# Investing In A 21st Century Health Workforce: A Call For Accountability


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The US health workforce is receiving a massive boost in federal investment under the $1.9 trillion American Rescue Plan Act of 2021. Included provisions will allow states to receive higher federal matching funds through Medicaid, adding approximately $12.7 billion over the next year to strengthen the workforce for home- and community-based services; rural health providers will see an additional $8.5 billion in Provider Relief Fund dollars; more than $7.0 billion will be invested to expand, train, and retain the public health workforce; $1.55 billion will be allocated to expand critical programs that strengthen the workforce in underserved communities and address unmet health care needs; and nearly $250.0 million will be used to strengthen behavioral health workforce capacity. This infusion of health workforce investments comes on the heels of substantial provider support already allocated by the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 and is likely to be followed by additional investments under the infrastructure plan proposed by President Joe Biden.

It is imperative that these public funds be used wisely to build a workforce that responds to the urgent and enduring health care needs of society, rather than the interests of health care organizations, health insurers, or professional groups. These societal needs include bolstering access to maternity care while rural hospitals are closing, filling the long-standing shortage of primary care services, increasing the availability of mental health and substance use disorder services for patients and providers as behavioral health needs and "deaths of despair" have dramatically increased during the COVID-19 pandemic, mitigating critical shortfalls in long-term care, and effectively addressing social determinants that prompt and exacerbate health inequities. Taking full advantage of these new funds will require a consensus understanding among stakeholders of the specific changes needed to reshape the workforce. It will also require development and implementation of accountability mechanisms to routinely evaluate the impact of these investments.

## Reshaping The Workforce

Exhibit 1 proposes a framework for reshaping the workforce that can help focus stakeholder conversations about accountability. The Health Workforce Policies Framework rests on four classic pillars of health workforce planning: production, distribution, maximization, and resiliency.

Exhibit 1: Health workforce policies framework

*Source: Authors' analysis.*

First, the production of health care workers requires a dynamic plan that lays out the numbers and types of health care workers needed to address population health priorities, such as access to primary care, behavioral health care, oral health care, geriatric and long-term care, and maternal care. These are fields in which there are chronic shortages of health professionals, despite being areas in which our society has the greatest need.

Second, workforce distribution efforts must go beyond improving geographic location of health workers. They must also fill gaps in provider capacity and training, as maldistribution exists by specialty and by setting, with a disproportionate focus on acute care rather than community-based care. The expansion of telehealth coverage is one way that current investments help address barriers by improving access to health care professionals regardless of geographic areas, specialty types, and home or other settings.

Third, maximizing the current and future health workforce requires modernizing our approach to regulating state- and organizational-level scope of practice. The pandemic has spurred temporary changes in scope of practice laws across states under a variety of emergency acts, opening the door to expansions that previously appeared impossible due to opposition from dominant health professions. The reconfiguration of teams within health systems that include less traditional occupations such as dieticians, community health workers, and peer mental health workers, is needed to maximize current human resources for health.

Fourth, a focus on workforce resilience acknowledges the widespread burnout across the health professions, not only in hospitals, nursing homes, primary care, and behavioral health, but also among the public health workforce, which often faces resistance from their community. Health workers experienced working conditions that failed to protect them from the risk of infection during the COVID-19 pandemic. In addition, many health workers—especially home care aides and nursing assistants providing long-term care services—are financially insecure, which exacerbates work-related stress. Establishing supportive policies that address the financial and emotional security and safety of all health workers can promote well-being and prevent burnout and attrition that threaten the resilience and sustainability of the health workforce.

Identifying Goals, Metrics, And Accountability Through A Consensus-Building Process

We believe that an iterative consensus process is immediately needed to establish goals, metrics, and accountability mechanisms in each of these four workforce domains to ensure that the significant investments of public funds into various health workforce programs are spent effectively and yield improved patient and population health outcomes. Illustrative examples of such metrics related to high-priority health needs could include:

- To ensure equitable delivery of foundational public health services to all communities, the proposed Public Health AmeriCorps program should develop and implement a public health workforce pipeline that targets high-need state and local health departments by 2022.
- To increase access to behavioral health services, all states will adopt and maintain service and reimbursement parity policies for tele-behavioral health by 2025.
- To increase the number of primary care providers who work in underserved communities, resulting in a 50 percent reduction in the number of high-need primary care health professional shortage areas (that is, with scores of 14 or higher) by 2025.
- To increase access to health care and quality of life for older Americans, the median turnover of long-term care workers will be reduced to 50 percent (currently estimated at about 100 percent) by 2025.
- To mitigate vast disparities in Black, American Indian, and Alaska Native maternal mortality rates, by 2025, all maternal health care professionals will be educated in the impact of racism on maternal and infant health, empowered to refer birthing people to supportive services, and trained to combat unconscious bias.

- To improve the quality of health care, the diversity of the health workforce educational pipeline will be increased, so that by 2030, new entrants to every health care occupation in every community in the country match the racial/ethnic characteristics of the population residing there.

The federal government should take the lead in convening, through a health workforce commission or strategic planning process, a multisector body composed of consumers; health care delivery organizations and systems; insurers; educators; researchers and program evaluators; foundations; federal, state, and local government partners; and other stakeholders. Furthermore, the consensus-building effort could be modeled on the process used to develop the national Healthy People initiative, a long-standing effort that has received input from a diverse group of individuals and organizations.

In the short term, this group should be charged with assembling evidence and establishing metrics to inform decisions currently being made about the health workforce priorities targeted by public investments, including the types of training that will be supported and the organizations that will be eligible for these federal funds. In the longer term, the group should be tasked with developing strategies for ongoing data collection and monitoring to evaluate progress and outcomes of these efforts. The group should also consider the balance between state and federal power when articulating accountability mechanisms, as the pandemic response has illustrated the interplay between the two on workforce issues such as scope of practice regulations and reimbursement policies.

Efforts to develop a more efficient and equitable health workforce have been advocated by others. The 2010 Affordable Care Act established the National Health Care Workforce Commission, which ultimately became entangled in partisan squabbles over “ObamaCare” and was never funded by Congress. Ten years later, the CARES Act called for the development of a “comprehensive and coordinated” health workforce plan that includes performance measures to assess whether federally funded health workforce training programs are meeting the nation’s health workforce needs. The Council on Graduate Medical Education has also issued recommendations for a national workforce strategy. This work is vital to effective workforce planning. Without broad agreement on how those who influence the production, distribution, maximization, and resiliency of the workforce will be held accountable, it will be very difficult to reshape the nation’s workforce into one that delivers greater health and social value to individuals, communities, and populations.

Conclusion

The nation requires a workforce adequately sized and educated in the specialty areas needed to address the health needs of all people (production); that practices in the places, settings, and specialties where they are needed most (distribution); that works efficiently and effectively (maximize potential); and practices in systems that protects worker health and well-being (resilience). The specific actions needed to accomplish the goals of each of these four domains require vision; organizational and individual leadership; and coordination across local, state, and federal government, as well as cooperation from professional regulatory bodies, health care organizations, and payers. Now is the time to act, with establishing a consensus process as the immediate first step. We urgently stand at the intersection of great opportunity and considerable responsibility to maximize all health workforce investments and make demonstrable progress toward addressing the nation’s pressing health care needs.

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