

# Mental Health Workforce: Supply of Psychiatrists



**MENTAL HEALTH  
WORKFORCE**  
ADVISORY COMMITTEE

A psychiatrist may be defined as a medical practitioner who identifies as being a specialist—that is, a person who holds a qualification awarded by a specialist college; for example, the Royal Australian and New Zealand College of Psychiatrists (RANZCP)—and whose main specialty of practice is psychiatry.<sup>i</sup> Psychiatrists may work as clinicians or non-clinicians, and in the public or private sectors, or both. Psychiatrists-in-training are medical practitioners who have been accepted by the RANZCP into a training position supervised by a member of the college.

Between 2000 and 2004 the number of FTE employed psychiatrists and psychiatrists-in-training increased by 9.8% from 3,089 to 3,392, an annual average increase of 2.4%.<sup>ii</sup> In 2004, psychiatrists and psychiatrists-in-training made up five percent (5.4%) of all employed medical practitioners in Australia, and psychiatrists made up eleven percent (11.4%) of all specialists.<sup>iii</sup>

The World Health Organisation recommends 1:10,000 as a psychiatrist: population ratio. Overall, for every one RANZCP fellow in Australia there are 8,919 people, however, they are unevenly distributed, and (like most medical specialists) concentrated in capital cities. Victoria and South Australia have a higher ratio of psychiatrists to population, whereas in the Northern Territory, Tasmania, Queensland and Western Australia, the ratio of psychiatrists to population exceeds 1:10,000. When all College members are considered, including trainees, exemption candidates, and overseas trained psychiatrists, there are 6,042 people per RANZCP member.

Table 1: Ratio of RANZCP members to population<sup>iv</sup>

	Population June 2006	Fellows	Fellows per population	All Members	Members per population
NSW	6,827,700	733	1:9314	1151	1:5931
VIC	5,091,700	685	1:7433	995	1:5117
QLD	4,053,400	378	1:10723	555	1:7303
SA	1,554,700	232	1:6701	312	1:4983
WA	2,050,900	199	1:10306	272	1:7540
TAS	488,900	38	1:12865	57	1:8577
NT	206,700	10	1:20670	21	1:9843
ACT	328,800	35	1:9394	47	1:6996
AUSTRALIA	20,602,800	2310	1:8919	3410	1:6042

The 1999 Australian Medical Workforce Advisory Committee (AMWAC) report on the *Specialist Psychiatry Workforce in Australia*<sup>v</sup> found that access to psychiatrists was inadequate, particularly in rural areas. The finding was based on factors including epidemiological evidence of unmet need; evidence from invited experts; unacceptably long waiting times for consumers; advice from state and territory health authorities and divisions of general practice; evidence of maldistribution; and the number of funded vacancies for psychiatrists. The report found that the inadequate access to psychiatrists was related to:

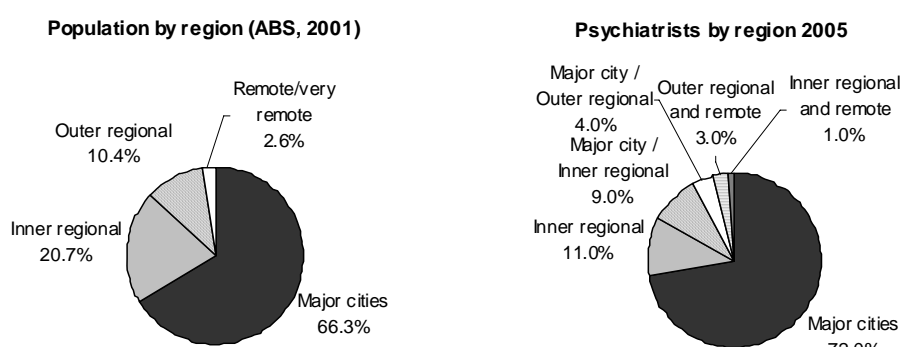
- Inadequate supply of psychiatrists;
- Maldistribution of the workforce; and
- Work practices of some psychiatrists.

The report recommended increasing the graduate output of the training program to 120 annually.

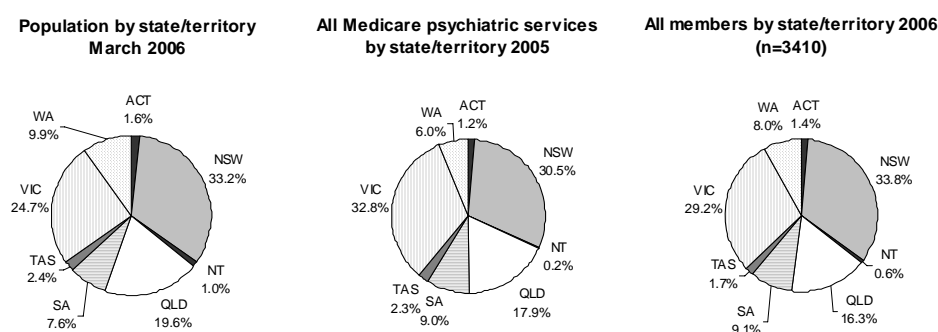
## Distribution of the workforce

In 2004 it was estimated there were 3,151 employed psychiatrists in Australia, or 3,392 FTE.<sup>vi</sup> For the majority of FTE psychiatrists (90.1%), their main place of work was in a major city. Major cities had 22 FTE employed psychiatrists and psychiatrists-in-training per 100,000 population, and there were 6, 3, and 3 FTE employed psychiatrists and psychiatrists-in-training per 100,000 population in inner regional, outer regional, remote and very remote areas respectively. Some 5% of psychiatrists residing in capital cities or inner regional areas report servicing, at least part-time, outer regional, remote, or very remote areas.<sup>vii</sup>

People resident in non-metropolitan areas, particularly those in rural and remote communities, have less access to psychiatric services than their urban counterparts. They are less than half as likely to receive services from a private psychiatrist than people residing in capital cities. When people in rural and remote areas do see private psychiatrists, they are likely to have about one-third less consultations.<sup>viii</sup> Based on MBS data, the estimated number of FTE private psychiatrists for 2004-05 was 1062.9. The RANZCP estimates that 41% of psychiatrists work exclusively in private settings, 23% exclusively in public settings, and 36% in both sectors.



The maldistribution of psychiatrists between urban and rural areas differs between and within states and territories. South Australia, WA and Victoria are most heavily skewed to the cities, whereas NSW and Queensland have comparatively large regional workforces. Victoria accounts for a quarter of Australia's population, and 29% of College members, who generate about a third of all Medicare psychiatric services. The proportion of College members residing and practicing in NSW correlates closely with the NSW proportion of the Australian population, however the level of Medicare psychiatric services provided is slightly less.



Locally trained psychiatrists are poorly distributed between private practice and the public sector. The public system has difficulty in recruiting local graduates, and has an increasing reliance on overseas graduates, particularly in rural areas. In Victoria, the proportion of psychiatrists-in-training who obtained their initial qualification overseas has increased significantly, from 14.8% in 2000, to 27.6% in 2004.<sup>ix</sup> Overall, there are difficulties in filling psychiatry training positions, raising concerns about future supply.

## Other workforce characteristics

The majority of qualified psychiatrists (some 55%) were aged between 35-54 years in 2003. A significant proportion (31%) were > 55 years. A workforce survey undertaken by the College in 2005 found that 17% of psychiatrists planned to retire in the next five years, while a further third planned to reduce their hours of work. The College estimates that from 2006-2010 some 22% of the workforce will be lost through retirement or reduced hours. Part time practitioners as a proportion of total private psychiatrists have been increasing annually since 1996/97.<sup>x</sup> The impact of ageing of the workforce may be more immediate for psychiatry than other specialties. About three-quarters of psychiatrists are aged over 40, compared to 65% of all medical specialists and 58% of general practitioners.<sup>xi</sup>

In 2004, 64.1% (2,020) of the estimated 3,152 psychiatrists and psychiatrists-in-training in Australia were male, and 35.9% (1,131) were female. Females made up 56% of psychiatrists-in-training in 2004. Psychiatry attracts a comparatively high number of women, possibly because it is a medical discipline that can facilitate controllable work hours.<sup>xii</sup> Over time, gender balance will have an impact on workforce FTE. As women tend, on average, to work fewer hours, a greater number of trainees will be required to maintain the same amount of psychiatry FTE. However, it should also be noted that both male and female psychiatrists are working fewer average hours, with a drop from 45.0 average weekly hours in 1995 to 40.9 in 2004.<sup>xiii</sup> Younger psychiatrists are also working fewer hours than their predecessors did at the same age.<sup>xiv</sup>

## Training

The RANZCP has responsibility for training, examining and awarding the qualification of Fellowship of the College to medical practitioners. It was estimated that there were 742 psychiatrists in training in 2004.<sup>xv</sup> Between 1999 and 2003, the proportion of female FTE trainees rose from 42.0% to 51.2%. The College's Fellowships Board and Committee for Training oversee a vocational training program, consisting of a minimum of three years basic training and two years advanced training. Training must be completed in accordance with the RANZCP Training and Assessment Regulations. Training is based around rotations in adult general psychiatry, child/adolescent psychiatry, and consultation liaison, together with training experiences in rural psychiatry and indigenous mental health, psychiatry of old age, addiction, ECT and psychotherapy. Part-time training is available, and on average, trainees take in excess of six years to complete the program.

There is no set number of training places for psychiatry, and the College reports that more trainees could be accommodated. The current annual intake across the country is approximately 120 trainees, with an average of 83 trainees successfully completing the program each year. The intake and completion rate has been fairly consistent over the period 2001-2006.

Table 2: Psychiatry trainees by year<sup>xvi</sup>

	<b>Total Number of trainees</b>	<b>Number of 1<sup>st</sup> year training entrants</b>	<b>Number of Trainees completing training</b>
2000	667		80
2001	653	116	70
2002	720	104	82
2003	711	109	70
2004	725	116	109
2005	725	116	85
2006	780	141*	83
<b>Average</b>	<b>712</b>	<b>117</b>	<b>83</b>

\*In 2006 the selection criteria for the RANZCP training program changed to allow applicants who had completed PGY1 to apply. Previously, PGY2 had been required.

## Future supply of psychiatrists

There are two major methods of forecasting workforce supply and demand, time series, and stocks and flows analysis. They can be used individually or together. Time series uses historic information. Stocks and flows analysis relies on the use of data from a selected base year and are calculated using Full Time Equivalent (FTE). These projections account for inflows from graduates entering the workforce for the first time, migration, and workers who re-enter the workforce after a period of absence. Projections also account for outflows such as retirement, death, and outward migration.

In 1999, AMWAC's report on the specialist psychiatry workforce concluded that 'without corrective action, the workforce will move towards a situation of escalating undersupply. The current projected level of new entrants into the workforce from the RANZCP training program will not be sufficient to meet expected future requirements. It is estimated that requirements will grow by a minimum of 1.4 per cent per year. Future supply will be affected by the cohort of psychiatrists aged 55 years and over proceeding through to retirement (32.9%) and the comparatively large and increasing representation of female psychiatrists'.<sup>xvii</sup>

The AMWAC report recommended an increase in the number of commencing psychiatry trainees to some 131 trainees annually, to achieve an average annual output of 120 fellows. The number of trainees successfully completing the program is well below this target. Psychiatry service requirements will be affected by factors including population growth and ageing. Overseas Trained Psychiatrists (OTPs) provide some psychiatric services in Australia, but may be disproportionately represented in rural areas. Under the National Health Workforce Strategic Framework, Australia aims to achieve national self-sufficiency in health workforce supply.<sup>xviii</sup>

The College estimates that the current ratio of population to fellows would be maintained if 131 first year training places were filled, and the pass rate was 100%. In order to increase the output of psychiatrists to 131 completions annually, the College further estimates that an increased intake of first year entrants to some 176 trainees is required. This calculation is based on the average retention and success rate over the last several years.

The factors affecting workforce supply and demand for psychiatrists have not greatly changed since the AMWAC report. Australia's population continues to grow, and the distribution of the psychiatry workforce remains skewed to capital cities. A significant proportion of the workforce is approaching retirement, more psychiatrists are choosing to work fewer hours, and more women are choosing psychiatry. Given these factors, workforce demand for psychiatrists is expected to significantly exceed supply in the short and medium term.

## Strategies to meet demand

Strategies for addressing workforce imbalance include improving supply by increasing the number, retention and pass rate of trainees, and the number of Overseas Trained Psychiatrists; and improving existing supply by increasing retention rates. Specific strategies that could be considered include:

- Active promotion to medical students of psychiatry as a good career choice, possibly with a particular focus on rural students.
- Increased positive prevocational exposure of junior doctors to psychiatry.
- Development of incentives to attract junior doctors to psychiatry.
- Provision of support to trainees who may be at risk of withdrawing from the program or failing.
- Development of strategies to improve pass rates, including tailored strategies for international medical graduates.
- Improvements to the training experience.
- Development of incentives for practice change to improve utilisation of the existing workforce.
- Use of incentives to improve distribution of the existing workforce.

## Notes

---

<sup>i</sup> Australian Institute of Health and Welfare (AIHW) 2005, *Mental Health Services in Australia 2003-04*. AIHW cat no. HSE 40. Canberra: AIHW (Mental Health Series no. 8)

<sup>ii</sup> Australian Institute of Health and Welfare (AIHW) 2007, *Mental Health Services in Australia 2004-05*. AIHW cat no. HSE 47. Canberra: AIHW (Mental Health Series no. 9). The Full-time equivalent (FTE) measure of supply is based on the total hours worked by all psychiatrists, divided by 38 hours. Hence the FTE measures how many 38 hour week workloads are being worked by psychiatrists. It provides a measure of supply of psychiatrists because it takes into account both psychiatrists working full-time and those working part-time. Defining supply in terms of FTE per 100,000 population (or the FTE rate) enables meaningful comparisons across geographic areas and over time

<sup>iii</sup> AIHW 2007.

<sup>iv</sup> Royal Australian and New Zealand College of Psychiatrists (RANZCP), RANZCP Workforce, unpublished, March 2007.

<sup>v</sup> Australian Medical Workforce Advisory Committee (AMWAC) 1999, *The Specialist Psychiatry Workforce in Australia: supply, requirements and projections 1999-2010*, AMWAC Report 1999.7 Sydney.

<sup>vi</sup> AIHW 2007.

<sup>vii</sup> RANZCP, March 2007.

<sup>viii</sup> Department of Health and Ageing 2005, *National Mental Health Report 2005: Summary of Ten Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2003*. Commonwealth of Australia, Canberra.

<sup>ix</sup> Victorian Government Department of Human Services 2006, *The Medical Workforce of Victoria*, State Government of Victoria, Melbourne.

<sup>x</sup> Department of Health and Ageing, 2005.

<sup>xi</sup> S Fletcher and D Schofield, 2007, 'The impact of generational change and retirement on psychiatry to 2025', *BioMed Central Health Services Research*, Vol 7: 141.

<sup>xii</sup> Australian Medical Workforce Advisory Committee (AMWAC) 1998, *Influences on Participation in the Australian Medical Workforce*, AMWAC Report 1998.4, Sydney.

<sup>xiii</sup> AIHW 2007

<sup>xiv</sup> S Fletcher and D Schofield, 2007.

<sup>xv</sup> AIHW 2006, *Medical Labour Force 2004*. National health labour force series No. 38. Cat no. HWL 39. Canberra: AIHW.

<sup>xvi</sup> Royal Australian and New Zealand College of Psychiatrists (RANZCP), RANZCP trainee data, unpublished, April 2007.

<sup>xvii</sup> AMWAC 1999, p 7.

<sup>xviii</sup> Australian Health Ministers' Conference, 2004, *National Health Workforce Strategic Framework*, Sydney.