AMN Healthcare | B.E. Smith LEADERSHIP SOLUTIONS

The New Economics of Pediatric Specialty Care

Why Children's Hospitals Are Redesigning Care Delivery

Executive Summary

Pediatric subspecialist shortages now constrain care delivery across children's health systems and traditional recruiting tactics no longer solve the problem. AMN's quantitative and qualitative interviews with senior leaders at major U.S. Children's Health Systems point to five forces reshaping pediatric specialty care.

1. **A fellowship pipeline that cannot keep up with demand**
2. **Reimbursement models that fail to support the highest-need specialties**
3. **Accelerating need and concentration of pediatric specialty care**
4. **Physician expectations moving toward flexibility and greater control over work**
5. **Policy and geographic headwinds that limit how quickly hospitals can expand capacity**

Nearly 90% of organizations report vacancies that take 9 months or longer to fill, and 55% say time-to-fill has worsened over the past three years.

The economic pressure falls hardest on the specialties with the greatest need. In the survey, Developmental Behavioral Pediatrics ranked highest in projected need, followed by Pediatric Anesthesiology, Child and Adolescent Psychiatry, Pediatric Neurology, and Pediatric Pulmonology. Yet many operate under weak reimbursement conditions. Hospitals with significant Medicaid influence on staffing strategy average a 19.4% vacancy rate, compared with 5.5% among those reporting no Medicaid influence. Recruiting alone does not change the underlying economics.

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AMN's research also reveals a bifurcated market changing how hospital leaders operate. Pipeline owners, i.e., large academic and destination systems with fellowship programs, attract talent through prestige, research infrastructure, and institutional reach. Pipeline buyers, i.e., mid-size, rural, and community-based systems without internal training pipelines, differentiate instead through speed, customized roles, and greater control over careers. Organizations that misread their market position often compete on the wrong terms.

Health systems making progress approach the problem in three ways:

- **Competing more selectively for scarce talent and customizing offers around candidate priorities**
- **Building Advanced Practice Provider (APP)-led and team-based models that move routine and lower-acuity care away from physician panels**
- **Replacing the traditional full-time, fully relocated employment approach with fly-in coverage, shared appointments, fractional FTEs, and regional partnerships**

The organizations best positioned for the next decade are already moving past hiring alone. They are rethinking how pediatric specialty care is staffed, distributed, and supported in a market where subspecialist scarcity has become a lasting workforce shortage. Meaningful progress begins when leaders recognize the crisis for what it is: a structural market problem that recruitment alone cannot solve.

90%
of organizations report average time-to-fill of nine months or longer.

55%
say the problem has worsened. Only **10%** report improvement.

47.8
average additional subspecialists that each organization would hire if financial constraints disappeared.

73.5
The largest organizations report 73.5 desired-but-unfilled positions.

66%
of respondents say 10–27 pediatric subspecialties require institutional subsidy.

23%
say every subspecialty requires subsidy.

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Introduction

Executives at children's hospitals have lamented the same crisis for years. Too few fellows enter hard-to-fill specialties. Financial hurdles limit how far they can compete on pay. Demand concentrates in too few institutions. AMN launched this research to test whether these issues reflected isolated breakdowns in recruitment or a broader reworking of how pediatric care is delivered — and what leading health centers are doing in response.

The answer was clear. The growing shortage of pediatric subspecialists stems from challenges pervasive across the entire system — limited training pipelines, changing physician expectations, uneven talent distribution, and reimbursement structures that don't match demand. No hiring cycle or compensation approach can solve those burdens on their own.

Methodology

AMN conducted the study from April 10 to 27, 2026, combining a quantitative survey of 30 senior decision-makers with 12 semi-structured executive interviews. Respondents included Children's Hospital CEO's, COO's, Pediatric Department Chairs, Pediatric Department Administrators, Pediatric Division Chiefs, and Vice Presidents of Physician Recruitment across major U.S. Children's Health Systems. Interview participants were selected to reflect varied geographies, organizational structures, and institutional types, with findings analyzed thematically in aggregate.

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A Structural Problem, Beyond Recruiting

For years, children's hospitals approached subspecialty vacancies like traditional recruiting challenges. Open the position. Post the role. Raise the salary. Repeat the process. But that strategy now delivers diminishing returns.

> ***"We're not going to recruit our way out of this."***
>
> *— CEO, Large Pediatric Health System*

Our research found that the fellowship pipeline is the top barrier to staffing, cited by 23 out of 30 respondents. Training growth continues to cluster around hospital-based and procedural specialties, while needs increase in developmental behavioral pediatrics, child and adolescent psychiatry, pediatric neurology, and pulmonology.

The economics intensify the disparity between demand and staffing. Needs keep rising in specialties with some of the weakest reimbursement support. Medicaid-heavy subspecialties, meanwhile, carry high staffing needs and thin margins, forcing hospitals into an unsustainable financial position.
And this financial strain stretches across pediatric specialty care. In our survey, 23% of respondents said every subspecialty requires institutional subsidy, while 66% said between 10 and 27 subspecialities do. With 50% of children covered by Medicaid, said one CEO of a large pediatric health system, *"I can't negotiate a contract to increase salaries."*

When supplemental Medicaid payments are fully accounted for, Medicaid can become one of the strongest payers on a net basis. But many children's hospitals still separate supplemental Medicaid payments from compensation strategy and workforce investment decisions.

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As a result, systems may undervalue pediatric care even when Medicaid performs more favorably on a net basis than commonly assumed. That disconnect weakens recruitment, retention, and long-term workforce planning. At the same time, visa friction, GME funding limits, telehealth licensure rules, and APP scope-of-practice laws restrict subspecialist supply and limit the alternative care strategies hospitals can use to extend capacity.

Even as demand rises, community hospitals and adult networks continue to pull back from pediatric specialty care, pushing higher-acuity patients toward children's hospitals.

Academic children's hospitals often carry the heaviest workforce burden. In our survey, community hospitals reported shorter time-to-fill, lower vacancy rates, lower turnover, higher acceptance rates, and stronger pay positioning than their academic counterparts. The data also suggests workforce shortages can become self-reinforcing, with institutions already stretched facing higher vacancy rates, greater reliance on non-FTE staffing, and weaker recruiting leverage.

The pattern shows up in the data as well. Higher vacancy rates were linked to longer times-to-fill, suggesting that employers with the greatest gaps in staffing may face the hardest path to recovery.

A Tale of Two Markets

Our research points to a more divided pediatric subspecialist market, with different health systems navigating very different workforce realities.

Pipeline owners, typically, large academic and destination centers, control fellowship programs and produce their own supply of trainees. They attract and retain talent through prestige, size, infrastructure, and academic reputation. But academic governance and budget cycles often slow their response.

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Even with brand, philanthropy, pipelines, and infrastructure, these employers still face a long time-to-fill, high compensation burden, and cost-of-living barriers in many destination markets.

Pipeline buyers, on the other hand, operate under very different constraints. Mid-size, community-aligned, and non-destination hospitals lack internal training pipelines and rely more heavily on non-FTE labor. Across our survey, non-FTE staffing averaged roughly 20%, while the smallest tier averaged 35%, compared with 12% for the largest tier. In some cases, reliance reached as high as 90%. These providers rely on customized staffing arrangements, including fractional FTE arrangements, fly-in coverage, reduced call structures, hybrid roles, and flexible scheduling. Several executives described these redesigns as operational necessities rather than innovation initiatives.

**Smallest Tier is represented by hospitals employing <100 subspecialist FTEs, while the Largest Tier employed 200-299 subspecialist FTEs.*

> ***"Challenges in the workforce and market economics require us to rethink traditional delivery models and design care that is innovative and scalable using technologies and flexible team operating structures to ensure long-term sustainability."***
>
> *— CEO, Large Pediatric Health System*

But the workforce strategy depends heavily on market position. Destination systems are strongest when they lean into prestige, infrastructure, and career pathways — admittedly, their advantages. Non-destination hospitals are better positioned as offering the benefits larger institutions cannot accommodate, such as customized roles, mission, leadership access, geography, and greater control over scheduling and practice structure.

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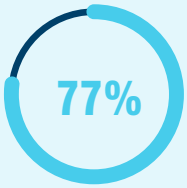
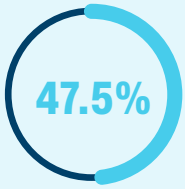
The New Workforce Strategy

Compete Harder, But More Precisely

Pay packages remain the strongest driver of offer acceptance. In our survey, organizations rating themselves as competitive reported acceptance rates of 76% to 77%, compared with 47.5% among those significantly below market.



ACCEPTANCE RATES
COMPETITIVE ORGANIZATIONS



ACCEPTANCE RATES
SIGNIFICANTLY BELOW MARKET ORGANIZATIONS

And this financial demand continues to rise. Twenty-five of 30 respondents, or 83%, reported pay escalation in hard-to-fill specialties. Another 28% said compensation had escalated across all pediatric subspecialties.

PAY ESCALATION
HARD-TO-FILL SPECIALITIES

COMPENSATION ESCALATION
ALL PEDIATRIC SUBSPECIALITIES

Destination systems often compete through broader institutional support, including academic backing, housing assistance, spousal placement, leadership pathways, and career development. Non-destination hospitals, on the other hand, compete through flexibility and customization, shaping their roles around candidate priorities instead of forcing them into rigid structures. Increasingly, that broader redesign extends beyond individual recruitment. As one C-suite executive explained, organizations can no longer *"think about hiring one person anymore." "It has to be a system approach,"* they said.

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Redesign Care Pathways

Among care redesign strategies, APP-led clinics received the highest weighted survey score at 90, followed closely by physician-APP team-based approaches at 87. Together, they outranked telehealth, e-consults, and AI-enabled decision support combined.

Many institutions have moved APP deployment beyond supplemental staffing. APPs now manage longitudinal and lower-acuity care, freeing physicians to focus on more complex patient care.

But APPs represent only one part of the redesign. To manage growing patient demand, destination systems use multidisciplinary clinics, centralized triage, embedded APP models, subspecialty hospitalists, and remote support. Yet, when recruiting full-time is unrealistic, non-destination networks instead maintain access through hub-and-spoke models, telehealth, shared specialists, and a heavier reliance on generalists.

While technology can extend capacity, our research does not position telehealth or AI-enabled decision support as substitutes for workforce redesign. After all, even well-designed care structures can stall without physician buy-in and referral alignment. Physicians may resist shared clinical responsibility, while referral patterns may bypass APP-led services, and governance structures may restrict scope. Hospitals that scaled APP-led care successfully addressed culture, referrals, and physician alignment early. In many specialties, that kind of redesign has become necessary because physician supply alone cannot keep pace with demand. *"You'll never be able to serve this patient population with psychiatrists and developmental pediatricians,"* said one pediatric physician executive. *"You have to develop a care model which will be flexible and innovative."*

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Restructure the Employment Model

The traditional physician employment model, e.g., full-time, fully relocated, physician-centric, no longer aligns with how many younger subspecialists want to work.

Many now build portfolio careers that combine partial FTE arrangements, locum coverage, hybrid academic roles, remote work, and flexible scheduling. That change creates a double supply shock. Certain subspecialties are losing ground on both supply and capacity, with fewer physicians entering the field and, in some markets, fewer clinical hours from those already practicing.

Leading non-destination systems have responded with *"FTE 2.0,"* using fly-in coverage, shared appointments, hybrid academic-clinical roles, and flexible call structures that allow scarce subspecialists to cover wider geographies without permanent relocation.

For many smaller and rural institutions, these models now function as core operating structures rather than temporary workarounds.

> ***"If we don't change how we deliver care, we're not going to keep up."***
>
> — *Pediatric Medical Group C-Suite Leader*

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Strategic Implications for Hospital CEOs

Health networks falling behind often respond to workforce shortages through recruiting alone, rather than rethinking how care is staffed and delivered. Instead of rethinking how care is staffed and delivered, they optimize it. But as structural pressures intensify, that approach may widen the divide between stronger and weaker programs.

Hospital executives should start with latent demand. AMN's survey found average latent demand of 47.8 subspecialists per organization, while the largest programs reported 73.5 desired-but-unfilled positions. Those gaps represent both access failures and capital allocation decisions.

47.8 AVERAGE LATENT DEMAND SUBSPECIALISTS PER ORGANIZATION

73.5 DESIRED-BUT-UNFILLED POSITIONS

Leaders also need to know which market they occupy. The pipeline owner/buyer distinction determines where recruitment dollars produce returns. Pipeline buyers often gain more by competing on flexibility, customization, and speed than by chasing prestige.

What's more, APP deployment requires executive attention beyond clinical operations. Organizations that scaled APP-led models addressed physician culture, referral behavior, and governance early. When that alignment is missing, even strong care structures may remain underused.

Medicaid economics deserve the same scrutiny. Many children's hospitals continue separating supplemental Medicaid payments from compensation tactics, potentially undervaluing pediatric subspecialty work and weakening recruitment and retention.

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Retention strategy also requires more precision. Below-market employers often face internally generated turnover tied to compensation, workload, or operational strain. At-market employers more often battle external poaching. Leaders who blur those differences risk deploying the wrong interventions.

> ***"We're constantly reacting... instead of getting ahead of it."***
>
> *— C-Suite Physician Executive, Pediatric Health System*

Conclusion

Children's hospitals built pediatric subspecialty programs around a workforce model that no longer matches the market. The traditional approach depends on the supply of physicians that no longer exists.

The data suggest a different future. Demand is concentrating faster than supply can grow. The specialties that families need most often carry the weakest economics. And many physicians entering the field now favor flexible careers that blend clinical, academic, remote, and locum work.

Hospital leaders now face a set of decisions many institutions have delayed for years. They will need to decide which services require physician capacity, which can be redesigned around APPs or teams, which markets can support full-time employment, and which require shared or regional approaches. They also need a more honest view of Medicaid economics, latent demand, and the competitive position they occupy in the market.

Leaders who make those decisions deliberately will have more control over access, growth, and workforce stability. Those that keep trying to fill yesterday's roles in yesterday's model will find the market has already moved on.

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