

CONGRESSIONAL TESTIMONY

The Health Care Workforce Shortage

Testimony before the

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My name is Rachel Greszler. I am a Research Fellow in Economics, Budgets, and Entitlements at The Heritage Foundation. The views I express in this testimony are my own and should not be construed as representing any official position of The Heritage Foundation.

My area of expertise is in economics and labor policies, so I would like to focus first on the unprecedented labor shortage in the U.S. today, including why it exists and how policymakers can help alleviate it.

I will then discuss recent trends in health care employment and provide recommendations for state and federal policymakers to allow the health care workforce to more freely expand to meet growing health care demands.

It is important to note that since state licensing laws serve as the gatekeepers to the health care workforce, the federal government has limited the ability to increase the supply of health care workers. Federal policymakers must take these limits into account to avoid wasting taxpayer dollars.

The Labor Shortage

The U.S. is in the midst of a labor shortage unlike any other in U.S. history. This is affecting every sector of the economy and exists across all levels of jobs. Total employment today is between 4.1 million¹ and 5.3 million² below where it might have been without the pandemic and absent other changes

¹The 4.1 million estimated gap relies on total employment figures from unpublished tabulations from the Current Population Survey (CPS) of the U.S. Bureau of Labor Statistics (BLS).

²The 5.3 million estimated gap relies on total payroll employment figures from the Current Employment Statistics of the BLS. Payroll employment figures are lower than total employment figures in the Current

in economic conditions.³ This employment gap is entirely a labor-supply problem. Without the shortage of willing workers, employment would likely be above trend right now, with an employment surplus instead of a gap.

This is the opposite of what was expected at the start of the pandemic, and in many ways is the result of bad policies that have restricted the supply of willing workers while simultaneously pumping large amounts of deficit-financed federal spending into the economy with the effect of increasing the demand for workers.

Labor Shortage Demographics. Throughout the pandemic, different groups of workers have been affected differently. For example, at the beginning of the pandemic, lower-wage workers and women who were caregivers were more likely to have lost or dropped out of employment, and older workers who were at greater risk from COVID-19 were more likely to stop working.

Table 1 provides a breakdown of the employment gaps for various groups of workers, as measured by the percentage difference between current employment (December 2021) and where it would have been if, absent the pandemic, employment had followed steady-state employment growth.⁴ (All tables and charts are also provided in full-size graphics at the end of this testimony).

Population Survey because they do not include some workers such as the self-employed.

³For methodology of the employment gap, see Rachel Greszler, “What Is Happening in This Unprecedented U.S. Labor Market?, February 2022 Update,” Heritage Foundation *Backgrounder* No. 3684, forthcoming, <http://report.heritage.org/bg3684>

⁴All demographic employment data comes from unpublished tabulations from the Current Population

Employment Gaps by Gender, Presence of Children, and Age

DIFFERENCE BETWEEN ACTUAL EMPLOYMENT LEVELS AND COUNTERFACTUAL EMPLOYMENT TREND,* FEBRUARY 2020 TO OCTOBER 2021

Group	Employment Gap, Individuals	Employment Gap, Percentage	Share of Total Employment Gap
All Workers	-4,137,893	-2.6%	100%
Men	-1,996,801	-2.4%	48.3%
Women	-2,141,091	-2.9%	51.7%
Workers with children	-1,889,868	-3.8%	45.7%
Workers without children	-2,248,024	-2.1%	54.3%
Men with children under 18	-823,138	-3.2%	19.9%
Women with children under 18	-1,066,730	-4.3%	25.8%
Men without children under 18	-1,173,663	-2.1%	28.4%
Women without children under 18	-1,074,361	-2.1%	26.0%
Workers with children 6 to 17, none younger	-1,490,634	-5.1%	36.0%
Workers with children under 6	-399,234	-1.9%	9.6%
Men with children 6 to 17, none younger	-731,803	-5.1%	17.7%
Women with children 6 to 17, none younger	-758,831	-5.2%	18.3%
Men with children under 6	-91,335	-0.8%	2.2%
Women with children under 6	-307,899	-3.1%	7.4%

* Counterfactual trend is based on a definition of steady-state employment growth from the Federal Reserve, equal to monthly growth of about 84,000 (0.053 percent).
 SOURCE: Unpublished tabulations from the U.S. Bureau of Labor Statistics' Current Population Survey. Data should be interpreted with caution as they are based on small sample sizes.

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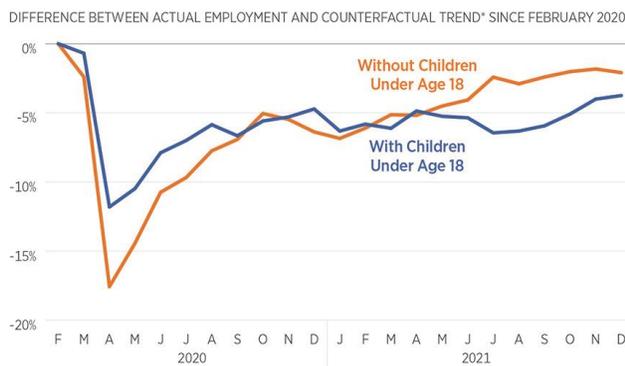
Employment gaps are widespread. Women’s employment gap is slightly higher than men’s, and parents’ gap is significantly higher than non-parents. Notable, however, is that the parental employment gap is entirely the result of lower employment among parents of school-aged children (ages 6–17) as opposed to younger children (under 6). In fact, the 1.9 percent employment gap of workers with young children is lower than the 2.1 percent employment gap of workers without children, and significantly lower than the overall 2.6 percent employment gap. This implies that while parents struggle with finding accessible and affordable childcare, this is not unique to the COVID-19 pandemic and is not a cause of the recent labor shortage.

The rationale for large employment gaps of both men (5.1 percent) and women (5.2 percent) with school-aged children is unclear.

Survey of the BLS. According to the BLS, these data are based on a very small number of observations and should be interpreted with extra caution. For further information on the CPS, see BLS, “Labor Force Statistics from the Current Population Survey: Technical Documentation,” <http://www.bls.gov/cps/documentation.htm> (accessed January 31, 2022).

Initially, parents consistently experienced lower employment gaps than non-parents. That changed in late spring 2021. One factor that could have been weighing on parents' employment in the latter half of 2021 was Congress's passage of the American Rescue Plan including monthly child payments (beginning in July 2021) that were not conditioned on work.

Pandemic Employment Gap by Presence of Children



* Counterfactual trend is based on a definition of steady-state employment growth from the Federal Reserve, equal to monthly growth of about 84,000 (0.053 percent).
 SOURCE: Unpublished tabulations from the U.S. Bureau of Labor Statistics' Current Population Survey. Data should be interpreted with caution as they are based on small sample sizes.

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A study by researchers at the University of Chicago estimated that making the child payments permanent would reduce the labor-force participation and employment of parents by 2.6 percent, which is 1.5 million workers.⁵ With these payments now expired, future economic studies may help reveal the impact of unconditional child payments on parents' work decisions.

Labor Shortage Creating Tremendous Struggles for Employers, Consumers. Businesses across nearly every industry in the United States are desperate for workers and have expanded their pay and benefit packages

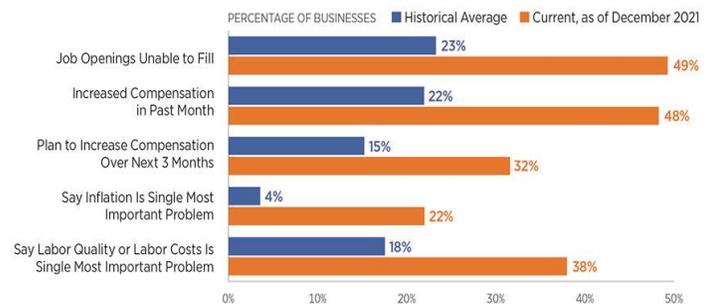
⁵Kevin Corinth, Bruce D. Meyer, Matthew Stadnicki, and Derek Wu, "The Anti-Poverty, Targeting, and Labor Supply Effects of the Proposed Child Tax Credit Expansion," Becker Friedman Institute for Economics at the University of Chicago, October, 2021, <https://bfi.uchicago.edu/wp-content/uploads>

in response to the shortage of willing workers. Yet the number of job openings in the United States remains at record levels, with 10.9 million job openings in December 2021—the equivalent of 1.7 jobs available for each of the 6.3 million unemployed workers.

The current 10.9 million job openings are 3.4 million above the pre-pandemic high (November 2018) and reveal how difficult it is for employers to find the workers they need.⁶ Simultaneously, workers are quitting their jobs at record-high rates. In 2021, 47 million workers quit their jobs, requiring employers to replace 11 million more workers than they had to in 2020, and 14 million more than the average between 2011 and 2020.⁷

With 4.3 million or 2.9 percent of workers quitting their jobs each month over the past six months, this pace translates into employers having to replace 35 percent of their workers (more than one of three) over the course of a year.

Businesses Struggle Amidst Labor Shortages, Rising Costs



SOURCES: National Federation of Independent Businesses, "Small Business Economic Trends Survey," <https://www.nfib.com/surveys/small-business-economic-trends/> (accessed February 1, 2022), and National Federation of Independent Businesses, "Small Business Jobs Report," <https://www.nfib.com/foundations/research-center/monthly-reports/jobs-report/> (accessed February 1, 2022).

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According to the National Federation of Independent Businesses, 49 percent of businesses had job openings that they were unable to fill in December 2021, with 95

/2021/10/BFI_WP_2021-115-1.pdf (accessed February 4, 2022).

⁶BLS, "Job Openings and Labor Turnover Survey," <https://www.bls.gov/jlt/> (accessed February 2, 2022).

⁷Ibid.

percent of those businesses saying that they had no or few qualified applicants.⁸

Adding to Inflation. The labor shortage has caused employers to raise compensation, with a record-high 48 percent of businesses reporting that they increased compensation in December, and another 32 percent saying that they plan to raise compensation over the next three months.⁹ Although hourly pay increased by an above-average 4.7 percent over the past year (December 2020 to December 2021), real average earnings (taking into account the effect of inflation) were down 2.4 percent.¹⁰

When employers have to pay workers more to perform the same jobs, they have to raise their prices, which has contributed to a four-decade high in annual inflation of 7.0 percent in December 2021.¹¹

Causes of the Current U.S. Labor Shortage

While some factors related to COVID-19 may be affecting certain workers' employment, it does not appear that the pandemic itself is weighing significantly on employment. Rather, some of the policies enacted in response to the pandemic have reduced workers' willingness and capacity to work. Maximum employment requires not only that it pay to work, but also that it not pay to not work.

Compensation Is Rising. Wages have been rising and workplace benefits have expanded (though high levels of inflation have reduced the value of wage gains). Over the past decade,

average hourly earnings of all employees in the U.S. increased by 35.3 percent while average hourly earnings in health care increased 32.5 percent. Within the health care sector, average hourly earnings at hospitals rose 34.7 percent and earnings at nursing care facilities increased 39.5 percent.

Since the start of the pandemic, in February 2020, overall average earnings in the U.S. have increased 9.9 percent (through December 2021), but health care has experienced significantly larger wage gains of 11.6 percent across all health care, 12.4 percent within hospitals, and 16.1 percent in nursing care facilities.

Welfare-without-work Policies. Various government programs and policies enacted in the name of COVID-19 have made it easier for people to not work, and almost certainly continue to play a role in weak employment, particularly among lower- and middle-wage workers. Those include \$600 weekly bonus unemployment insurance benefits, a 21 percent increase in food stamps, massive expansion in Obamacare subsidies, and an eviction moratorium and rental assistance.

A measure called the reservation wage, which is the lowest wage at which individuals will accept a job, surged 26.4 percent between March 2020 and March 2021 for workers making less than \$60,000 (from \$40,197 to \$50,825). It has since declined significantly as the bonus unemployment insurance benefits ended.

Evidence from past studies of welfare -without-work benefits find that they tend to reduce the

⁸National Federation of Independent Businesses, "Labor Market Challenges Breaks 48-Year Record as Biggest Issue Impacting Small Businesses," November 2021, <https://assets.nfib.com/nfibcom/2021-Nov-Jobs-Report-FINAL.pdf> (accessed date January 12, 2022).

⁹Ibid.

¹⁰BLS, "Real Earnings News Release," Table A-1: Current and real (constant 1982–1984 dollars) earnings

for all employees on private nonfarm payrolls, seasonally adjusted, December 10, 2021, <https://www.bls.gov/news.release/realer.htm> (accessed January 13, 2022).

¹¹BLS, U.S. Department of Labor, Consumer Price Index Summary, December 2021, <https://www.bls.gov/news.release/cpi.nr0.htm> (accessed January 12, 2022).

supply of work, and a recent National Bureau of Economic Research study on the effects of the pandemic unemployment insurance benefits found that they significantly restricted employment.¹²

Federal Spending Spree. The federal government has spent \$6.6 trillion on COVID-19 packages—the equivalent of \$51,600 for every U.S. household. All this deficit-financed spending—over half of which has been purchased by the Federal Reserve—increases the demand for goods and services, which requires more workers to meet those demands.

Vaccine Mandates. Various states, private businesses, and medical facilities began implementing COVID-19 vaccine, or vaccine-and-testing, mandates in the late summer and fall of 2021. The Federal Reserve’s October 2021 Beige Book noted that vaccine mandates were contributing to high turnover and production slowdowns, and that impending “federal vaccine mandates were expected to exacerbate labor problems.”¹³

Comprehensive data does not exist on how many health care workers have lost their jobs because of the vaccine mandate, but employment growth in health care between September 2021 and December 2021 was more than 60 percent below total U.S. employment growth over the same period. Had the health care sector experienced the same growth rate as total employment over just those three months,

there would be 72,900 more health care workers today.¹⁴

This was during a time in which only some states had imposed vaccine mandates on the health care sector, and the legality of the Center for Medicaid and Medicare Services (CMS) vaccine mandate was still in question. With the CMS mandate going into effect across 25 states and the District of Columbia between now and February 28th, the health care worker shortage will almost certainly increase.

The experience thus far of health care providers subject to vaccine mandates shows that they have had a significant impact on employment and operations. While some providers have been able to keep terminations over vaccine requirements down to 0.5 percent or less of its workforce, some providers have had to terminate 2 percent or more of their employees. A sampling of news reports documenting significant effects include:

New York State’s largest health care provider, Northwell Health, had to lay off 1,400 workers—nearly 2 percent of its workforce.¹⁵

The Mayo Clinic fired roughly 700 workers—about 1 percent of its staff—due to the vaccine mandate.¹⁶

UVM Health Networks in New York reported that, “vaccination mandate for healthcare workers has brought long-standing healthcare

¹²Harry J. Holzer, R. Glen Hubbard, and Michael R. Strain, “Did Pandemic Unemployment Benefits Reduce Employment? Evidence from Early State-Level Expirations in June 2021,” National Bureau of Economic Research *Working Paper* No. 29575, December 2021, <https://www.nber.org/papers/w29575> (accessed February 5, 2022).

¹³U.S. Federal Reserve, *The Beige Book*, October 20, 2021, https://www.federalreserve.gov/monetarypolicy/files/BeigeBook_20211020.pdf (accessed October 22, 2021).

¹⁴BLS, “Employment, Hours, and Earnings from the Current Employment Statistics Survey,” available for

download at <https://www.bls.gov/data/> (accessed February 2, 2022).

¹⁵Joseph Choi, “Largest New York Health Care Provider Fires 1,400 Employees over Vaccine Refusal,” *The Hill*, October 4, 2021 <https://thehill.com/homenews/state-watch/575283-largest-new-york-healthcare-provider-fires-1400-employee-over-vaccine> (accessed February 5, 2022).

¹⁶Chantal Da Silva, “Mayo Clinic Fires 700 Workers Who Failed to Comply with Covid Vaccine Mandate,” NBC News, January 5, 2022, <https://www.nbcnews.com/news/us-news/mayo-clinic-fires-700-workers-failed-comply-covid-vaccine-mandate-rcna11004> (accessed February 7, 2022).

staffing shortage into sharper focus.”¹⁷ With 55 employees voluntarily resigning for a variety of reasons since the mandate went into effect and another 30 leaving or being terminated as a result of the mandate, UVM has had to temporarily close units and delay inpatient surgeries by a week.

Mowhawk Valley Health System (MVHS) in New York State had to fire nearly 5 percent of its employees—180 in total—which increased the system’s vacancy rate from 13.7 percent to 17.5 percent, meaning the hospital had only about four employees for every five positions.¹⁸

When vaccine mandates leave hospitals and health care providers short-staffed, this reduces patients’ access to care and can diminish the quality of care they receive. One of my own family members had to take her four-year-old daughter to a hospital in another state, 160 miles away, for emergency diagnosis and surgery because the nearest Children’s Hospital was experiencing significant staffing shortages due to the vaccine mandate.

As a labor policy economist, I have focused this Causes section on the current widespread labor shortage. I include some longer-term causes of health-care-specific labor shortages in the Solutions section.

Health Care Labor Shortage

Shortages of health care workers—especially primary care doctors—existed before the pandemic and are projected to grow drastically

as the population of people ages 65 and older is expected to increase by 50 percent with the aging of the baby boomer population. Older people have more medical problems and more complex problems that result in higher medical utilization and costs.

A 2018 analysis by the Association of American Medical Colleges predicted that by 2030, there will be a shortage of between 42,600 and 121,300 physicians in both primary and specialty care.¹⁹ There are also current and rising shortages in other health care positions such as nurses, home health care workers, and nursing home health aides. Too few health care providers translates into limited access to health care and worse health outcomes.

Prior to the pandemic, health care employment had been growing faster than overall employment, but not fast enough to keep pace with growth in the aging population that consumes the most medical care. Between December 2011 and the start of the pandemic in February 2020, total employment grew by 14.8 percent while health care employment grew 16.7 percent.

Since the start of the pandemic (February 2020 through December 2021), health care employment has been particularly hard-hit, experiencing a 2.7 percent employment decline compared to the overall 2.3 percent workforce decline.

Factoring in where employment would otherwise have been if the economy had experienced steady-state employment growth

¹⁷The University of Vermont Health Network, “UMV Health Network NNY Affiliates Continue to Provide Care Despite Mandate,” Champlain Valley Physicians Hospital, September 28, 2021, <https://www.cvph.org/News/Detail/297> (accessed February 8, 2022).

¹⁸“MVHS Outlines COVID-19 Vaccine Mandate Impact on Health System,” September 28, 2021, <https://www.mvhealthsystem.org/news/2021-09->

[28/mvhs-outlines-covid-19-vaccine-mandate-impact-on-health-system](https://www.mvhealthsystem.org/news/2021-09-28/mvhs-outlines-covid-19-vaccine-mandate-impact-on-health-system) (accessed February 5, 2022).

¹⁹Tim Dall et al., The Complexities of Physician Supply and Demand: Projections from 2016 to 2030 (2018 Update), IHS Markit Ltd., for the Association of American Medical Colleges, March 2018, https://aamc-black.global.ssl.fastly.net/production/media/filer_public/85/d7/85d7b689-f417-4ef0-97fb-ecc129836829/aamc_2018_workforce_projections_update_april_11_2018.pdf (accessed August 24, 2018)

since February 2020, the overall employment gap is 3.5 percent²⁰ and the health care employment gap is 3.9 percent, or 644,000 fewer health care workers than might otherwise have existed absent the employment changes that occurred since the pandemic.

Federal Government’s Role in Health Care Workforce

The federal government has a limited ability to affect the supply of health care workers because state licensing boards regulate who can obtain professional licenses and what medical services they can perform. Nonetheless, the federal government’s role in health care through federally funded health care programs has created barriers to the health care workforce. Many of the rules and regulations of these federal programs affect the supply of the health care workforce.

Significant Control of the Graduate Medical Education (GME) System. The federal government currently spends billions of dollars each year on GME, or residency programs. Prior to the mid-20th century, hospitals usually absorbed the cost of GME without government subsidies, but in the 1960s, federal funding for GME became part of Medicare spending. These federal subsidies were supposed to be temporary, but have become the primary source of GME funding. By providing about \$15 billion in funding per year, it is likely that the federal government has crowded out financing that might otherwise have come from various other stakeholders.

²⁰This employment gap is based on the BLS’s Current Employment Statistics Survey. This is larger than the 2.6 percent gap reported in the demographic data because they include different populations and sample sizes. The demographic data is a survey of workers (not employers), and it has a smaller sample size and also a different method of measuring employment. (The demographic data can include self-reported employment whereas the

The U.S. GME system fails to produce a sufficient number and adequate allocation of doctors to meet Americans’ health care needs. Factors such as a 25-year-old cap on the number of Medicare-funded residency slots and the direct payment of GME funds to hospitals instead of being tied to students’ results is a focus on teaching hospitals’ needs instead of the health care needs of the American population as a whole.

Recent Federal Investments in Health Care and the Health Care Workforce. Pandemic legislation, including the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 and the American Rescue Plan (ARP) of 2021 provided huge investments in the U.S. health care workforce. Some of those investments include \$12.7 billion of increased federal Medicaid matching funds to increase the workforce for home- and community-based services; \$8.5 billion for rural health providers; \$7.0 billion to invest in the public health care workforce; \$1.55 billion to address unmet health care needs and expand health care workforce programs in underserved communities; and about \$250 million for behavioral health workforce expansions.²¹

These recent funds are an enormous investment and will take significant time for their potential benefits to accrue. Congress should focus on ensuring the efficacy and accountability of these funds to meet their designated needs.

Instead of jumping to spend more federal money to increase the health care workforce, policymakers should allow time (with proper oversight) for the existing tens of billions of dollars in investments in the health care

health care and total employment figures mentioned above are based on firms’ payroll employment).

²¹Angela J. Beck et al., “Investing in a 21st Century Health Workforce: A Call for Accountability,” Health Affairs, September 15, 2021, <https://www.healthaffairs.org/doi/10.1377/forefront.20210913.133585/full/> (accessed February 6, 2022).

workforce to play out. Moreover, federal lawmakers should not spend money in areas where existing state-imposed barriers to the expansion of the health care workforce and health care access will prevent those federal dollars from achieving their full value.

Veteran’s Administration Not a Gold-Standard for Care. The federal government’s direct provision of health care through the Veteran’s Health Administration (VHA) and Veterans Affairs (VA) facilities falls short of its delivery of quality, timely, and affordable care.

According to a 2016 report from The Heritage Foundation:

Since 2014, investigations of the Veterans Health Administration (VHA) have revealed glaring issues with the Administration’s policies and practices, including excessively long wait times and secret waitlists for health care at hundreds of Veterans Affairs (VA) facilities. A report from a VA whistleblower²² shows that as many as 238,000 veterans may have passed away before receiving care.²³

The VA is uniquely structured to provide care for veterans and has plenty of need to improve on access, quality, and accountability. The VA should not become a means of expanding the government’s role in health care beyond veterans.

²²Ryan Grim, “Leaked Document: Nearly One-Third of 847,000 Vets with Pending Applications for VA Health Care Already Died,” *The Huffington Post*, July 13, 2015, http://www.huffingtonpost.com/2015/07/13/veterans-health-care-backlog-died_n_7785920.html (accessed June 14, 2016).

²³John O’Shea, “Reforming Veterans Health Care: Now and for the Future,” Heritage Foundation Issue Brief No. 4585, June 24, 2016, <https://www.heritage.org/health-care-reform/report/reforming-veterans-health-care-now-and-for-the-future>.

²⁴Sheena McConnell, Kenneth Fortson, Dana Rotz, Peter Schochet, Paul Burkander, Linda Rosenberg,

Federal Government’s Failed Track Record in Job-Training Programs Evidence It Should Not Enact Health Care Workforce Training Programs. In light of the health care worker shortage, it may be suggested that the federal government embark in health workforce job-training programs. But the federal government has a terrible track record on job-training programs.

A gold standard evaluation of the Workforce Investment Act found that despite the Department of Labor’s directive to provide training for in-demand services, only 32 percent of participants found occupations in their area of training, and the majority of participants—57 percent—did not believe that their training helped them find employment.²⁴ Moreover, individuals receiving the full workforce training were less likely to obtain health insurance or pension benefits, their households earned several thousand dollars less, and they were more likely to be on food stamps than participants who received minimal services.

The National Job Corps Study (a youth job-training program), found that a federal taxpayer investment of \$25,000 per Job Corps participant resulted in participants being less likely to earn a high school diploma, no more likely to attend or complete college, and to earn only \$22 more per week, on average.²⁵

Annalisa Mastri, and Ronadl D’Amic, “Providing Public Workforce Services to Job Seekers: 15-Month Impact Findings on the WIA Adult and Dislocated Worker Programs,” Mathematica Policy Research, May 30, 2016, <https://www.mathematica.org/publications/providing-public-workforce-services-to-job-seekers-15-month-impact-findings-on-the-wia-adult> (accessed February 4, 2022).

²⁵David B. Muhlhausen, “Job Corps: An Unfailing Record of Failure,” Heritage Foundation *WebMemo* No. 2423, May 5, 2009, <https://www.heritage.org/jobsand-labor/report/job-corps-unfailing-record-failure>.

It is not surprising that federal job-training programs are out of touch with the needs of employers in high-demand occupations because politicians and bureaucrats will never know businesses' needs better than employers themselves. Politicians are particularly ill-equipped to understand and meet the needs of the health care industry. Any training efforts they may attempt to undertake would not only be thwarted by existing government regulations, but in the fast-paced and rapid-response health care industry, federal efforts would almost certainly come up a day late and a dollar short.

Solutions to Increase Health Care Workforce, Health Care Access

The severe labor shortage across the U.S. has had disproportionately large effects on the health care workforce, at the same time as the pandemic has increased the demand for health care and required new health care protocols that have made the provision of health care more costly and time-consuming.

Even prior to the pandemic, however, the U.S. faced a shortage of health care professionals. According to the Health Resources and Service Administration, 88 million Americans live in areas designated to have shortages of primary care health professionals.²⁶

Although there are some actions federal policymakers can take to make it easier for international medical professionals to enter the U.S., most barriers to expanding the health care workforce and access to health care rely on removing state-level barriers. No matter how much money the federal government may spend attempting to increase employment in and access to health care, it will be of limited

use so long as states continue to restrict entry into health care occupations and unnecessarily restrict the services health care workers can provide.

There are steps, however, that federal policymakers can take to enable greater flexibility for the health care industry to respond to Americans' health care needs, as well as to remove unnecessary burdens in federal health care programs that limit health care access and prevent more innovative and cost-effective care.

It is also important for the federal government to ensure proper accountability and effectiveness of the tens of billions of federal dollars recently allocated to expanding the health care workforce. This may require the federal government working with states to encourage them to remove barriers to that funding to achieve its intended purposes.

First, Ensure a Well-Functioning U.S. Labor Market

Foundational to expanding the health care workforce—or any sector's workforce—is a well-functioning U.S. labor market with ample participants. For individuals, that requires that it pays to work and does not pay to not work. To help encourage more people to pursue their productive capabilities, policymakers should:

Limit Taxes and Reduce Regulations so that individuals and employers can enjoy higher returns to work (such as greater pay, higher productivity, and increased opportunities).²⁷

Enable Greater Natural Wage Increases by making it easier and less expensive for people to obtain income-enhancing education and

²⁶Health Resources and Services Administration, "Shortage Areas," U.S. Department of Health and Human Services, <https://data.hrsa.gov/topics/health-workforce/shortage-areas> (accessed February 7, 2022).

²⁷Adam N. Michel, "The Tax Cuts and Jobs Act: 12 Myths Debunked," Heritage Foundation *Backgrounder* No. 3600, March 23, 2021, <https://www.heritage.org/taxes/report/the-tax-cuts-and-jobs-act-12-myths-debunked>.

skills, and by eliminating the double tax in investments that boost productivity and wages.²⁸

Make Welfare Work Better Through Work-Oriented Programs that help people achieve independence (and also help break cycles of poverty).

Let People Pursue the Work They Want by not forcing workers into unions, by not enacting laws that prohibit companies from doing business with independent workers, and by clarifying the definition of “employee” across federal laws based on the level of control the individual maintains over his work.

Expand Accessible, Affordable Childcare by allowing parents to use federal childcare subsidies and Head Start funds at a provider of their choice.²⁹

Do Not Increase Government Spending. Passing big spending bills with new unfunded entitlement programs in addition to the recent \$6.6 trillion in COVID-19 spending and atop the \$30 trillion U.S. federal debt would be reckless and further interfere in the already troubled labor market.

Second, Remove Barriers that Restrict the Healthcare Workforce

Abandon Federal Vaccine Mandates. The federal government’s vaccine mandate for Medicare and Medicaid providers extends to

²⁸Jamie Bryan Hall and Mary Clare Amselem, “Time to Reform Higher Education Financing and Accreditation,” Heritage Foundation *Issue Brief* No. 4668, March 28, 2017, <https://www.heritage.org/education/report/time-reform-higher-education-financing-and-accreditation>.

²⁹Rachel Greszler and Lindsey M. Burke, “Rethinking Early Childhood Education and Childcare in the COVID-19 Era,” Heritage Foundation *Backgrounder* No. 3533, September 30, 2020, <https://www.heritage.org/sites/default/files/2020-09/BG3533.pdf>.

about 14 million workers. An October 2021 “Vaccine Monitor” survey from the Kaiser Family Foundation reported that 5 percent of adults say they would leave their job if their employer required them to get a vaccine or get tested weekly, and that figure jumped to 9 percent if weekly testing was not an option.³⁰

While health care workers may be less likely than the general population to quit their jobs over a vaccine mandate, if even 0.5 percent of the 14 million workers subject to the CMS COVID-19 mandate quit, this would result in a loss of 70,000 health care workers.

The federal government should abandon the CMS mandate and instead allow health care providers to set their own vaccination policies, based on their simultaneous goals of providing safe environments and ensuring access to quality care.

Third, State and Federal Lawmakers Need to Remove Barriers to Entry and Eliminate Unnecessary Burdens in Health Care Delivery

Reform the Graduate Medical Education System. Becoming a practicing physician in the U.S. requires between seven and 10 years of education that involves the certification of at least four different medical accreditation boards and councils.³¹ Dr. Kevin Pham explains that while these organizations originally arose “to weed out sham schools and shoddy practitioners,” their safeguards have

³⁰Liz Hamel et al., “KFF COVID-19 Vaccine Monitor: October 2021,” Kaiser Family Foundation, October 28, 2021, <https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-october-2021/> (accessed October 31, 2021).

³¹Kevin Pham, MD, “America’s Looming Doctor Shortage: What Policymakers Should Do,” Heritage Foundation *Backgrounder* No. 3343, September 5, 2018, https://www.heritage.org/sites/default/files/2018-09/BG3343_1.pdf.

become a bottleneck, and the “organizations are becoming monopolistic.”³²

These barriers and the GME system’s reliance on federal funding makes it extremely difficult for smaller and rural community hospitals to sponsor residency programs, which results in a shortage of residency spaces and a misallocation of physicians across the U.S.

Policymakers should improve the GME system by consolidating GME financing into a single funding stream based on the cost of training residents; allocating GME funding management to the states based on agreed-upon criteria; having funds follow the residents rather than the training programs; and by including all stakeholders—not just governments—in GME financing.³³

Moreover, policymakers should break the accreditation monopoly to encourage the development of additional and innovative GME programs.

Allow Provisional Licensing for Medical School Graduates Who Do Not Receive a Residency Position. Completing a residency program is generally necessary for medical school graduates to begin practicing medicine on their own. Yet, between 2014 and 2018, an average of 8,444 medical school graduates per year did not find a position in a residency program (which operates through a monopoly matching system).³⁴ States could potentially utilize the talent of these highly educated individuals by allowing for provisional

licensing of medical graduates to work under the supervision of qualified physicians. A publication by Kevin Dayaratna, Paul Larkin and John O’Shea recommends that such provisional licenses, issued by state licensing boards, should include “earning a medical degree from an accredited medical school, passing the USMLE, and collaborating with a supervising licensed physician.”³⁵

Accelerate Visas for International Medical Graduates (IMGs). According to the Council on Graduate Medical Education, IMGs make up about 20–25 percent of the physician workforce, but visa restrictions and delays limit their ability to come to the U.S. and help fill unmet health care needs. According to the American Medical Association, “The proportion of residency programs sponsoring H-1B visas for training has gradually decreased in the last few years as the immigration requirements are multistep, costly (for the employer), and often complicated with bureaucratic immigration nuances.”³⁶ U.S. immigration laws should make it easier for the U.S. to fill unmet physician needs through International Medical Graduates.

Streamline Entry for Experienced Medical Professionals from Abroad. To obtain a license to practice medicine in the U.S., many experienced doctors from foreign countries have to spend years completing the same type of internship and residency program as U.S. medical school graduates, even though many of those foreign doctors have already completed

³²Ibid.

³³John O’Shea, MD, “Reforming Graduate Medical Education in the U.S.,” Heritage Foundation *Backgrounder* No. 2983, December 29, 2014, http://thf_media.s3.amazonaws.com/2014/pdf/BG2983.pdf.

³⁴Kevin Dayaratna, Paul J. Larkin, Jr., and John O’Shea, MD, “Reforming American Medical Licensure,” *Harvard Journal of Law and Public Policy*, Vol. 42, No. 1, [http://www.harvard-jlpp.com/wp-](http://www.harvard-jlpp.com/wp-content/uploads/sites/21/2019/02/Larkin-Final.pdf)

[content/uploads/sites/21/2019/02/Larkin-Final.pdf](http://www.harvard-jlpp.com/wp-content/uploads/sites/21/2019/02/Larkin-Final.pdf) (accessed February 7, 2022).

³⁵Ibid.

³⁶American Medical Association, “International Medical Graduates (IMG) Toolkit: Types of Visas and FAQs,” International Medical Education, <https://www.ama-assn.org/education/international-medical-education/international-medical-graduates-img-toolkit-types-visas> (accessed February 6, 2022).

similar education and have years of practical experience.³⁷ American medical licensing boards should streamline the process for experienced foreign doctors to practice in the U.S., potentially utilizing a provisional licensing system.³⁸

American medical boards could also establish reciprocity agreements with other countries, so that the U.S. could accept certain levels of education and experience in other countries towards American licensure. Both of these policies would help reduce the shortage of spots in America's Graduate Medical Education system.

Reduce Administrative and Regulatory Burdens. According to Dr. Kevin Pham, “The essential health care interaction occurs between the physician and the patient, and anything that interferes with that relationship makes the best practice of medicine harder.”³⁹ The more time that doctors and medical professionals have to spend complying with administrative and regulatory burdens, the less time they can spend doing what they were trained and desire to do—treating patients.

Excessive regulatory burdens that make it less desirable to work in health care can cause workers to prematurely leave their professions. According to a Physicians Foundation survey,

49 percent of doctors feel often or always burned out, and 58.3 percent of doctors' primary complaints are the paperwork and regulatory burden.⁴⁰ Moreover, almost half of physicians are considering retiring earlier than planned because of reasons related to changes in the health care system. This includes 41.2 percent of physicians younger than 45, and 50 percent of those 46 and older.⁴¹

Some of the most significant administrative burdens include quality-reporting measures, prior authorization requirements, and excessive documentation of details in clinical encounters. For example, an American Medical Association study found that a small, three-physician practice will complete an average of 100 prior authorizations per week. And Medicare requires doctors to recertify durable medical equipment every year for patients with chronic medical conditions, such as insulin pumps for individuals with type 1 diabetes.⁴² The federal government, through the CMS should reduce and eliminate unnecessary administrative burdens.⁴³

Do Not Reduce Home Healthcare Workers Paychecks Through “Dues Skimming.” The Biden Administration seeks to force more workers into unions by extracting union dues from home healthcare workers' Medicare and Medicaid payments, without their consent.

³⁷Dayaratna, Larkin, Jr., and O'Shea, “Reforming American Medical Licensure.”

³⁸Australia's Medical Board provides a promising example whereby foreign medical professionals that are licensed in their own country and have passed the Australian licensing exam or similar equivalent can obtain a provisional license. Provisionally licensed doctors are granted one of four different levels of practitioner supervision, based on their qualifications. After proving their competence, foreign practitioners are eligible to obtain a full medical license.

³⁹Pham, MD, “America's Looming Doctor Shortage: What Policymakers Should Do.”

⁴⁰The Physicians Foundation, 2016 Survey of America's Physicians, Practice Patterns & Perspectives, 2016, pp. 7–17, [https://physiciansfoundation.org/wp-](https://physiciansfoundation.org/wp-content/uploads/2018/01/Biennial_Physician_Survey_2016.pdf)

[content/uploads/2018/01/Biennial_Physician_Survey_2016.pdf](https://physiciansfoundation.org/wp-content/uploads/2018/01/Biennial_Physician_Survey_2016.pdf) (accessed February 8, 2022).

⁴¹The Physicians Foundation, 2016 Survey of America's Physicians, Practice Patterns & Perspectives, pp. 29–33.

⁴²Pham, MD, “America's Looming Doctor Shortage: What Policymakers Should Do.”

⁴³Ibid. This report includes the following recommendations: “Ease policies driving administrative burdens in the form of paperwork requirements; ease documentation requirements for clinical visits; rescind the mandate to use EHRs in order to receive full compensation by Medicare; and respect and support the role the private sector has to play in developing products that meet doctors' needs.”

Docking the paychecks of home healthcare workers’—or any workers’—paychecks and requiring them to cede control over their work to union officials will make healthcare work less attractive. The fact that only 6.1 percent of private sector workers are union members⁴⁴ shows that unions do not benefit all workers, and they would likely prevent some would-be healthcare workers from continuing in their jobs due to the higher costs and restricted autonomy that comes with union membership. No government—federal nor state—should ever require workers to join a union as a condition of performing their desired jobs.

Reform State Licensure Laws and Accreditation Rules. State licensing laws determine who can perform various health care professions within a state. In many instances, state licensure boards function as political monopolies to prevent new entrants into the market, as opposed to public safety protectors. There are many ways states can and should prevent unnecessary licensure barriers, including by taking power away from monopolistic licensing boards, by reducing and eliminating unnecessary licensing requirements, by expanding options for individuals to obtain health care education, and by enacting reciprocity agreements with other states.

Reform State Scope of Practice Laws. Scope of practice laws act as a second barrier to the delivery of health care by restricting the range of health care services and procedures that already licensed professionals can provide, and by requiring varying levels of supervision for these professionals to practice in their field.

Most often, scope of practice laws apply to nonphysician providers such as nurse practitioners, or Advanced Practice Registered Nurses (APRNs). Currently, 25 states plus the District of Columbia provide Full Practice Authority (FPA) for nurse practitioners to perform all of the services and procedures they were trained to perform.⁴⁵ The other 25 states reduce or restrict the ability of nurse practitioners to engage in one or more element of their practice and require career-long collaboration or supervision.

A Federal Trade Commission explains how scope of practice laws can limit the supply of primary health services and restrict competition between different types of practitioners:

Physician supervision requirements may raise competition concerns because they effectively give one group of health care professionals the ability to restrict access to the market by another, competing group of health care professionals, thereby denying health care consumers the benefits of greater competition. In addition, APRNs play a critical role in alleviating provider shortages and expanding access to health care services for medically underserved populations. For these reasons, the FTC [Federal Trade Commission] staff has consistently urged state legislators to avoid imposing restrictions on APRN scope of practice unless those restrictions are necessary to address well-founded patient safety concerns. Based on substantial evidence and experience, expert bodies have concluded that

⁴⁴BLS, “Union Members—2021,” News Release, January 20, 2022, <https://www.bls.gov/news.release/pdf/union2.pdf> (accessed February 8, 2022).

⁴⁵American Association of Nurse Practitioners, “State Practice Environment,” <https://www.aanp.org/advocacy/state/state-practice-environment> (accessed February 7, 2022).

ARPNs are safe and effective as independent providers of many health care services within the scope of their training, licensure, certification, and current practice.⁴⁶

Eliminate State Certificate-of-Need (CON) Laws or Require States to Bear Financial Burden. Imagine if opening a business required procuring detailed analysis and projections, hiring lawyers, lobbyists, and consultants, and convincing existing competitors to not oppose your entry into the market. This is what hospital offices and medical providers must do to prove to a state agency that there is a “need” for the new or expanded facility they want to build. Academic studies show that Certificate-of-Need (CON) laws that exist in 35 states and the District of Columbia lead to lower quality, reduced access, and higher costs, including 30 percent fewer hospitals and 11 percent higher healthcare costs.⁴⁷ The FTC and the Anti-Trust Division of the Department of Justice (DOJ) have consistently come to the same conclusion under both Democratic and Republican Administrations.⁴⁸

States should eliminate CON laws and Congress should consider evaluating the extent to which CON laws are driving up federal healthcare costs and adjust payments to the states accordingly, to prevent federal taxpayers

from bearing the financial burden of states’ bad policies.⁴⁹

Expand the Use of Telemedicine. Access to telemedicine can be extremely beneficial for all populations, and especially those in rural areas and older people or individuals with disabilities for whom it can be more difficult to travel to appointments. Ongoing private investments along with a recent \$48 billion in federal investments in broadband services will greatly expand broadband access. Federal lawmakers should provide parity of payments within federal programs for telehealth and in-person visits. And state lawmakers should remove barriers that prevent healthcare practitioners in one state from providing telehealth services to patients in another state.

Summary

The U.S. is experiencing a labor shortage unlike any before in U.S. history, and the health care sector has been particularly hard-hit.

The federal government has limited availability to affect the supply of the health care workforce and it should not be in the business of directly training health care workers.

Ultimately, states control the entry gates to the health care workforce. States need to eliminate unnecessary licensing and scope of practice restrictions. Unless or until they do so, any

⁴⁶Federal Trade Commission, “Competition and the Regulation of Advanced Practice Nurses,” Policy Perspectives, March 2014, <https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf> (accessed February 6, 2022).

⁴⁷See State Policy Network, “Certificate-Of-Need Laws: Why They Exist and Who They Hurt,” SPN Blog, April 1, 2021, <https://spn.org/blog/certificate-of-need-laws/#:~:text=The%20Kaiser%20Family%20Foundation%20found,residents%20across%20the%20entire%20state> (accessed February 8, 2022).

⁴⁸Maureen K. Ohlhausen, “Certificate of Need Laws: A Prescription for Higher Costs,” *Antitrust*, Vol. 30, No. 1, Fall 2015, © 2015 by the American Bar Association, available at: https://www.ftc.gov/system/files/documents/public_statements/896453/1512fall15-ohlhausenc.pdf (accessed February 8, 2022).

⁴⁹Robert E. Moffit, “State Certificate-of-Need Laws Deserve a Federal Response,” Real Clear Health, January 10, 2022, https://www.realclearhealth.com/articles/2022/01/10/state_certificate-of-need_laws_deserve_a_federal_response_111288.html (accessed February 8, 2022).

federal funding aimed at expanding the health care workforce will be of limited value.

Federal policymakers should immediately focus on removing barriers that are contributing to the nationwide labor shortage, such as vaccine mandates, welfare-without-work programs, and restrictions on individuals' ability to work in the ways that work best for them. Moreover, policymakers should refrain from enacting further massive federal spending bills that would artificially and unsustainably pump up the demand for workers.

Within existing federal funding and health care programs, policymakers should enable greater flexibility to respond to America's health care needs, and remove unnecessary burdens in federal health care programs that limit health care access and that prevent more innovative and cost-effective care.

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Employment Gaps by Gender, Presence of Children, and Age

DIFFERENCE BETWEEN ACTUAL EMPLOYMENT LEVELS AND COUNTERFACTUAL EMPLOYMENT TREND,* FEBRUARY 2020 TO OCTOBER 2021

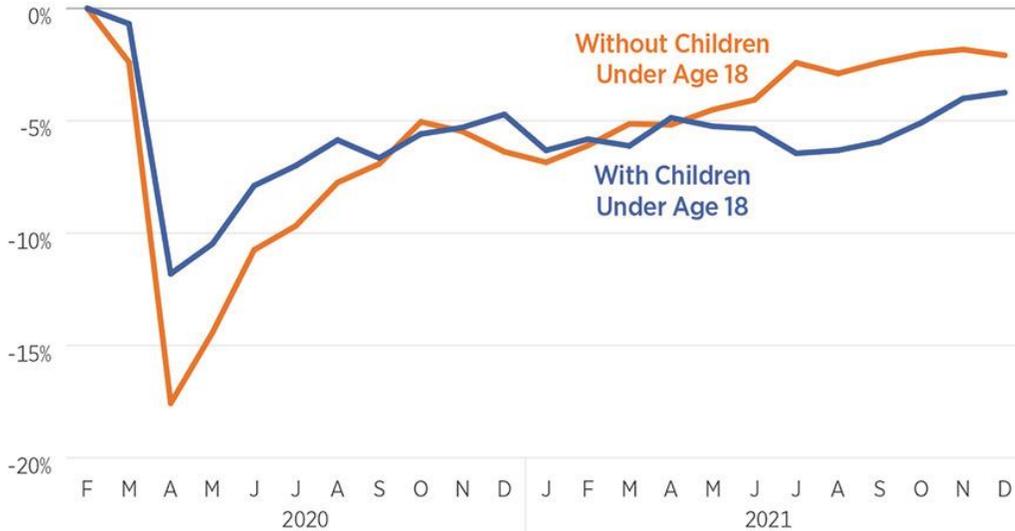
Group	Employment Gap, Individuals	Employment Gap, Percentage	Share of Total Employment Gap
All Workers	-4,137,893	-2.6%	100%
Men	-1,996,801	-2.4%	48.3%
Women	-2,141,091	-2.9%	51.7%
Workers with children	-1,889,868	-3.8%	45.7%
Workers without children	-2,248,024	-2.1%	54.3%
Men with children under 18	-823,138	-3.2%	19.9%
Women with children under 18	-1,066,730	-4.3%	25.8%
Men without children under 18	-1,173,663	-2.1%	28.4%
Women without children under 18	-1,074,361	-2.1%	26.0%
Workers with children 6 to 17, none younger	-1,490,634	-5.1%	36.0%
Workers with children under 6	-399,234	-1.9%	9.6%
Men with children 6 to 17, none younger	-731,803	-5.1%	17.7%
Women with children 6 to 17, none younger	-758,831	-5.2%	18.3%
Men with children under 6	-91,335	-0.8%	2.2%
Women with children under 6	-307,899	-3.1%	7.4%

* Counterfactual trend is based on a definition of steady-state employment growth from the Federal Reserve, equal to monthly growth of about 84,000 (0.053 percent).

SOURCE: Unpublished tabulations from the U.S. Bureau of Labor Statistics' Current Population Survey. Data should be interpreted with caution as they are based on small sample sizes.

Pandemic Employment Gap by Presence of Children

DIFFERENCE BETWEEN ACTUAL EMPLOYMENT AND COUNTERFACTUAL TREND* SINCE FEBRUARY 2020

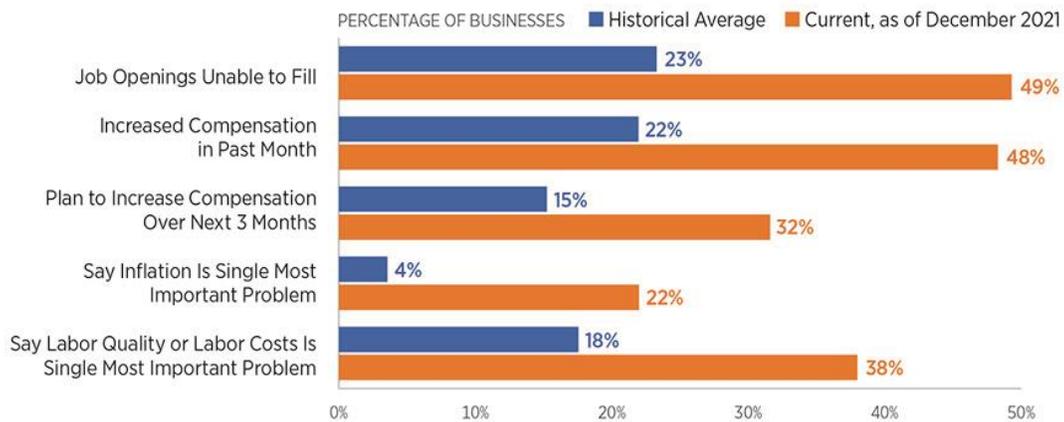


* Counterfactual trend is based on a definition of steady-state employment growth from the Federal Reserve, equal to monthly growth of about 84,000 (0.053 percent).

SOURCE: Unpublished tabulations from the U.S. Bureau of Labor Statistics' Current Population Survey. Data should be interpreted with caution as they are based on small sample sizes.

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Businesses Struggle Amidst Labor Shortages, Rising Costs



SOURCES: National Federation of Independent Businesses, "Small Business Economic Trends Survey," <https://www.nfib.com/surveys/small-business-economic-trends/> (accessed February 1, 2022), and National Federation of Independent Businesses, "Small Business Jobs Report," <https://www.nfib.com/foundations/research-center/monthly-reports/jobs-report/> (accessed February 1, 2022).

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