Deaths from COVID-19 are declining, but the pandemic continues to wreak havoc on the health care sector. The challenges resulting from COVID-19 are not exclusively the fault of the health care industry, but the structure of the health care industry has made them worse.

The most recent challenge is to the health care labor force. There are simply not enough workers for all the jobs that health care employers want to fill. This gap is leading to wage increases, putting pressure on hospital and physician margins and reducing access for needy patients.

The reduction in labor supply is partly due to issues related to COVID-19. In 2021 alone, more than 100,000 registered nurses left the labor force. Some workers retired rather than face COVID-19–related workplace risks and stresses. More recently, workers report leaving because of safety concerns unrelated to COVID-19 (such as workplace violence and harassment) and burnout from being asked to do more with less.1 The reduction in immigration begun in the Trump administration has also taken its toll by exacerbating an existing shortage of health care workers.

Overall, health care employment has increased a mere 0.5% from before the COVID-19 pandemic through October 2022, far below the 3.4% in the comparable period before the pandemic. Employment in nursing homes and residential care is down 9.7%. Hospital employment is up a mere 0.2%.

Not having enough workers causes considerable disruptions in providing health care. Patients cannot be discharged from hospitals to post-acute care facilities because there are no workers to care for them. For a similar reason, emergency department boarding is on the rise.2

Health care employers have responded by raising wages. That is normal; wages always increase when demand for labor outstrips supply. The problem in health care is that prices generally do not rise with costs. Thus, rising wages cut severely into margins. Private insurance rates are set up to 3 years in advance. Medicare and Medicaid payments are set legislatively or administratively; neither adjusts automatically to changing economic conditions. Based on data from more than 900 hospitals, the typical hospital had a margin of −1.4% in the first quarter of 2022.3

In an era of high input costs, larger health care systems are generally more profitable than smaller ones and can afford to pay more for labor. Thus, there is a net flow of workers from smaller health systems to their bigger competitors. That would be fine if the movement of labor was to institutions where the care was most needed. But there is no evidence that profitability is related to value.4 Such disparities are also reflected in the travel nursing industry and its institutional clients. Travel nurses, typically employees of last resort, earn high wages. This, in itself, is not problematic. Emergency labor comes at a premium. But in health care, the reliance on emergency labor can be problematic. Those institutions that can afford to hire travel nurses (ie, the richer, higher-priced health care systems) are not necessarily those where nurses are most needed. Again, profitability is not correlated with value. Further, it is not clear that the extra payment is being earned by nurses themselves. Most travel nurses work through travel nursing companies, many of which are owned by private equity companies. These companies are very profitable—sufficiently so that calls for antitrust scrutiny are on the rise.5 At least in part, the labor shortage appears to be lining the pockets of rich investors.

The only system-wide solution to the worker shortage is to increase the supply of workers and reduce the demand for care. Here again, dysfunction in the health care system asserts itself. The...
The easiest way to reduce demand is to care for people at home rather than in institutions. The “hospital at home” model has been around since the 1990s, but uptake has been minimal. Indeed, the use of home care after an acute stay varies enormously in different parts of the country. This variation has been known for years, but little has been done about it—and the persistence of this inaction is especially problematic when resources become scarce.

Increasing the supply of health care workers is similarly difficult. The nation's nursing schools could turn out more nurses, but we have underinvested in training spots. Pay is also an issue, and here health care is hampered by poor policy making in other areas. The cost of living has increased markedly with economy-wide inflation, especially in areas that have been slow to build adequate housing. When the cost of living is so high, even maintaining the current workforce is challenging.

The ultimate irony of health care is that medical treatments change greatly over time, but the structure of the medical system does not. This inertia creates real problems for patients and clinicians when major change is needed. If policy makers and health system leaders cannot figure out how to address this inertia, these problems will continue to fester.

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ARTICLE INFORMATION

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