Staffing Shortages in Public Healthcare: Neoliberal Policy and Its Consequences for Clinicians and Patients

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Introduction

The term "mismedicine", coined by Dr. Pooya Beigi, refers to any component of patient care, from diagnostics to systemic components, that results in harm, inefficiency, or a failure to meet established standards of care (Beigi, 2019). Unlike narrower definitions of medical error, mismedicine captures the structural conditions of healthcare. System-level failures are consequential as they influence the conditions under which care is delivered before individual, clinical decisions are made. Such failures arise from policy or resource-related deficiencies, including inadequate staffing and are described as "latent", meaning they create high-risk clinical environments in which adverse events and errors increase (Rodziewicz et al., 2024).

Staffing shortages are a system-level form of mismedicine. Driven by neoliberal health policy, understaffing represents a patient safety concern with clinical and psychological implications for patients and clinicians. Its severity is underscored by recent projections that estimate a shortage of 117,600 nurses by 2030 in Canada (Buchan & Catton, 2023). This paper analyzes how neoliberal policy priorities contribute to staffing shortages and examines resulting implications for clinicians' well-being and patient outcomes.

The Main Contributing Factor

The primary factor to staffing shortages is the adoption of neoliberal health policy (Virdo, 2026). Neoliberal health policy is characterized by the application of market-based logic to public sector governance, prioritizing financial efficiency, cost containment, and productivity over public values, such as service quality and accountability (Church et al., 2018; Virdo, 2026). This ideology has been implemented through reforms that treat healthcare delivery as measurable outputs and conceptualize labour as a controllable cost, rather than a core determinant of safe care (Church et al., 2018). In publicly funded health systems, neoliberal policy does not require full privatization to exert influence. Instead, it manifests through chronic under-funding, fiscal austerity measures, and efficiency-driven workforce management strategies (Krubnik & Mcbride, 2024; Virdo, 2026). Although healthcare delivery is a provincial responsibility, this can be demonstrated in the declining federal cost-sharing through the Canada Health Transfer, which has increased fiscal pressure on provinces such as Ontario, contributing to funding reforms designed to moderate spending growth and intensify efficiency management practices (Laberge et al., 2022). Fiscal austerity measures are reflected in wage suppression policies, like Ontario's Bill 124, which capped annual wage increases for healthcare providers, at one percent over a three-year period in 2019 (Phuong Thu Nguyen & Bochnak, 2023; Russell & Dufour, 2016). Together, these policies have shaped workforce conditions characterized by hiring freezes, persistent vacancies, and increasing reliance on overtime and temporary labour (Russell & Dufour, 2016). Staff shortages are evident in declining nurse-to-population ratios in Ontario, alongside a national nursing vacancy rate of approximately 6.4% (Wu et al., 2025). Between 2015 and 2022, paid nursing overtime rose from 37.9 to 58.6 million hours, indicating that demand for care has outpaced workforce growth, and that overtime has become a response to understaffing (Wu et al.,

2025). As funding and personnel are reduced without corresponding decreases in clinical responsibility, remaining staff are required to manage excessive work loads with limited resources (Church et al., 2018). This creates unsafe conditions in which care is delivered under constant strain by demoralized and overworked clinicians, increasing the likelihood of corner-cutting and adverse incidents and the deterioration of health service quality (Church et al., 2018). In this way, neoliberal health policy contributes directly to staffing shortages by eroding workforce capacity and sustainability, transforming understaffing into a system-level failure.

Consequences

As clinicians attempt to compensate for system deficiencies through increased individual effort, this compensation occurs at the expense of their own well-being (Senek et al., 2022).

Impact on Clinician Well-being and Clinical Performance

Nurses working in understaffed units face higher risk of elevated blood pressure and increased total cholesterol levels, with sustained elevations indicating progression towards chronic hypertension (Weigl et al., 2019). A survey of 4,467 practicing Canadian nurses found that 94% reported experiencing burnout (Buchan & Catton, 2023). These conditions are linked to job dissatisfaction, and an intention to leave the profession, contributing to the shortages (Brophy et al., 2024; Buchan & Catton, 2023; Weigl et al., 2019). These conditions affect clinical performance with understaffing as a primary driver of missed care, defined as a situation in which necessary care activities are delayed or omitted due to insufficient time or resources (Senek et al., 2022). Clinicians also experience depersonalization and chronic exhaustion, forcing them to prioritize acute tasks over preventative care, emotional support, patient education, and health promotion (Senek et al., 2022; Winter et al., 2020).

Impact on Patient Safety and Outcomes

Understaffing affects patient safety, clinical outcomes, and care experience. Research shows lower staffing levels are associated with increased adverse, preventable clinical events and higher mortality (Alaskar et al., 2025). In emergency and acute care settings, understaffing contributes to delays in critical interventions, such as vital sign monitoring, and timely medication administration, which increases the risk of life-threatening events, including cardiac arrest (Alaskar et al., 2025). Patient safety is further compromised through an increased incident of administrative errors, as explained by Dr. Pooya Beigi, which include documentation and information-entry mistakes and prescription errors (Blissy, 2024). Furthermore, perceived nurse and physician shortages are associated with lower patient satisfaction and diminished trust in the healthcare system (Winter et al., 2020). Additionally, Dr. Pooya Beigi shared that accurate diagnosis relies on the use of differential diagnosis, a process requiring physicians to consider multiple explanations for a patient's condition before initiating treatment (Blissy, 2024). However,

in understaffed clinical environments, the cognitive and temporal demands of this process are constrained and lead clinicians to interpret diagnostic tests prematurely or narrow too quickly on a single diagnosis, thereby increasing misdiagnosis and treatment errors (Blissy, 2024; Skovdal et al., 2020).

Conclusion

Neoliberal health policies have reshaped healthcare into a system that treats labour as a controllable cost, rather than a determinant of patient safety, producing staffing shortages that compromise clinician and patient well-being (Church et al., 2018; Virdo, 2026). Addressing this form of mismedicine requires policy action that moves beyond market-based logic, including reinvestment in workforce capacity, increasing wage growth, and reframing labour as essential infrastructure. Future research should examine the impact of alternative health-policy and funding models on workforce sustainability, clinician well-being and patient safety outcomes.

Q&A: Understanding Staffing Shortages in Healthcare

What is "mismedicine" and how does it relate to staffing shortages?

Mismedicine refers to any component of patient care, including diagnostic, therapeutic, communicative, or systemic processes, that results in harm, inefficiency, or failure to meet established standards of care (Beigi, 2019). Staffing shortages constitute a system-level form of mismedicine because they are produced by policy-driven and resource-deficient system failures, creating persistently high-risk clinical environments in which errors and adverse events become structurally likely (Rodziewicz et al., 2024; Virdo, 2026).

How does neoliberal policy directly contribute to current healthcare staffing crises?

Neoliberal health policy applies market-based logic to public healthcare governance, prioritizing financial efficiency and cost containment over patient care quality (Church et al., 2018; Virdo, 2026). This approach manifests through fiscal austerity measures, including Ontario's Bill 124 wage suppression and chronic federal and provincial underfunding that fails to meet system demand (Krubnik & Mcbride, 2024; Phuong Thu Nguyen & Bochnak, 2023; Russell & Dufour, 2016; Virdo, 2026). By treating healthcare labour as a controllable cost, these policies have entrenched reliance on nursing overtime and temporary staffing, producing staffing shortages (Wu et al., 2025).

What are the primary health and professional consequences for clinicians in unders

Clinicians in understaffed environments experience severe psychological and physiological strain, including high rates of burnout, job dissatisfaction, and intentions to leave their positions (Brophy et al., 2024; Buchan & Catton, 2023; Weigl et al., 2019). Physiological effects include chronic hypertension and elevated cholesterol (Weigl et al., 2019). Professionally, understaffing drives missed care, situations where necessary patient care activities are delayed or omitted, and contributes to depersonalization, chronic exhaustion, and reduced capacity for patient engagement, emotional support, education, preventative care, and health promotion (Senek et al., 2022; Winter et al., 2020).

In what ways does inadequate staffing compromise patient safety and diagnostic ac

Inadequate staffing compromises patient safety by increasing adverse, preventable clinical events and mortality, delaying critical interventions such as vital sign monitoring and medication administration, and raising the risk of life-threatening events, including cardiac arrest (Alaskar et al., 2025). It also contributes to administrative and prescription errors, reduces patient satisfaction, erodes trust in the healthcare system, and increases the likelihood of misdiagnosis and treatment errors (Blissy, 2024; Skovdal et al., 2020; Winter et al., 2020).

What policy shifts are recommended to address these systemic failures?

Addressing these systemic failures requires moving beyond market-based logic and reframing healthcare labour as essential infrastructure rather than a controllable cost. Recommended policy actions include reinvesting in workforce capacity, ensuring fair and sustainable compensation for healthcare staff, and exploring alternative funding models that prioritize long-term workforce sustainability, clinician well-being, and patient safety.

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