Workforce

AUSTRALASIAN PSYCHIATRY

Australasian Psychiatry
2024, Vol. 32(5) 446–449


Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/10398562241267138
journals.sagepub.com/home/apy
Sage

Australian specialised mental healthcare labour shortages: Potential interventions for consideration and further research

Jeffrey CL Looi Academic Unit of Psychiatry and Addiction Medicine, The Australian National University School of Medicine and Psychology, Canberra Hospital, Canberra, ACT, Australia; and Consortium of Australian-Academic Psychiatrists for Independent Policy and Research Analysis (CAPIPRA), Canberra, ACT, Australia

Stephen Allison Consortium of Australian-Academic Psychiatrists for Independent Policy and Research Analysis (CAPIPRA), Canberra, ACT, Australia; and College of Medicine and Public Health, Finders University, Adelaide, SA, Australia

Tarun Bastiampillai Consortium of Australian-Academic Psychiatrists for Independent Policy and Research Analysis (CAPIPRA), Canberra, ACT, Australia; College of Medicine and Public Health, Finders University, Adelaide, SA, Australia; and Department of Psychiatry, Monash University, Clayton, VIC, Australia

Martin Hensher Menzies Institute for Medical Research, University of Tasmania, Medical Science Precinct, Hobart, TAS, Australia

Steve Kisely School of Medicine, The University of Queensland, Princess Alexandra Hospital, Brisbane, QLD, Australia; and Departments of Psychiatry, Community Health and Epidemiology, Dalhousie University, Halifax, NS, Canada

Stephen J Robson Department of Obstetrics and Gynaecology, The Australian National UniversityMedical School of Medicine and Psychology, Canberra Hospital, Canberra, ACT, Australia; and Federal President, Australian Medical Association, Barton, Canberra, ACT, Australia

Abstract

Objective: Specialised mental healthcare delivery is highly labour intensive, and the COVID-19 pandemic has exacerbated workforce shortfalls. We explore the information on the mental healthcare labour supply in Australia from a health policy viewpoint. Our purpose is to stimulate discussion, further research and development of interventions.
Conclusions: The mental healthcare labour market has a number of features that make it prone to shortages and other distortions. These include: the labour-intensive nature of healthcare work;, long-training periods; that traditional policy levers like pay are only partially effective; as well as other challenges in retaining and recruiting mental health nurses and psychiatrists, especially in public mental health services. Further research is needed to develop and evaluate effective interventions.

Keywords: Healthcare workforce, labour market, shortages, mental healthcare

Introduction – The healthcare labour market in context and in Australia

The healthcare labour market in context

Specialised mental healthcare services face urgent workforce challenges, which can be understood within the broader healthcare environment. This paper focuses on the issues affecting the general healthcare labour market in Australia and the implications for psychiatry, and specialised mental health services, public and private. Our purpose is to provide an overview that encourages discussion of the potential health policy changes needed to address these challenges.

Corresponding author:
Jeffrey CL Looi, Academic Unit of Psychiatry and Addiction Medicine, The Australian National University School of Medicine and Psychology, Building 4, Level 2, Canberra Hospital, PO Box 11, Garran, ACT 2605, Australia.
Email: jeffrey.looi@anu.edu.au

Well before the COVID-19 pandemic, there were concerns about possible shortfalls in the global healthcare workforce.[1] The pandemic exacerbated and accelerated this pre-existing trend, highlighting many of the well-recognised issues affecting the healthcare labour market.[2] This is because healthcare delivery is highly labour intensive, as workers perform or mediate most health system functions.[2] They make treatment decisions at the point of service, and their actions determine how efficiently other resources are used.[3]

The healthcare labour market is prone to shortages due to supply and demand factors. There are long training periods for some workers – most notably psychiatrists and other medical specialists – along with extensive regulation of entry and of conduct once in the sector, along with multiple types of employment contracts. For example, there are relative shortages of psychiatrists in rural and remote Australia.[4] The healthcare sector is also a 'mission-orientated' sector and therefore will attract individuals who are motivated by non-financial (altruistic) as well as financial concerns.[5]

The healthcare labour market in Australia

Healthcare labour shortages are an apparent mismatch between health workforce supply and demand (defined by need), with evidence of an increasing imbalance both in Australia and internationally.[6] The resulting effect on healthcare delivery has led to calls for national regulatory and other reforms to planning, based on improved workforce data collection.[2] This is complicated by the fact that, compared to many other OECD nations, Australia already relies heavily on overseas-trained health professionals including psychiatrists and nurses, raising ethical issues around the effects on healthcare in low- and middle-income countries.[7] A further challenge is the ageing of the healthcare workforce, which may lead to retirements impacting workforce capacity.[6] With this current and worsening shortage, further actions are required to attract and retain the healthcare workforce.[8]

The specialised mental healthcare labour market

There are shortfalls in the specialised psychiatrist (and trainee) and mental health nurse workforces, both projected and in the extant data. Very recently, one in four funded staff specialist psychiatrist positions have not been substantively filled in NSW and ACT, leading to public mental health service shortfalls.[9] This occurs in the context of 90% of 1269 (of the 7200) trainees and psychiatrists of the RANZCP reporting that workforce shortages negatively impact patient care in 2024.[10] And, of these respondents, 70% reported burnout symptoms, of which 82% attributed to workforce shortages. Seventy-three percent of trainee psychiatrists reported burnout, and 33% of the total number of psychiatrists, 13% of trainees and 14% of early career psychiatrists, considered leaving the profession in the next 3 years.[10]

The Australian National Health Workforce Data Set, AIHW and ABS data indicate that from 2013 to 2022, most psychiatrists are maldistributed to major metropolitan areas.[4] While there has been a rise in the total full-time equivalent numbers from 12.6 per 100,000 population to 15.2 per 100,000, there has been a decline in the average hours worked by each psychiatrist. The greatest shortfalls, relative to population, are in rural NSW and SA, and the majority of this small workforce are female and predominantly overseas-trained.[4]

The projections of healthcare workforce capability have been hampered by the disbandment of Health Workforce Australia, as there is now no centralised agency that is responsible for data collection and monitoring of the healthcare workforce. The last dated workforce capability projections from HWA are from 2014 to 2016, when the organisation last published analyses. The Department of Health published the last analysis of HWA on the psychiatrist workforce in 2016, which predicted an undersupply of 425 psychiatrists by 2025.[11] The HWA last analysis for mental health nurses in 2024 projected an astonishing 61% shortfall of nurses,[12] and we could not find a similar contemporaneous workforce data analysis to that for psychiatrists. Though these figures are dated, and projections are potentially less accurate as events ensure, there is evidence, contemporary and projected of shortfalls in psychiatrist and mental health nurse workforce levels, including maldistribution. This is evidence of reduction in mental healthcare labour supply.

Framing healthcare labour policy

For our purposes, we will focus on factors related to the workforce supply to address the labour shortages, and some measures to assist productivity, since industrial infrastructure simply cannot function without an adequate workforce.

We suggest some potential healthcare policy levers that may be useful in addressing the extant and projected shortage in the mental healthcare workforce supply. These will need to be considered, further researched and evaluated for effectiveness.

Potential interventions to address insufficient mental healthcare worker supply

Burnout and retaining staff. Due to the long training periods for most healthcare professions including psychiatry, simply increasing educational places is insufficient. The priority should be retention through addressing continuing effects of the pandemic,[13] and known causes of moral injury and burnout.[14] The 2024 RANZCP survey that we referred to above identified that the majority of trainees and psychiatrists had symptoms of burnout they attributed to workforce shortages, and that up to a third of psychiatrists and more than 10% of trainees and early career psychiatrists endorsed exiting the profession in the next 3 years.[10]

These challenges are also reflected in increased turnover of physicians and long-term care workers in the United

States during the pandemic,[15] as well as disengagement from careers, and reduced quality of patient care.[16] For example, a recent systematic review identified that burnout symptoms and job satisfaction are the key drivers of healthcare workers' (HCWs) intention to leave, mediated by factors such as the meaning of work and self-efficacy.[8] In the same review, self-efficacy and experience were protective against turnover, while opportunities for part-time work, career or learning development social support and leadership, enhanced productivity and morale.[8]

Pay increases might appear a natural way to enhance HCW retention and recruitment. While a recent systematic review of studies on HCW retention in the UK NHS found that pay did influence job satisfaction and retention, the authors also observed that pay increments alone were unlikely to address other relevant issues leading to staff turnover.[17] This review also recommended that improving staffing levels (and reducing the dependency on locums), flexible work arrangements, opportunities for continuing professional development, preventing discrimination, valuing staff and staff autonomy, action to counteract negative narratives regarding the NHS, and also targeted wage increases to prevent being outbid by other employers. In relation to pay discrepancies, the UK NHS as a public sector employer likely faces similar challenges to a public sector in Australia, with the added impact that Australia has a very much larger and partially publicly subsidised private health sector, including in mental healthcare. Improving pay may also improve retention, but needs to be accompanied by other workplace interventions that effect better working conditions.

Telepsychiatry and substitutes for face-to-face care can help healthcare workers provide more efficient and effective care. There is potential for expanding telehealth in general primary healthcare, based on the experience in Australia during the COVID-19 pandemic.[18] Similarly, the evidence during the pandemic is that many other healthcare services can be provided using telehealth.[19] Furthermore, in the context of existing hospital access block, signifying unmet demand, there is emerging evidence that at least some telehealth usage can avoid hospital service use.[20] In mental healthcare where telehealth may be particularly suitable, it has been specifically recommended as a strategy to address psychiatrist workforce shortages.[21] Nonetheless, telepsychiatry still requires an adequate psychiatric workforce to be available. Telepsychiatry is still unlikely to be suitable for many patients and circumstances, such as for those acute and severe illness, and in terms of equitable access, which may not be possible in underserved rural and remote regions.

Adapting digital health infrastructure may assist skilled HCWs to work more efficiently.[22] In mental healthcare, digital transcription of letters and notes could improve workflows, as would portable and reliable access to EHRs via secure networks for information on patient home visits.

Healthcare worker role substitution. Examples include employing skilled HCWs (psychiatrists, nurses and allied HCWs) to supervise paramedical staff with lower levels of healthcare training and expertise to enable role substitution, for example, similar to enrolled nurses supervised by registered nurses. Although there is limited evidence of improved economic outcomes from role substitution in primary care,[23] there remain issues in evaluating the clinical effectiveness of such role substitution.[24]

Healthcare rationing. These health economic decisions are indeed challenging for HCWs to consider and participate in. While the principles of health stewardship are generally accepted in terms of equitable access to care based on need and available resources, a systematic review of physicians' approaches to healthcare rationing concluded that they found it most difficult at the bedside, and as it pertains to an individual patient.[25] Healthcare workers find such rationing and triaging difficult, and this has been a contributor to moral injury during the COVID-19 pandemic.[26] While such decisions on rationing may need to take place at higher administrative and policy-maker levels, these decisions also need to be carefully considered for their effects on patients, HCWs and health services. In the absence of formal approaches, increased waiting lists for healthcare are a byproduct of healthcare system rationing where healthcare demand exceeds supply.[27]

Healthcare efficiency benchmarking may identify why some systems are most costly or inefficient relative to their peers based. Examples include indices such as the national efficient price[28] and relative stay index.[29] Data must be accurate, and comparisons both appropriate and clinically meaningful. Measures such as psychiatric care length of stay, re-admission rates and hospital-related complications must be considered in context of quality of care provided, and not in isolation.

Improved healthcare labour market data collection and analysis

We need better Australian and local health workforce (all professions) modelling data through investment in high-quality business and clinical analysis capability, including accurate data and relevant software for access. Such analysis should be transparent and effectively communicated to all the relevant executive and clinical stakeholders. Ideally, Health Workforce Australia should be reconstituted to provide a centralised data repository and reporting.

Healthcare system redesign and reorganisation

Integrated redesign of both public and private services will be necessary to ensure whole system sustainability. This includes addressing the imbalance in HCWs across medical specialties and between metropolitan and rural areas.

Productivity

To address healthcare worker (HCW) shortages, we may also need to increase our relative healthcare productivity

levels. The challenge of improving productivity in human service industries has long been recognised[30]; yet rather than traditional approaches of technological intensification, the most direct route to productivity enhancement in healthcare is likely to involve reducing the incidence of both adverse events and low-value care.[31]

Conclusion

We have suggested several ways to address the mental healthcare worker shortage in Australia and to improve workforce supply. These proposed interventions are intended to encourage further discussion, research and evaluation of effectiveness. Clinicians, patients, policymakers and broader society will need to work together to develop an agreed societal compact.

Disclosure

The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: JL, SA, TB and SK are editorial team members for the journal – they were not involved in the independent peer review process.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Authorship

All authors made substantial contributions to the conception or design of the work; or the acquisition, analysis or interpretation of data for the work; drafting the work or revising it critically for important intellectual content; final approval of the version to be published; and agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

ORCID iDs

Jeffrey CL Looi https://orcid.org/0000-0003-3351-6911
Stephen Allison https://orcid.org/0000-0002-9264-5310
Tarun Bastiampillai https://orcid.org/0000-0002-6931-2913

References

1. Liu JX, Goryakin Y, Maeda A, et al. Global health workforce labor market projections for 2030. *Hum Resour Health* 2017; 15: 11. DOI: 10.1186/s12960-017-0187-2.
2. Looi JCL, Allison S, Bastiampillai T, et al. Supply and demand – a health economic perspective on the Australian hospital and elective surgery crisis. *Aust Health Rev* 2023; 47: 391–393. DOI: 10.1071/ah23048.
3. McPake B, Maeda A, Araujo EC, et al. Why do health labour market forces matter? *Bull World Health Organ* 2013; 91: 841–846. DOI: 10.2471/BLT.13.118794.
4. Hayter CM, Allison S, Bastiampillai T, et al. The changing psychiatry workforce in Australia: still lacking in rural and remote regions. *Aust J Rural Health* 2024; 32: 332–342. DOI: 10.1111/ajr.13092.
5. Lee T, Propper C and Stoye G. Medical labour supply and the production of healthcare. *Fisc Stud* 2019; 40: 621–661. DOI: 10.1111/1475-5890.12198.
6. Segal L and Bolton T. Issues facing the future health care workforce: the importance of demand modelling. *Aust N Z Health Pol* 2009; 6: 12. DOI: 10.1186/1743-8462-6-12.
7. OECD. Health workforce migration, DOI: 10.1787/1497601f-en (2023, accessed 20 November 2023).
8. de Vries N, Boone A, Godderis L, et al. The race to retain healthcare workers: a systematic review on factors that impact retention of nurses and physicians in hospitals. *Inquiry* 2023; 60: 469580231159318. DOI: 10.1177/00469580231159318.
9. Robinson N. Psychiatrists are fleeing the public system in record numbers, https://www.theaustralian.com.au/nation/psychiatrists-are-fleeing-the-public-system-in-record-numbers/news-story/0473bb4a5228fa0c902f19f309fff610 (2024, accessed 3 May 2024).
10. RANZCP. Burnout and moral injury: Australian psychiatry at its limits, https://www.ranzcp.org/getmedia/f1e48356-bfa6-46b6-a068-e383bbbe2683/ranzcp-workforce-report-feb-2024.pdf (2024).
11. Department_of_Health. *Australia's future health workforce – psychiatry*. Canberra, ACT: Department of Health, 2016.
12. HWA. Health Workforce Australia. *Australia's future health workforce: nurses detailed report*. Canberra, ACT, Australia: HWA, 2014.
13. Poon YR, Lin YP, Griffiths P, et al. A global overview of healthcare workers' turnover intention amid COVID-19 pandemic: a systematic review with future directions. *Hum Resour Health* 2022; 20(09/25): 70. DOI: 10.1186/s12960-022-00764-7.
14. Dean W, Talbot S and Dean A. Reframing clinican distress: moral injury not burnout. *Fed Pract* 2019; 26: 400–402.
15. Frogner BK and Dill JS. Tracking turnover among health care workers during the COVID-19 pandemic: a cross-sectional study. *JAMA Health Forum* 2022; 3: e220371. DOI: 10.1001/jamahealthforum.2022.0371.
16. Hodkinson A, Zhou A, Johnson J, et al. Associations of physician burnout with career engagement and quality of patient care: systematic review and meta-analysis. *BMJ* 2022; 378: e070442. DOI: 10.1136/bmj-2022-070442.
17. Bimpong KAA, Khan A, Slight R, et al. Relationship between labour force satisfaction, wages and retention within the UK National Health Service: a systematic review of the literature. *BMJ Open* 2020; 10: e0349194. DOI: 10.1136/bmjopen-2019-034919.
18. Jonnagaddala J, Godinho MA and Liaw ST. From telehealth to virtual primary care in Australia? A Rapid scoping review. *Int J Med Inf* 2021; 151: 104470. DOI: 10.1016/j.ijmedinf.2021.104470.
19. Garfan S, Alamoodi AH, Zaidan BB, et al. Telehealth utilization during the Covid-19 pandemic: a systematic review. *Comput Biol Med* 2021; 138: 104878. DOI: 10.1016/j.compbiomed.2021.104878.
20. Peters GM, Kooij L, Lenferink A, et al. The effect of telehealth on hospital services use: systematic review and meta-analysis. *J Med Internet Res* 2021; 23(Review 1.9): e25195.
21. Gardner JS, Plaven BE, Yellowlees P, et al. Remote telepsychiatry workforce: a solution to psychiatry's workforce issues. *Curr Psychiatr Rep* 2020; 22: 8. DOI: 10.1007/s11920-020-1128-7.
22. Orton M, Agarwal S, Muhoza P, et al. *Strengthening Delivery of Health Services Using Digital Devices Global Health*. Science and Practice, 2018, vol 61, pp. S61–S71.
23. Anthony BF, Surgey A, Hiscock J, et al. General medical services by non-medical health professionals: a systematic quantitative review of economic evaluations in primary care. *Br J Gen Pract* 2019; 69: e304-e313. DOI: 10.3399/bjgp19X702425.
24. Mutsekwa RN, Wright C, Byrnes JM, et al. Measuring performance of professional role substitution models of care against traditional medical care in healthcare-A systematic review. *J Eval Clin Pract* 2022; 28: 208-217. DOI: 10.1111/jep.13613.
25. Strech D, Persad G, Marckmann G, et al. Are physicians willing to ration health care? Conflicting findings in a systematic review of survey research. *Health Pol* 2009; 90: 113-124. DOI: 10.1016/j.healthpol.2008.10.013.
26. Shale S. Moral injury and the COVID-19 pandemic: reframing what it is, who it affects and how care leaders can manage it. *BMJ Leader* 2020; 4: 224–227. DOI: 10.1136/leader-2020-000295.
27. Rotstein DL and Alter DA. Where does the waiting list begin? A short review of the dynamics and organization of modern waiting lists. *Soc Sci Med* 2006; 62: 3157-3160. DOI: 10.1016/j.socscimed.2005.11.030.
28. IHACPA. *National efficient price determination*, 2023, https://www.ihacpa.gov.au/health-care/pricing/national-efficient-price-determination (accessed 10 July 2023).
29. VAGO. Hospital performance: length of stay, https://www.audit.vic.gov.au/report/hospital-performance-length-stay?section= (2023, accessed 10 July 2023).
30. Baumol WJ. Health-care, education and the cost disease - a looming crisis for public choice. *Publ Choice* 1993; 77: 17–28.
31. Hensher M, Canny B, Zimitat C, et al. Health care, overconsumption and uneconomic growth: a conceptual framework. *Soc Sci Med* 2020; 266: 113420.