures originate in industry surveys rather than federal data or peer-reviewed research, they are presented as indicative and attributed accordingly.