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# From crisis to catalyst: Rethinking the healthcare workforce in the wake of the OBBB

The [One Big Beautiful Bill](#) (OBBB) has drawn attention for its [headline provisions](#): millions likely will lose their [health insurance](#) and there will be a [reduction in cumulative federal health spending](#) of an estimated \$1 trillion over 10 years. These measures, which will strain budgets and heighten pressures on U.S. health providers, have rightfully captured attention. But hidden within the law are elements that may reshape the healthcare workforce profoundly.

Caps on medical education loans will make the pathway to becoming a physician, which is already expensive, even less accessible. The OBBB does not cut GME funding outright, but its [downstream pressure on hospital finances](#) threatens to suppress medical education.

The OBBB contains some Medicaid budget tightening, and—because some [states use Medicaid funding to support](#) direct and indirect GME costs—this may narrow the path for physician education. As federal [research dollars](#) have faced substantial cuts independently of the OBBB, the downstream pressures on health systems are myriad.

These changes strike at the supply pipeline for physicians, researchers and academic clinicians, even as demand for care continues to grow.

## The workforce crunch: Physicians down, APPs not fully used

The results could cascade across the entire care system. Hospitals already face difficulty recruiting and retaining top talent. Even before the OBBB, [projections](#) pointed to worsening physician shortages over the next decade.

And the impact will not be limited to physicians. [The shortage of registered nurses](#) remains severe, and the pipeline of [direct-care workers](#) is struggling to keep pace with rising demand.

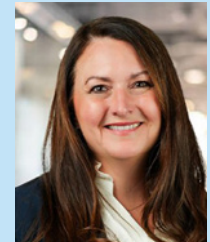
To compensate, many systems have expanded their workforce of advanced practice providers (APPs) such as nurse practitioners (NPs) and physician assistants. This has often occurred rapidly and at significant cost. Yet too often APPs are hired [without clear role definitions](#) or



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integration into team-based care models. Health system leaders know by looking at the numbers that something is wrong, but they have trouble pinpointing exactly what, much less how to fix it.

Another challenge is readiness. Newly graduated APPs, particularly NPs, frequently start their careers without the know-how to perform at the level expected of them — a knowledge that only comes with experience. [Transition-to-practice](#) support is uneven, leaving many to “sink or swim.” But systems cannot seamlessly offset physician shortfalls with NPs when those NPs require structured onboarding, ongoing competency development and role alignment.

Without those investments, labor will cost more. But opportunities to boost budgets are few. The OBBB may therefore hasten a reckoning: health systems cannot rely on simply adding APP head count. They must clarify team structures, support APP integration and rethink how the entire care team is organized and incentivized if they are to meet patient demand.

## Technology’s promise, and the measurement blind spot

Technology often promises to be a relief valve for workforce shortages. Sometimes, it delivers. Wider [adoption of artificial intelligence \(AI\) could produce savings](#) of up to 10% in U.S. healthcare spending,

resulting in approximately \$200 billion to \$360 billion in savings a year. These potential savings are as enticing as the tools are powerful.

For instance: artificial intelligence-enabled applications such as ambient listening systems that automatically generate clinical documentation can free up hours of provider time. For a provider, this could translate into capacity to see more patients or simply reduce the burden of administrative tasks.

Unfortunately, current workforce planning frameworks have not caught up. Staffing models, productivity benchmarks and even state-mandated staffing ratios assume that all patient care hours are delivered by a human being. Those assumptions are about to become outdated.

The implications are substantial. In states with mandated nurse-to-patient ratios, for example, what happens if technology safely substitutes for part of that workload? Regulators, payers and providers have not resolved how to measure or reimburse productivity gains created by technology. Neither have they considered the unintended consequences that technology inevitably will create.

The OBBB is largely silent on these matters. But because the law's [technology implications](#) are so weighty, so too will be their impact on the healthcare workforce.

### Turning crisis into opportunity

The disruptions brought by OBBB are daunting, but they are [not without precedent](#). Health systems have endured seismic change before — from the advent of managed care to the shocks of the Covid-19 public health emergency. Each disruption carried real risk, but also the chance to experiment, adapt and emerge stronger.

The new law should be viewed the same way. It will exacerbate shortages and strain budgets, but it also creates the urgency to rethink outdated models. This is the opportunity to ask fundamental questions: who

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should do what work, where should that work occur and how can technology and team-based care be integrated more effectively?

Meeting future workforce needs takes more than hiring incentives. Providers must streamline workflows and enable clinicians to practice not just at the top of their license but at the top of their competency. Demand management tools (e.g., asynchronous visits, digital intake, self-service) can ease workloads. Combined thoughtfully with strong physician alignment and partnerships, these efforts create a strong foundation for effective recruitment and retention.

The path forward will require holistic redesign, encompassing both clinical and non-clinical roles. It will require investing in transition-to-practice programs to ensure APPs can contribute at their highest potential. It will require a thoughtful investment in technology, which includes properly training staff to use it. And it will require forging stronger community partnerships to manage the rising burden of uninsured and underserved populations.

The OBBB forces healthcare organizations to confront uncomfortable truths. The challenge is real, but so is the opportunity: to create a more sustainable workforce model that can deliver care reliably and efficiently in a transformed environment. Smart organizations will not let a good crisis go to waste.

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