

Dealing With Staffing Shortage

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Introduction

Healthcare staffing shortages are not simply a recruitment problem. They arise from the relationship between workforce supply, population need, training capacity, geographic distribution, working conditions, retention, and the way clinical work is organised. A hospital or primary-care system may employ many professionals overall and still experience serious shortages in particular specialties, shifts, or locations. Rural communities and underserved areas are especially vulnerable because attracting and retaining clinicians can be difficult.

The problem is global. The World Health Organization (WHO, 2026) estimates a projected shortage of approximately 11 million health workers by 2030, concentrated mainly in low- and lower-middle-income countries, while noting that countries at all income levels experience problems involving education, employment, deployment, retention, and workforce performance. This paper examines the consequences of short staffing and evaluates strategies that can improve workforce capacity without relying on unsafe workloads.

Why Staffing Shortages Occur

Shortages can occur for several reasons. An ageing population increases demand for health services, while health workers themselves retire or reduce working hours. Training new clinicians takes years, and educational institutions may be limited by faculty, clinical placements, funding, or accreditation capacity. Geographic maldistribution can leave rural areas short of staff even when national workforce numbers appear adequate.

Retention is equally important. Organisations that recruit successfully but lose experienced staff through burnout, poor leadership, inflexible schedules, unsafe workloads, or limited career progression may remain chronically understaffed. Workforce planning should therefore consider both entry and exit from the profession.

Effects on Patient Care

Inadequate staffing can affect waiting times, continuity, surveillance, communication, and the ability to respond promptly when a patient deteriorates. Nurses and other clinicians working with excessive workloads have less time for assessment, education, documentation, coordination, and emotional support.

Research has associated nurse staffing levels with patient outcomes. Haegdorens et al. (2019), for example, found relationships between staffing, nursing education, and mortality in medical and surgical wards. The precise impact varies by setting, patient acuity, skill mix, and organisational processes, but the general principle is clear: staffing decisions are a patient-safety issue rather than merely a labour-cost issue.

Effects on Healthcare Workers

Short staffing increases pressure on the remaining workforce. Employees may work overtime, miss breaks, accept additional patients, or perform tasks at a pace that is difficult to sustain. Over time, this can contribute to fatigue, emotional exhaustion, job dissatisfaction, and turnover.

This creates a self-reinforcing cycle. Vacancies increase workload, heavy workload causes additional employees to leave, and the organisation becomes more dependent on overtime or temporary staffing. Breaking the cycle requires retention measures as well as recruitment.

Psychological safety also matters. Staff should be able to report unsafe workload, near misses, and system problems without being treated as personally responsible for conditions outside their control. A workforce that is afraid to speak up may conceal risks until they cause harm.

Expanding Education and Training Capacity

One long-term response is to increase the capacity to educate nurses, physicians, allied-health professionals, and other workers. Funding scholarships and training positions can reduce financial barriers, while investment in faculty and clinical placements can allow schools to admit more qualified students.

However, increasing student numbers without increasing educational capacity can reduce training quality. Workforce investment therefore needs to cover instructors, simulation facilities, supervised clinical experience, and support for students as well as tuition assistance.

Training should also reflect population needs. Expanding a specialty that is already well supplied will not solve shortages in primary care, mental health, geriatrics, or rural practice. Workforce planning should connect educational investment with reliable labour-market and health-needs data.

Advanced Practice and Team-Based Care

Advanced practice registered nurses, nurse practitioners, physician assistants, pharmacists, therapists, and other clinicians can contribute to more efficient team-based care when roles are matched appropriately to training and regulation. The objective should not be to replace one

profession with a cheaper substitute. Instead, each professional should work at the top of their competence while tasks that do not require specialist expertise are delegated safely.

In primary care, team-based models can improve access by distributing preventive care, chronic-disease management, education, medication review, and follow-up across several professionals. Physicians can then focus more attention on complex diagnostic and treatment decisions.

Role redesign must include clear scope, communication, referral pathways, and accountability. Simply transferring workload without increasing total capacity can move burnout from one professional group to another.

Rural and Underserved Areas

Rural shortages often require targeted solutions. Financial incentives may help, but recruitment is more sustainable when clinicians have professional support, manageable workloads, appropriate facilities, and opportunities for family and career development.

Training people in underserved communities can improve retention because students with local connections may be more likely to practise there later. Rural clinical placements and community-based training can also expose students to careers they may not otherwise consider.

Telehealth can supplement local services by connecting patients and clinicians with specialists, but it should not be treated as a complete substitute for an on-site workforce. Physical examination, emergency care, procedures, and many forms of hands-on treatment still require local personnel.

Teaching Health Centers and Community-Based Training

Community-based training can align education more closely with primary-care needs. Teaching Health Center programmes train clinicians in settings such as community health centres rather than relying only on large academic hospitals. Chen, Chen, and Mullan (2012) argued that this model can strengthen graduate medical education in underserved settings.

The principle remains relevant: where professionals are trained affects the kind of care they understand and the communities in which they may later choose to work. Expansion should therefore include primary care, community health, behavioural health, and other settings experiencing persistent shortages.

Retention and Working Conditions

Retention strategies can often produce results faster than expanding education, because keeping an experienced clinician avoids the time required to recruit and train a replacement. Organisations should examine workload, scheduling, management quality, compensation, workplace violence, administrative burden, professional development, and career progression.

Flexible scheduling can help employees with caregiving responsibilities or those approaching retirement remain in the workforce. Career pathways can provide experienced staff with opportunities to develop without leaving clinical practice entirely. Managers should also recognize that appreciation campaigns cannot compensate for persistently unsafe staffing or poor working conditions.

Technology and Administrative Burden

Technology can reduce workload when it eliminates unnecessary documentation, improves scheduling, supports communication, or automates repetitive administrative tasks. Poorly designed technology can have the opposite effect by increasing clicks, duplicate documentation, and alert fatigue.

Health organisations should therefore evaluate digital systems according to time saved for patient care, not merely whether new software has been implemented. Artificial intelligence may assist with documentation, scheduling, coding, and information retrieval, but clinical oversight, privacy, reliability, and bias must be addressed.

Flexible Staffing and Internal Workforce Pools

Hospitals often need flexibility because patient demand changes by season, day, and clinical unit. Internal float pools, cross-training, part-time options, and carefully managed temporary staffing can help organisations respond to fluctuations.

However, excessive dependence on agency staff may be costly and can affect continuity. The best approach is usually a stable core workforce supported by flexible capacity rather than permanent crisis staffing.

Financial Sustainability

Labour is a major component of healthcare expenditure. Staffing strategies therefore have to be financially sustainable, but cutting positions can create hidden costs through turnover, overtime, recruitment, adverse events, and lost capacity. The American Hospital Association (2026) reports

continuing financial pressure from labour and other operating costs across U.S. hospitals.

Workforce investment should be assessed through total value rather than salary expenditure alone. Retaining an experienced nurse, for example, may avoid recruitment costs while preserving clinical knowledge, mentoring capacity, and team stability.

Workforce Planning

Organisations need forward-looking workforce plans rather than reacting to vacancies individually. Planning should use data on retirement risk, turnover, vacancy duration, patient demand, service growth, skills, training pipelines, and regional labour markets.

Scenario planning can help leadership prepare for changes in demand. A hospital might model the workforce implications of opening a new service, increased chronic disease, changes in reimbursement, or adoption of new technologies. This allows recruitment and development to begin before shortages become critical.

Recommendations

A comprehensive staffing strategy should combine several measures: expand education where genuine shortages exist; strengthen community-based training; improve retention and management; develop advanced-practice and team-based models; target rural recruitment; use technology to reduce low-value administrative work; maintain flexible staffing capacity; and collect better workforce data.

Most importantly, healthcare organisations should avoid framing short staffing as a temporary inconvenience that employees must absorb indefinitely. Sustainable staffing requires enough trained people, suitable working conditions, clear roles, and systems that allow professionals to spend their time on the work for which they are qualified.

Conclusion

Healthcare staffing shortages threaten both access and quality, but the problem cannot be solved by recruitment alone. Education, deployment, retention, leadership, workload, technology, professional roles, geography, and finance all influence workforce capacity. The global projected shortfall of 11 million health workers by 2030 demonstrates the scale of the challenge, while local shortages can occur even in well-resourced health systems (WHO, 2026).

A sustainable response therefore combines long-term training investment with immediate improvements in retention and work design. Health systems that protect staff well-being, use

professionals efficiently, and plan workforce needs in advance will be better positioned to maintain safe patient care than organisations that depend on repeated overtime and crisis recruitment.

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