ACHSM Asia-Pacific Journal of Health Management

COMMENTARY

BURNOUT AND WORKFORCE SHORTAGES IN HEALTHCARE: AN EMERGING PUBLIC HEALTH CRISIS

Rajdip Mandal

Department of Health Promotion and Education, All India Institute of Hygiene and Public Health, Kolkata, India

*Correspondence: rajdip296@gmail.com

ABSTRACT

Burnout and workforce shortages among healthcare professionals have emerged as major concerns across healthcare systems worldwide. Global estimates project a shortfall of about 18 million health workers by 2030, and a meta-analysis estimated that roughly one in ten nurses experience burnout, although estimates vary across professions, settings, and measurement approaches. Although these problems became more visible during the COVID-19 pandemic, they did not end with the pandemic and continue to affect healthcare delivery in many settings. In daily practice, many healthcare workers face excessive workload, prolonged working hours, emotional exhaustion, staffing shortages, and increasing administrative responsibilities. These pressures are often more severe in rural and underserved areas where healthcare resources and trained professionals are already limited.

In my view, burnout and workforce shortages should not be treated as separate workplace issues alone. They are closely connected public health challenges. They appear to be interrelated public health challenges that may influence the quality, safety, and sustainability of healthcare systems. When healthcare professionals work under persistent physical and emotional strain, the effects extend beyond individual well-being and can ultimately affect patient care, service delivery, and health system resilience. This commentary discusses the structural factors contributing to workforce exhaustion and highlights the need for long-term organizational and policy-level responses to support a more sustainable healthcare workforce.

KEYWORDS

burnout, healthcare workforce, workforce shortages, health system resilience, public health.

BACKGROUND

Healthcare systems across the world are facing increasing pressure due to burnout among healthcare professionals and persistent workforce shortages. Although these concerns became more visible during the COVID-19 pandemic, the underlying problems existed long before the pandemic and continue to affect healthcare delivery in many countries [1]. In many healthcare settings, professionals are expected to maintain quality care despite overcrowded facilities, staffing shortages, long working hours, emotional stress, and growing administrative responsibilities.

Burnout is often discussed mainly as an individual psychological problem. However, this explanation does not fully capture the broader structural pressures within healthcare systems that contribute to workforce exhaustion. Excessive workload, inadequate staffing, poor organizational support, and inefficient workplace systems can all contribute to chronic stress

among healthcare workers [2,3]. When burnout becomes normalized within healthcare environments, it may gradually affect both workforce stability and the quality of healthcare delivery.

At the same time, workforce shortages continue to place additional pressure on existing healthcare staff. In many hospitals and primary healthcare settings, a limited number of professionals are expected to manage increasing healthcare demands with insufficient support and resources. This creates a cycle in which workforce shortages increase burnout, while burnout itself may contribute to absenteeism. These pressures may form a reinforcing cycle in which workforce shortages are associated with higher burnout, while burnout may in turn contribute to absenteeism, workforce attrition, migration, and early retirement [2]. From a public health perspective, this interconnected crisis has important implications for healthcare accessibility, patient safety, continuity of care, and long-term health system resilience. However, this relationship should be interpreted cautiously: most available evidence shows association rather than proven causation, and the direction and strength of the effects are likely to differ across professions, health systems, and settings.

BURNOUT AMONG HEALTHCARE WORKERS

Burnout among healthcare workers has become an increasingly important concern in healthcare systems worldwide. It is commonly described as a state of emotional exhaustion, depersonalization, and reduced professional accomplishment resulting from prolonged workplace stress [3]. Healthcare professionals often work under physically and emotionally demanding conditions that involve continuous patient care, emergency decision-making, long working hours, and repeated exposure to suffering, illness, and death. Over time, these experiences may lead to significant mental and emotional fatigue. Burnout is best understood as a work-related syndrome arising from chronic occupational stress, rather than as a general mental disorder. It overlaps with, but is conceptually distinct from, depression and occupational stress. Depression is not limited to the work context, whereas burnout is specifically related to the work environment and is characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment. Occupational stress may contribute to burnout but is conceptually distinct from the burnout syndrome [3,4]. These conditions may coexist, but the distinction matters because understanding burnout as a work-related syndrome shifts attention towards organizational and structural determinants rather than framing it solely as an individual weakness or failure.

Several studies have reported that burnout among healthcare workers is associated with anxiety, depression, sleep disturbances, reduced job satisfaction, and emotional detachment from work [4,5]. For example, a meta-analysis of 49 countries estimated the pooled prevalence of burnout among nurses at 11.23%, although estimates varied considerably across countries and measurement approaches [5]. In some healthcare settings, professionals may also experience frustration, helplessness, and declining motivation toward their work. Despite increasing evidence about these effects, burnout is still often treated as something unavoidable within the healthcare profession [6].

In my view, the normalization of burnout reflects a deeper institutional problem. Healthcare workers are frequently praised for resilience, dedication, and sacrifice, but the structural conditions contributing to exhaustion often receive less attention. Expecting healthcare professionals to continue functioning under constant pressure without adequate support is neither realistic nor sustainable over time.

Burnout may also affect healthcare quality and patient safety. Evidence suggests that exhausted healthcare workers can experience reduced concentration, communication difficulties, lower emotional engagement, and increased risk of medical errors [7,8]. In already overstretched healthcare systems, these consequences may gradually affect patient satisfaction, continuity of care, and overall healthcare quality. Burnout, therefore, should not be viewed only as an occupational issue, but also as an important public health concern.

Another important issue is the psychological impact experienced by frontline healthcare workers during and after the COVID-19 pandemic. Many healthcare professionals worked under extraordinary physical and emotional pressure while facing fear of infection, uncertainty, resource limitations, and high patient mortality [9]. Although the emergency phase

of the pandemic has passed, its long-term mental health effects on healthcare workers continue to remain significant in many settings.

WORKFORCE SHORTAGES AND SYSTEMIC PRESSURE

Healthcare workforce shortages have become a major challenge affecting healthcare systems in both high-income and low- and middle-income countries. The World Health Organization has repeatedly raised concerns about the global shortage and unequal distribution of healthcare professionals [10]. Projections indicate a global shortfall of about 18 million health workers by 2030, mainly in low- and middle-income countries [10]. Multiple factors continue to contribute to this problem, including population growth, aging populations, increasing healthcare demands, workforce migration, limited recruitment, and difficulties in retaining trained professionals [10,11].

Rural and underserved areas are often affected most severely. In many such settings, healthcare facilities operate with limited staff and inadequate infrastructure, requiring healthcare workers to serve large populations under difficult conditions. This may increase workload, extend waiting times, reduce the amount of time available for patient interaction, and affect continuity of care [10,12].

The migration of healthcare professionals from low-resource settings to urban centers or higher-income countries has also widened workforce imbalances [11]. Although migration may offer better professional and financial opportunities for healthcare workers, it can place additional strain on already fragile healthcare systems in underserved regions. It can be argued that workforce shortages should not be viewed only as numerical gaps in staffing. They also reflect broader structural and policy challenges related to workforce planning, working conditions, professional support, and long-term investment in healthcare systems.

Previous studies have shown that inadequate staffing levels may contribute not only to burnout among healthcare workers but also to poorer patient outcomes and lower professional satisfaction [12]. In many healthcare systems, these shortages are now affecting both hospital services and primary healthcare delivery.

Another issue receiving increasing attention is the growing administrative burden placed on healthcare workers. Although digital systems and electronic records were introduced to improve efficiency, many professionals now spend substantial amounts of time on documentation and reporting requirements [13]. In some settings, administrative responsibilities may reduce the time available for direct patient care and meaningful interaction with patients.

It can be argued that healthcare systems sometimes place strong emphasis on documentation and performance indicators without fully considering their impact on workforce well-being. Technology should support healthcare delivery and reduce unnecessary workload, rather than increase workflow complexity and emotional exhaustion among healthcare professionals.

THE INTERCONNECTED CYCLE BETWEEN BURNOUT AND WORKFORCE SHORTAGES

Burnout and workforce shortages in healthcare are closely interconnected and often reinforce one another. Burnout and workforce shortages in healthcare may be interconnected, with evidence suggesting potential effects in both directions. When healthcare facilities operate with insufficient staff, the remaining professionals are frequently required to manage heavier workloads, longer working hours, and continuous emotional pressure [4,6]. However, much of the available evidence on this relationship is cross-sectional, so it shows association rather than establishing causation, and well-designed longitudinal studies are needed to clarify the direction and size of these effects [6,12]. Over time, this may contribute to fatigue, frustration, emotional exhaustion, and reduced professional satisfaction.

At the same time, healthcare workers experiencing burnout may reduce their working hours, leave clinical practice, migrate to other regions or countries, or retire earlier than expected [14]. This further intensifies workforce shortages. This may further intensify workforce shortages and place additional pressure on those who remain within the system. As this cycle continues, healthcare systems may gradually become less stable and more difficult to sustain. If these pressures persist, healthcare systems may become less stable and more difficult to sustain.

From my perspective, this cycle represents one of the most underestimated threats to long-term health system resilience. Discussions on healthcare reform often focus heavily on infrastructure, technology, and expansion of services, all of which are important. However, healthcare systems ultimately depend on people. No healthcare system can function effectively for prolonged periods. It is difficult for any healthcare system to function effectively for prolonged periods if its workforce remains continuously overworked and emotionally exhausted.

The consequences become even more visible during disease outbreaks, natural disasters, and other public health emergencies. The COVID-19 pandemic demonstrated how strongly healthcare systems depend on a stable, protected, and adequately supported workforce [15]. In many settings, exhausted healthcare professionals continued working under extreme pressure despite personal risk, staffing shortages, and limited resources. These experiences demonstrated that health system resilience is closely linked to workforce resilience.

Several experts have argued that burnout in healthcare should be addressed through organizational and systemic reforms rather than placing responsibility entirely on individual healthcare workers [16]. This perspective is important because workplace conditions, staffing patterns, institutional culture, and administrative pressures often contribute substantially to workforce exhaustion.

PUBLIC HEALTH IMPLICATIONS

Burnout and workforce shortages in healthcare have important implications for public health and healthcare delivery. These challenges may affect healthcare accessibility, patient safety, continuity of care, emergency preparedness, and healthcare equity. In underserved and geographically difficult areas, shortages of healthcare professionals can create even greater barriers to timely and quality care. [1,8,10]

Another growing concern is the long-term sustainability of the healthcare workforce itself. Continuous workplace stress, emotional exhaustion, and declining professional satisfaction may discourage younger people from choosing healthcare professions or remaining in them for long periods. Burnout and poor working conditions have been linked to intention to leave and attrition among existing healthcare workers [14,17]. Whether they also discourage younger people from entering healthcare professions is less well documented; this remains a plausible concern that requires further research. This could further worsen workforce shortages in the coming years. Continued attrition among existing staff could further worsen workforce shortages in the coming years [17].

Workforce instability may also gradually affect public trust in healthcare systems. In overcrowded and understaffed healthcare settings, patients may experience long waiting times, communication difficulties, reduced continuity of care, and lower satisfaction with healthcare services [8,12,14]. Over time, such experiences can weaken confidence in healthcare institutions and the systems meant to support communities.

Discussions on healthcare quality often focus mainly on patient outcomes, while workforce well-being receives less attention [14,18]. However, these issues are closely connected. This highlights that healthcare systems cannot consistently provide safe, compassionate, and high-quality care if healthcare professionals continue to work under conditions of chronic physical and emotional exhaustion.
Way Forward:

Addressing burnout and workforce shortages in healthcare requires long-term commitment at both the organizational and policy levels. Short-term solutions alone are unlikely to resolve the deeper structural pressures that many healthcare systems continue to face [1,10,16].

Healthcare institutions should try to create working environments where professionals feel supported rather than constantly overwhelmed. Adequate staffing, fair distribution of workload, reasonable working hours, mental health support, and professional well-being should be treated as important parts of healthcare management. Burnout should not be accepted as a normal or unavoidable part of working in healthcare [14,16,18]. Three priorities should be emphasized. First, healthcare organizations should align staffing and workload with service demand and establish routine mechanisms to identify and address workforce strain [14,16,18]. Second, policymakers should prioritize retention through equitable workforce distribution, rural recruitment, and supportive working conditions, rather than relying on recruitment alone [10,19]. Third, health systems should reduce avoidable administrative and documentation burdens so that digital systems return time to patient care rather than add workflow complexity [13]. Progress could be monitored using measurable indicators such as staff-to-patient ratios, workload and overtime monitoring, flexible scheduling, protected well-being time, staff turnover and sick-leave rates, and periodic burnout assessments [14,18].

At the policy level, stronger workforce planning is also necessary. Investments in healthcare education, workforce retention, rural recruitment, and equitable distribution of healthcare professionals may help strengthen healthcare systems over time [10,19]. In many regions, retaining trained professionals has become just as important as recruiting new ones. Reducing unnecessary administrative burden may also improve workforce well-being. Digital systems are intended to support healthcare delivery, but in some settings, they have added documentation pressure and increased workflow complexity. Many healthcare professionals now spend large amounts of time completing reports and interacting with screens instead of directly engaging with patients [13]. Over time, this may affect both professional satisfaction and the quality of patient-provider relationships.

Several recent reports have highlighted the importance of organizational strategies to protect clinician well-being and reduce burnout [18,20]. I can argue that healthcare worker well-being and patient care should not be treated as separate priorities. A healthcare system cannot remain strong if its workforce continues to experience chronic exhaustion without adequate support. Protecting healthcare professionals is therefore not only an occupational responsibility, but also an important investment in sustainable healthcare systems and future public health resilience.

CONCLUSION

Burnout and workforce shortages in healthcare are becoming serious public health concerns that affect healthcare systems across the world. Available evidence indicates that burnout and workforce shortages are serious public health concerns in many healthcare systems, although their magnitude varies substantially across professions, health systems, and geographic settings. These challenges are closely connected and continue to influence associated with each other and may influence the quality of care, patient safety, and the overall stability of health services. In many settings, healthcare professionals work under constant pressure, long working hours, emotional stress, and increasing workloads, often with limited support.

Healthcare workers are frequently expected to keep adapting and continue working despite these pressures. However, resilience should not mean silently carrying exhaustion for long periods without proper support or recognition. In my view, a healthcare system cannot truly be considered resilient if it is difficult to regard a healthcare system as resilient if the people delivering care are physically and emotionally overwhelmed. Protecting the well-being of healthcare professionals is therefore not only an occupational issue but also an essential part of building sustainable, equitable, and effective public health systems. Protecting the well-being of healthcare professionals is therefore best seen not only as an occupational issue but also as an important part of building sustainable public health systems. While the evidence supports organizational and systemic action, further longitudinal and context-specific research is needed to guide interventions.

References:

1. World Health Organization. Health workforce policy and management in the context of the COVID-19 pandemic response. Geneva: WHO; 2020. Available at: https://iris.who.int/server/api/core/bitstreams/21167089-ddc8-4d1e-ab47-1a7839a83b71/content (Accessed 02 April 2026)
2. The Lancet. Health and care workers are owed a better future. Lancet. 2021;397(10272):347. DOI: https://doi.org/10.1016/S0140-6736(21)00179-3.
3. Maslach C, Jackson SE. The measurement of experienced burnout. J. Organiz. Behav. 1981;2:99-113. DOI: https://doi.org/10.1002/job.4030020205.
4. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. J Intern Med. 2018;283(6):516-29. DOI: https://doi.org/10.1111/joim.12752
5. Woo T, Ho R, Tang A, Tam W. Global prevalence of burnout symptoms among nurses: A systematic review and meta-analysis. J Psychiatr Res. 2020;123:9-20. DOI: https://doi.org/10.1016/j.jpsychires.2019.12.015
6. Dall'Ora C, Ball J, Reinius M, Griffiths P. Burnout in nursing: A theoretical review. Hum Resour Health. 2020;18:41. DOI: https://doi.org/10.1186/s12960-020-00469-9
7. Tawfik DS, Profit J, Morgenthaler TI, Satele DV, Sinsky CA, Dyrbye LN, et al. Physician burnout, well-being, and work unit safety grades in relationship to reported medical errors. Mayo Clin Proc. 2018;93(11):1571-80. DOI: https://doi.org/10.1016/j.mayocp.2018.05.014
8. Hall LH, Johnson J, Watt I, Tsipa A, O'Connor DB. Healthcare staff wellbeing, burnout, and patient safety: A systematic review. PLoS One. 2016;11(7):e0159015. DOI: https://doi.org/10.1371/journal.pone.0159015
9. Dzau VJ, Kirch D, Nasca T. Preventing a parallel pandemic — A national strategy to protect clinicians' well-being. N Engl J Med. 2020;383(6):513-5. DOI: https://doi.org/10.1056/NEJMp2011027
10. World Health Organization. Global strategy on human resources for health: Workforce 2030. Geneva: WHO; 2016. Available at: https://iris.who.int/server/api/core/bitstreams/3ef6ee65-42fa-4d2b-9c75-d55b2df17f9a/content (Accessed 05 April 2026)
11. Tankwanchi AB, Vermund SH, Perkins DD. Has the WHO Global Code of Practice on the International Recruitment of Health Personnel been effective? Lancet Glob Health. 2014 Jul;2(7):e390-1. DOI: https://doi.org/10.1016/S2214-109X(14)70240-2.
12. Aiken LH, Clarke SP, Sloane DM, Sochalski J, Silber JH. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. JAMA. 2002;288(16):1987-1993. DOI: https://doi.org/10.1001/jama.288.16.1987
13. Sinsky C, Colligan L, Li L, Prgomet M, Reynolds S, Goeders L, et al. Allocation of physician time in ambulatory practice: A time and motion study in 4 specialties. Ann Intern Med. 2016;165(11):753-60. DOI: https://doi.org/10.7326/M16-0961
14. Dyrbye LN, Shanafelt TD, Sinsky CA, Cipriano PF, Bhatt J, Ommaya A, et al. Burnout among health care professionals: A call to explore and address this underrecognized threat to safe, high-quality care. NAM. 2017;7(7):1-11. DOI: https://doi.org/10.31478/201707b
15. Shanafelt T, Ripp J, Trockel M. Understanding and addressing sources of anxiety among health care professionals during the COVID-19 pandemic. JAMA. 2020;323(21):2133-2134. DOI: https://doi.org/10.1001/jama.2020.5893
16. Montgomery A, Panagopoulou E, Esmail A, Richards T, Maslach C. Burnout in healthcare: The case for organisational change. BMJ. 2019;366:l4774. DOI: https://doi.org/10.1136/bmj.l4774
17. International Council of Nurses. The global nursing shortage and nurse retention. Geneva: ICN;2021. Available at: https://www.icn.ch/sites/default/files/inline-files/ICN%20Policy%20Brief_Nurse%20Shortage%20and%20Retention_0.pdf (Accessed 09 April 2026)
18. National Academy of Medicine. Taking action against clinician burnout: A systems approach to professional well-being. Washington, DC: NAM; 2019. Available at: https://nam.edu/wp-content/uploads/2020/09/4.-NAM-Taking-Action-Against-Clinician-Burnout-systems-approach.pdf (Accessed 12 April 2026)
19. Boniol M, Kunjumen T, Nair TS, Siyam A, Campbell J, Diallo K. The global health workforce stock and distribution in 2020 and 2030: A threat to equity and 'universal' health coverage? BMJ Glob Health. 2022;7(6):e009316. DOI: https://doi.org/10.1136/bmjgh-2022-009316
20. Adams JG, Walls RM. Supporting the health care workforce during the COVID-19 global epidemic. JAMA. 2020;323(15):1439-40. DOI: https://doi.org/10.1001/jama.2020.3972