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Challenges for the Beleaguered Health Care Workforce During COVID-19

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Two years after it first appeared, COVID-19 continues to affect the population's health and the world economy. The good news is that recent waves of COVID-19 appear less likely to cause severe cases of disease compared with prior waves. As the health situation has improved, the economy has recovered as well—though only partially. A tremendous amount of dislocation remains, and working through the economic situation will be challenging.

Unfortunately for clinicians, health care businesses have been buffeted as much as any business. For decades, health care seemed immune from economic shocks[1] but that is no longer true.[2] Thus, physicians will continue to face the double burden of sick patients and practice-associated turmoil.

Burnout and the Great Resignation

Among health care workers, burnout is emerging as a central issue. In one recent survey, 55% of frontline clinicians reported that their experiences during the COVID-19 pandemic have somewhat or significantly reduced their interest, willingness, or ability to continue working in their field.[3] About 35% forecast they were not at all or only a little likely to still be working in the field in 5 to 10 years. Burnout has long been an issue for clinicians, but it has increased.

This trend mirrors the economy as a whole, where workers who interact directly with the public are suffering from burnout. From fears of becoming sick, to dealing with unruly customers, to the stress of juggling work and childcare, to dissatisfaction with inflexible work hours, people are quitting their frontline jobs. Economists have termed the high rate of job leaving the "Great Resignation." Nationally, employment is down about 5 million workers (roughly 3%) from levels prior to COVID-19. Some of this is explainable by population aging and some by lower immigration. About half is unexplained, a combination of burnout, low wages, and unappealing job prospects.

Job resignation has increased particularly rapidly in low-wage occupations, which includes a surprising number of jobs in the health care sector. Home health aides, licensed practical nurses, and personal care aides all earn low wages and many are leaving health care. Overall employment in home health care and nursing homes is down 12% from prepandemic levels.

Wage and Price Increases

The supply of health care workers is falling at the same time that demand for health care workers is high. After dropping off during the first months of the pandemic, use of medical care has returned to near-normal levels[4] (nursing homes being an exception). Organizations thus need their full slate of workers prior to COVID-19 plus additional workers to fill in for those absent because of COVID-19–related reasons.

The result of robust demand for workers and falling supply is wage increases. Health care workers are demanding more pay, reductions in hours, and other benefits. Employers have little choice but to meet these demands. Across the economy, workers in low-wage jobs have seen the largest relative pay increases of any group during the past 2 years.

Even so, the overall reduction in supply leaves clinicians and hospitals stretched. Hospitals and physicians' offices report lower staffing ratios, more overtime, shorter visit lengths, and greater use

of travel nurses. Many cannot discharge patients as rapidly as they would like because there is no space for the patients in postacute care settings.

Although the labor market challenges in health care are similar to those in other industries, some of the adjustment to higher input costs is more difficult in health care. Restaurants can charge more when wages increase. In contrast, health care prices are often negotiated years in advance (as with contracts between physician offices and private insurers) or set administratively, as in public insurance programs. For this reason, there is more concern about health care businesses going under in response to higher labor costs.

This concern should not be overstated, however. Sick patients tend to be more loyal than weekend diners. People are generally willing to move from one restaurant to another. In contrast, patients tend to stay with their physician much longer. Thus, massive health care bankruptcies seem unlikely. That said, many small practices will likely continue their race into bigger groups.[5]

Responding to the Changing Environment

Weathering the COVID-19 storm will require changes in how health care workers are treated. Health care workers take pride in the good work they do, but they experience great frustration in how difficult it is to practice.

At the beginning of the pandemic, pride was the dominant emotion—recall the throngs of people cheering health care workers at the end of each shift. As the pandemic has entered its third year, frustration is replacing it.

If burnout becomes too great and sufficient numbers of personal care aides, nurses, and physicians leave practice, the result could be an implosion of the health care system. Hospitals will be backed up with sick people who cannot be treated or discharged. Physicians' offices will be overwhelmed with people in need. Everyone will suffer.

The way to avoid this dystopian possibility is to have a system that reduces burnout. Requiring more people to be vaccinated is an important step that employers and state governments can take. By keeping health care workers less fearful, vaccination may become essential in avoiding widespread care turmoil.

Similarly, we need to cement positive changes in work conditions that emerged during COVID-19 and address practice frustrations. Consider the experience of telehealth during the pandemic. At the beginning of the pandemic, public and private insurers relaxed rules to allow equal access between physical and telehealth visits. Clinicians had more freedom, and they used it. Physicians and patients—including the most vulnerable ones—benefited.

Some insurers have since tightened telehealth access, and more tightening may be in store. The parity rules for telehealth from the Centers for Medicare & Medicaid Services will expire when the public health emergency ends. If those rules expire, there could be enormous frustration for clinicians and patients. Going back to the old normal will be harmful.

The same is true about billing hassles, prior authorization requirements, and quality reporting. Many of these administrative chores were eased after COVID-19 emerged. Bringing them back as they were will risk even greater burnout.

Thinking about reforming medical care in the midst of COVID-19 is difficult. But not doing so risks an even worse outcome. How will we feel if we finally manage to survive the COVID-19 pandemic, only to find that health care workers want nothing to do with what comes next?

ARTICLE INFORMATION

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