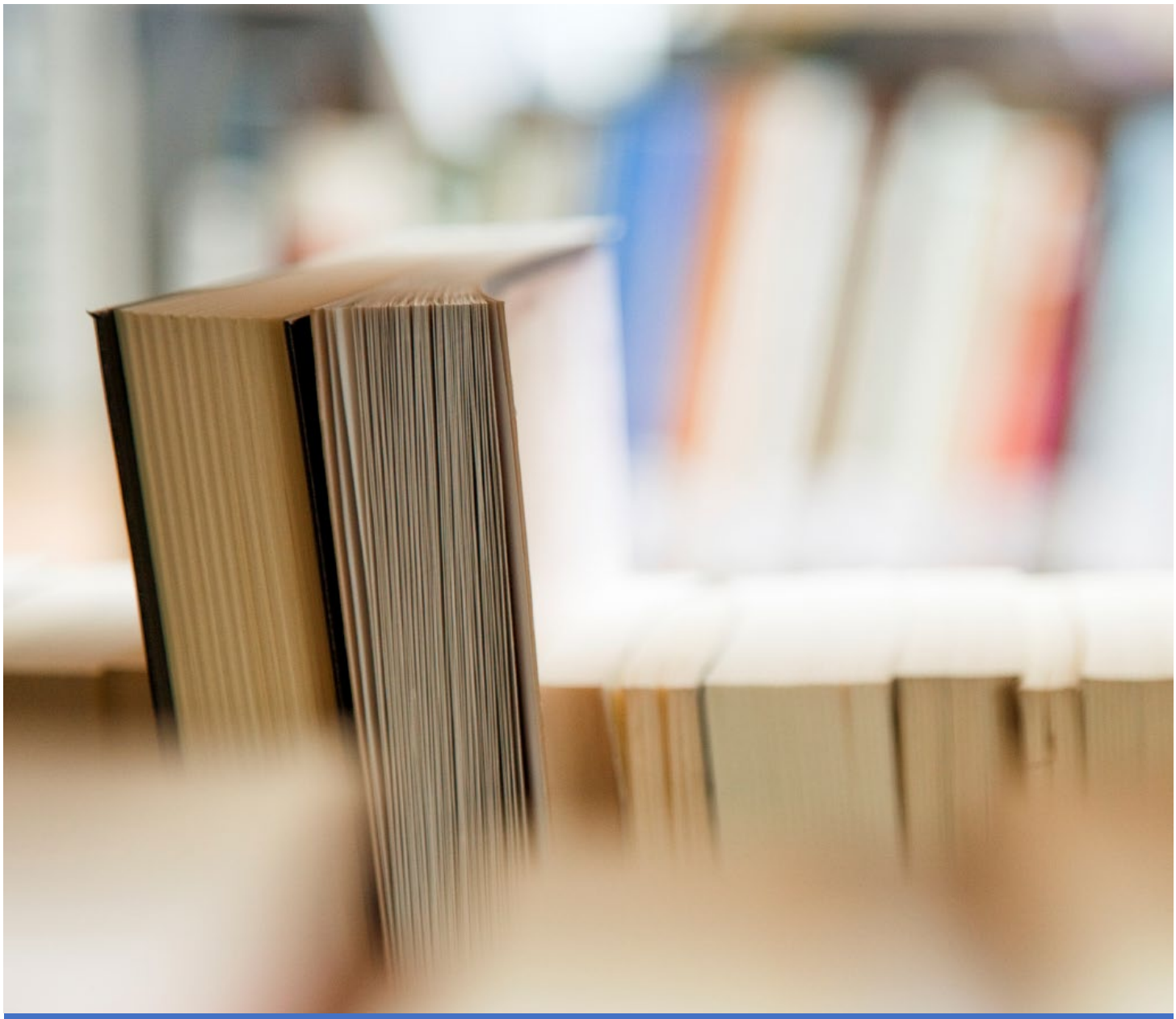


The Psychiatry Workforce Training Pipeline in Aotearoa New Zealand

The Royal Australian & New Zealand College of Psychiatrists

Contents

Introduction

Rationale for this report

Te Whatu Ora | Health New Zealand (HNZ) and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) convened a working group in 2023 to explore pathways and barriers to expanding the number of psychiatry training posts in Aotearoa New Zealand. This report is a collaboration between the two organisations.

The brief for this report was to understand the psychiatry workforce composition and sustainability, with particular focus on the psychiatry training pipeline. Current data and information were used to provide an overview of the capacity and constraints within different components of training, including how funding impacts the pipeline, and make recommendations for growth of the psychiatry workforce.

This report has been compiled from a review and analysis of documents, reports, and data sets from Te Kaunihera Rata o Aotearoa | The Medical Council of New Zealand (MCNZ), HNZ, Te Pou and the RANZCP and from interviews and discussions with key stakeholders.

Key Messages

Key messages represent a summary of the information and data collected. They suggest points for consideration in the development of a plan to support the training pipeline and do not represent policy of HNZ.

- Specialist mental health and addiction services are reliant on psychiatrists as key members of multi-disciplinary team. At a population level, Aotearoa New Zealand has 13.6/100,000 psychiatrists across all sectors, compared with 18/100,000 OECD average.
- There is a shortage of psychiatrists within the publicly funded health sector (19% vacancy rate, 106 FTE psychiatrists). This equates to 8.5/100,000. Data relating to the level of reliance on locums for these positions is not available.
- Within the next ten years, half of the current psychiatry workforce will be beyond the retirement age of 65. There is a risk of a tipping point occurring prior to that, whereby there will not be enough psychiatrists to provide supervision for trainees.
- NZ has a heavy reliance on overseas-trained psychiatrists (OTPs; more recently termed Psychiatrists with International Qualifications) and International Medical Graduates (IMGs; 60% of current workforce, increasing). OTPs are less likely to stay in Aotearoa New Zealand than NZ-trained, with 5-year retention rates of 64% and 93% respectively, and there is an increasingly competitive international marketplace for psychiatrists given shortages across most countries.
- As there is no centralised collection, analysis, monitoring or reporting of psychiatry workforce data, forecasts to date have been based on limited variables and have likely underrepresented the scale of the psychiatry workforce challenges. Improved data collection systems within HNZ and the RANZCP are needed.
- Psychiatry trainees make a significant contribution to the workload of specialist mental health and addictions teams within public services and represent good value for money as well as an investment in the future psychiatry workforce.
- There is sufficient capacity overall within the training pipeline to substantially increase the number of psychiatry trainees. The constraints in the pipeline are in the distribution of supervision regionally and across subspecialties, support for trainees to locate to where training runs are available and needed, provision of HNZ training funds for all positions and funding of additional FTE.
- 107 of 194 active (2023) trainee positions are subsidised by the HNZ training fund (55%). It is suggested that funding remedy this shortfall and provide for an increase in the total number of placements.
- To address vacancies and to increase the proportion of NZ-trained psychiatrists to 50% of total psychiatrist numbers, the number of active trainees would be required to increase by 10% percent annually for five years. That would mean an additional 19 trainees starting in 2025. This does not account for population growth or remedy the unmet need that is suggested by the discrepancy between the NZ psychiatry workforce and the OECD average.
- Specific funding for subspecialty trainees is also needed to ensure the availability of adequate Child and Adolescent Psychiatrist, Old Age Psychiatrists, Forensic Psychiatrists and Consultation-liaison Psychiatrists to meet community and service demand.

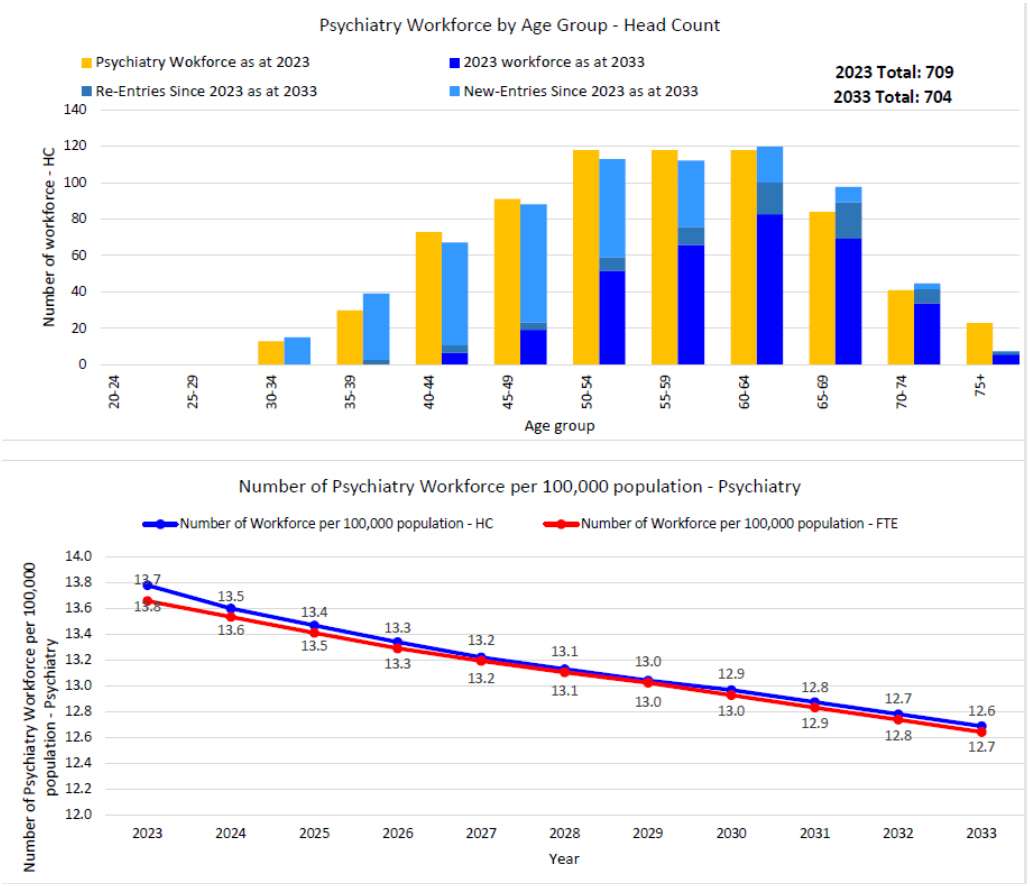
Data Limitations

Achieving a comprehensive account of the psychiatry workforce pipeline in Aotearoa New Zealand is critical for enabling planning. However, this task is being hindered by incomplete information. Workforce data is currently collected for a range of purposes, by a range of agencies, across varying time frames, and is reported in different ways. These limitations are detailed in Appendix 1 and will be noted as they arise in each section of this report. The data available does, however, provide snapshots of a workforce that is both unable to meet the current need and is forecast to significantly decline in relation to the population and expected need over the coming ten years.

Forecasts over the coming decade

Modelling of the psychiatry workforce by the Health Workforce Analytics and Intelligence Team within the HNZ People and Capability group, has been utilised in mental health workforce reporting for many years. This modelling considers shifts in population and how this drives demand. Forecasts are based on age-specific rates of new practitioners entering the workforce (including NZ-trained and overseas-trained psychiatrists), age-specific rates of practitioners returning to their profession after a break, and age-specific rates of practitioners leaving their profession temporarily or permanently (Figure 1.) [1]

Figure 1. Forecast of the psychiatry workforce.



Source: Health Workforce Analytics and Intelligence, 2023. [1, 2]

While this modelling was designed to keep pace with population growth and account for the current movements in and out of the workforce, it maintained status quo in terms of FTE/100,00, HNZ vacancies, and the current ratio of IMGs to NZ trained medical graduates. The narrow set of variables utilised by the Health Workforce Analytics has led to forecasts that are potentially misrepresentative, and significantly underestimate the magnitude of the psychiatry workforce shortage. The assumptions and missing variables of the model are outlined in Appendix 2.

Workforce demographics

As of 30 June 2023, there were 13.6 registered psychiatrists per 100,000 total population across all sectors in Aotearoa New Zealand, based on registration data from the MCNZ and population estimates by Stats NZ. While this headcount has increased by 13.4% over the past five years it remains significantly lower than comparable countries (see Appendix 3).

The number of registered psychiatrists represents a head count and does not indicate how many FTE psychiatrists are currently in the workforce. Within HNZ funded services there were a total of 549 FTE positions available for psychiatrists, 106 (19%) of which were vacant, amounting to 8.5 psychiatrists employed in public health services per 100,000 population.

Table 1. Snapshot of the psychiatry workforce in Aotearoa New Zealand.

Number Psychiatrists (HC across all sectors)	HNZ services (funded FTE)	HNZ services (filled FTE)	IMGs (%)	Per Capita (100,000)	Average age
709	549.5	443.4	61.5%	13.57	55

Source: HNZ and MCNZ, 30 June 2023. [2, 3]

Age and gender

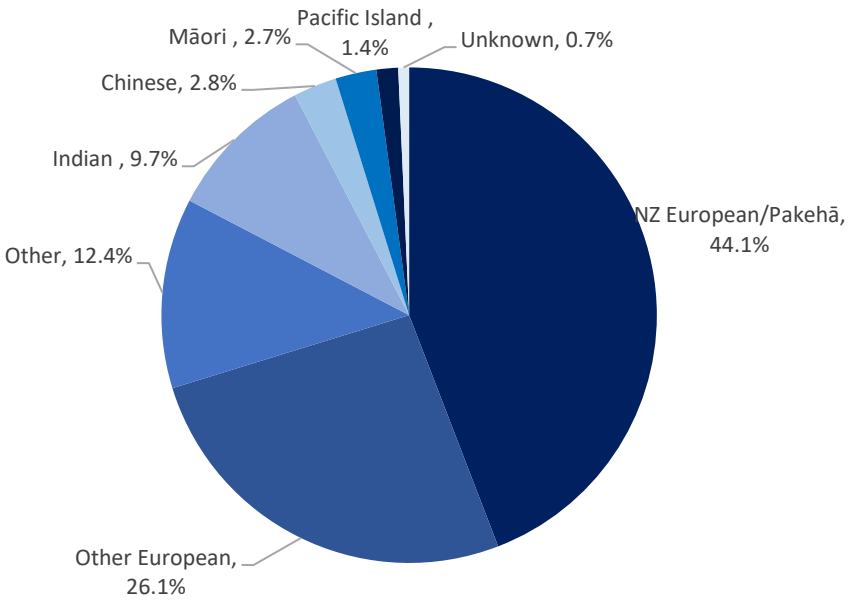
With an average age of 55 years, psychiatry has the oldest workforce of all vocational specialties in Aotearoa New Zealand. In 2005, the average age was 48 years, showing an upwards trend. [4] Compared to other specialties, psychiatry also has the least favourable ratio of trainees to older specialists approaching the age of 65; there are currently 373 psychiatrists (52% of the workforce) over the age of 55 years, and 228 psychiatry trainees. [5] The aging workforce is a key factor in the reliance on specialist international medical graduates to replenish the psychiatry workforce. It should signal alarm, as within 10 years, half of the current psychiatry workforce will be over the age of 65 and approaching retirement. However, long before that, there is a risk of a tipping point where there will not be enough psychiatrists to provide the necessary clinical training to replace themselves. On a positive note, the gap between males and females in the workforce is reducing over time, with 56% of the psychiatry workforce identifying as male and 44% identifying as female. [5]

Ethnicity

Aotearoa New Zealand needs more Māori and Pacific doctors at graduate level for all specialties to achieve demographic proportionality. As of June 2023, 2.7% of the psychiatry workforce identified as Māori, lagging dramatically behind the numbers that would be required for demographic proportionality, particularly when considering the high rates of service use and need. [5] Data from 2021-22 reported by Manatū Hauora | Ministry of Health showed that Māori accounted for 28.4% of all specialist's mental health service users. [6]

Similarly, only 1.4% of the psychiatry workforce identify as Pacific Peoples. Psychiatry compares unfavourably to the overall medical profession where 4.4% identify as Māori and 2.1% Pacific Peoples. [4, 5] However, the proportion of Māori and Pacific doctors is increasing amongst students and recently qualified doctors. Between 2018-2022, 12.3% of medical school graduates were Māori and 5.6% identified as Pacific Peoples. In 2023, psychiatry mirrored this figure with 11.5% of psychiatry trainees identifying as Māori. [5]

Figure 2. Ethnicity of the psychiatry workforce.



Source: MCNZ, June 2023. [5]

Retention

Retention data as it relates to the psychiatry training pipeline focuses on the movement of the workforce out of Aotearoa New Zealand, rather than movement out of HNZ into other sectors. The data provided by MCNZ and HNZ indicates that, overall, 72% of the psychiatry workforce was retained over 5 years (2017-2023). [2, 3]

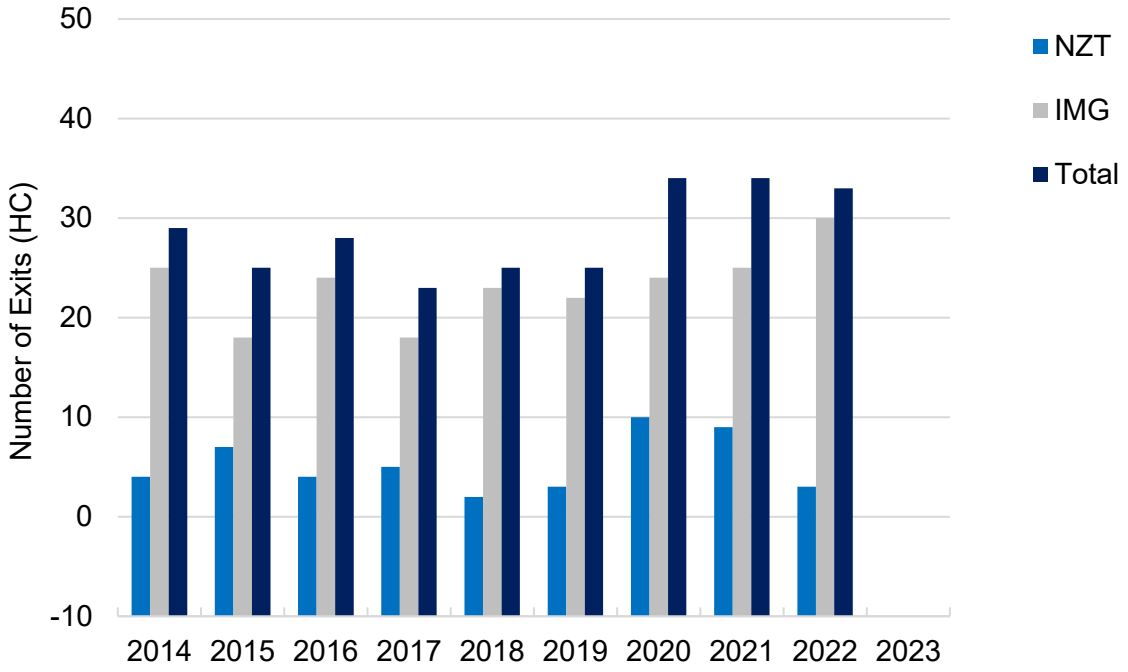
However, there is a marked difference in retention of NZ-trained doctors versus international medical graduates (Table 2). Psychiatrists who completed their primary medical degree and specialist psychiatry training in Aotearoa New Zealand have a retention rate of 93% after 5 years. In contrast, only 67% of psychiatrists who obtained their primary medical degree overseas but completed their psychiatry training in Aotearoa New Zealand were retained for more than 5 years. The poorest retention rate (64%) is achieved for doctors who completed both their primary medical degree and specialist vocational training overseas. [2] This figure includes doctors who move to Aotearoa New Zealand for a short period of time for locum positions.

Table 2. Number of psychiatrists leaving the workforce.

Year	IMG Exits (HC)	IMG Exits (% of previous year)	NZT Exits (HC)	NZT Exits (% of previous year)	Total Exit	Total Exits (% of previous year)
2014	25		4		29	
2015	18	5.6	7	3.1	25	4.6
2016	24	7.4	4	1.7	28	5.0
2017	18	5.3	5	2.2	23	4.0
2018	23	6.7	2	0.9	25	4.3
2019	22	5.9	3	1.2	25	4.0
2020	24	6.3	10	3.9	34	5.4
2021	25	6.2	9	3.4	34	5.1
2022	30	7.4	3	1.2	33	5.0

Source: HNZ and MCNZ, June 2023. [2, 3]

Figure 3. Psychiatrists exiting between 2014 and 2022.



Source: HNZ and MCNZ, June 2023. [2, 3]

Geographic Distribution of Psychiatrists

The narrative about retaining psychiatrists in the Aotearoa New Zealand workforce is given more detail when considering the psychiatry workforce within HNZ Mental Health and Addictions services. A 2023 article published in the Australian and New Zealand Journal of Psychiatry surveyed 500 psychiatrists' views on resourcing, demand, and workforce across New Zealand's mental health services. [7] The result and commentary are a stark critique of the mental health and addictions sector, with many participants mentioning the adversities arising from pervasive workforce shortages. This research and similar discussions detail the challenges of retaining psychiatrists in the public mental health and addiction sector and provide context to understanding the need for growth of the psychiatry training pipeline.

Table 3 illustrates the significant issue of vacancy rates in HNZ services. The national vacancy rate is around 19%, with some regions being impacted more severely; vacancy rates in the Central Region are around 25.6%, while only 10.6% of positions remain unfilled in Te Wai Pounamu | South Island. However, some districts within Te Wai Pounamu did not provide vacancy data (see Table 3), making regional comparisons unreliable. Examining specialty areas, services that support infants, children, and adolescents are most impacted with vacancy rates approaching 28% in 2022 (Table 3B).

Vacancy rates have increased in recent years as more psychiatrists leave the public funded health system or the country. Reports by HNZ Directors of Training suggest that there is a significant exodus to Australia, private practice, or into more lucrative locum positions.

Unfortunately, the reporting of vacancies has historically varied between regions, and the data provided by HNZ excludes casuals, contractors, locums, and people on parental leave or leave without pay.

Table 3. Contracted psychiatrists and vacancies by region and specialty.

A

Region	Filled positions (FTE)	Vacant positions (FTE)	Vacancy Rates (%)	Total (FTE)
Northern	193.2	44.7	23.3	237.9
Te Manawa Taki	69.2	23.3	25.2	92.5
Central	74.0	25.5	25.6	99.5
Te Waipounamu	105.8	12.5	10.6	118.3
Multi Region		1.3		1.3
National	443.4	106.1	19.3	549.5

B

Sub-specialty (FTE)	Filled positions (FTE)	Vacant positions (FTE)	Vacancy Rates (%)	Total (FTE)
Alcohol and Drug	28.0	5.4	16.1	33.4
Forensic	34.7	4.2	10.9	38.9
Mental Health	380.8	96.4	20.2	477.2
Total				549.5
Child	79.1	22.0	27.8	101.1
Adult	364.5	83.9	18.7	448.4
Total				549.5

Source: HNZ 2023 and Te Pou, 2023. [8]

Note: Vacancy data for 31 March 2023 was not available from the Canterbury and West Coast Districts, as they were undertaking data quality improvement processes.

Growing the pipeline

Entry into Psychiatry

Entry into the psychiatry workforce is via three routes:

1. Aotearoa New Zealand-trained medical graduates who then completed their specialist psychiatry training via the RANZCP fellowship programme.
2. International medical graduates who completed their undergraduate medical degree overseas then completed their specialist training in Aotearoa New Zealand.
3. Specialist international medical graduates who completed their specialist training overseas before joining the Aotearoa New Zealand workforce as qualified psychiatrists. The MCNZ also defines this group as IMGs; however, the RANZCP distinguishes this group by defining them as overseas-trained psychiatrists.

International Medical Graduates

For more than two decades, the psychiatry workforce has been dependent on international medical graduates (Table 4). IMGs constitute 61% of the psychiatry workforce in 2023, the highest proportion of all medical specialities in Aotearoa New Zealand and the second-highest proportion in the OECD. [9] This number comprises doctors who did their primary medical training overseas then entered specialty training for psychiatry in Aotearoa New Zealand (Route 2; 41% of trainees), and those who entered Aotearoa New Zealand as fully qualified psychiatrists (Route 3; referred to by the RANZCP as OTPs). This reliance on overseas doctors makes the workforce vulnerable in the context of the growing global health workforce shortages. The Covid-19 pandemic exacerbated this vulnerability as international recruitment ceased. [10]

This fragility of the reliance on an overseas workforce has recently been highlighted by impending changes to the health practitioner regulatory settings in Australia. OTPs have a supported and expedited pathway to register and work in Aotearoa New Zealand. Except for applicants from a small number of identified countries, Australia does not have the equivalent pathway for OTPs. Instead, OTPs are required to enter a period of training and supervised practice to gain RANZCP fellowship before being eligible to register in Australia. This can take years. Aotearoa New Zealand has therefore been a destination of both choice as well as ease.

In December 2023, the Australian National Cabinet endorsed a report into the Australian health practitioner regulatory settings. [11] This report, known as the Kruk report, highlighted that Australia was not benefitting from the overseas workforce due its stringent regulations and recommended that the registration pathway be made more flexible to allow for fast tracking and expansion (among a suite of other recommendations). Aotearoa New Zealand was held up as an exemplar for processes that expediate registration for international medical specialists. A recent implementation update communicated that the Medical Board of Australia (MBA) and the Australian Health Practitioner Regulation Agency (AHPRA) are now looking at ways to streamline the pathway for specialist IMGs. Psychiatry is one of four priority workforces for this project. The expectation is that the specialist medical colleges (including the RANZCP) will be engaged in achieving the recommended goals. This change of policy may have significant implications for the NZ psychiatry workforce as OTPs will be able to achieve registration in Australia with the same ease as in Aotearoa New Zealand.

Additionally, the Kruk report makes recommendations around recruitment and retention which, along with the regulation changes, may make Australia an attractive destination for OTPs who are currently working in Aotearoa New Zealand.

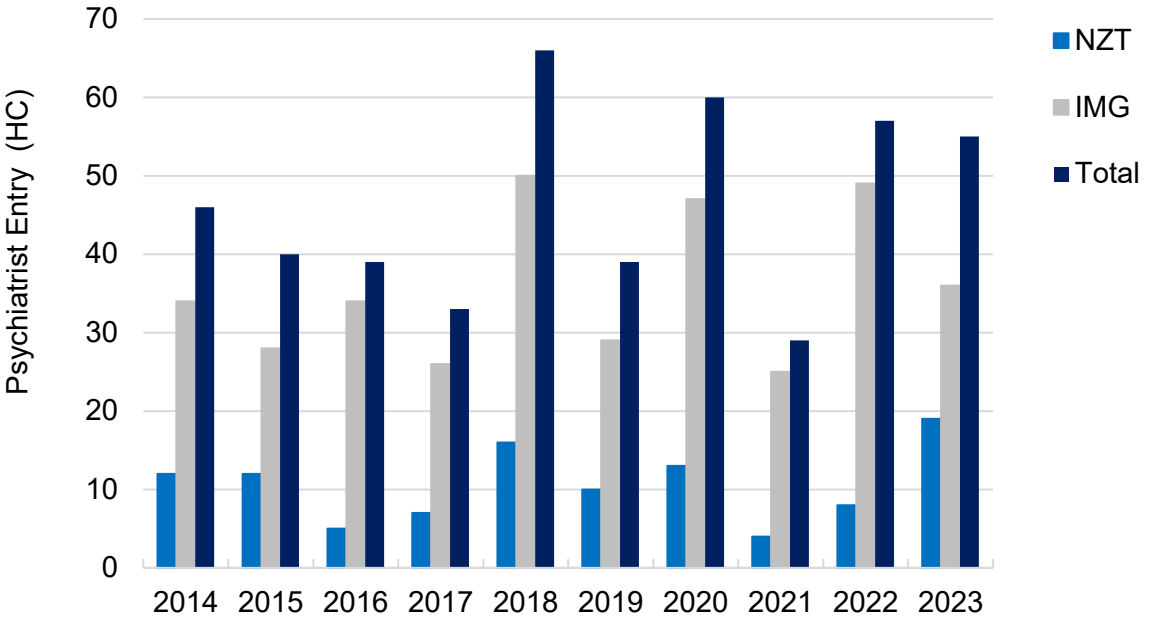
It is important to consider that there can be high costs associated with the recruitment of specialist IMGs. These costs are highly variable and there is no specific data available. It does, however, involve a payment to a recruitment agent, and expenses associated with registration, relocation, accommodation, vehicle, and other establishment costs, as well as staff costs to facilitate the recruitment. Recruitment expenditure must be considered in the context of the relative return that an overseas-trained psychiatrist brings long-term. A critical metric of this return is that the five-year retention of OTPs is poor (64%) compared to NZ-trained psychiatrists (93%). [2, 3]

Table 4. Number of psychiatrists who completed their primary medical degree in Aotearoa New Zealand (NZT) or overseas (IMGs).

Year	Total Head Count (HC)	Total IMG psychiatrists (HC)	Total NZT psychiatrists (HC)	Percentage IMGs
2014	547	321	226	58.7
2015	558	324	234	58.1
2016	572	340	232	59.4
2017	577	342	235	59.3
2018	620	374	246	60.5
2019	634	380	254	59.9
2020	669	405	264	60.5
2021	664	406	258	61.1
2022	687	430	257	62.6
2023	709	436	273	61.5

Source: HNZ and MCNZ, June 2023. [2, 3]

Figure 4. New and returning psychiatrists 2014-2023.



Source: HNZ and MCNZ, June 2023. [2, 3]

New Zealand Trained Workforce

The promotion of psychiatry as a career to medical school graduates is critical. Informal psychiatry interest groups at medical schools as well as a formal Psychiatry Interest Forum (PIF) aim to stimulate recruitment into psychiatry training. The PIF programme is delivered by the RANZCP via contracted funding from HNZ; it promotes psychiatry careers by expanding understanding of the discipline and supporting medical students and junior medical staff into a career in psychiatry. The programme has a particular focus on providing increased support to Māori and Pacific medical students and junior doctors, as well as those from rural areas. As of 2023, 542 medical students and junior doctors are members of the PIF, including 61 Māori members, and 15 Pacific members. [12]

Currently, there is a relatively level of interest from medical students seeking to specialise in psychiatry. This may in part be due to the increase in numbers at medical schools. Of importance to encouraging specialisation in psychiatry is the quality of the experience that House Officer have in their mental health rotation. Currently there is a paucity of House Officer rotations after several of these were disestablished over the last two decades, at least in part to cut costs. This lack of early exposure places psychiatry at a disadvantage in terms of recruitment of House Officers into training compared with other medical specialties.

The RANZCP fellowship programme

Specialist postgraduate psychiatry training in Aotearoa New Zealand takes a minimum of five years and consists of three stages. Stages 1 and 2 (Years 1-3) have a broad programme containing some mandatory training rotations (adult acute inpatient services, Child and

Adolescent Psychiatry, Consultation-liaison Psychiatry, and older adult services), and various professional activities/competencies that must be signed off. Stage 3 (Years 4-5) focuses on advanced training, with some registrars also completing subspeciality training certificates in Child and Adolescent Psychiatry, Consultation-liaison Psychiatry, Psychiatry of Old Age, Psychotherapy, Addictions Psychiatry, or Forensic Psychiatry. Subspeciality training in neuropsychiatry and intellectual disability are being explored but are currently not available in Aotearoa New Zealand. Around 50% of all trainees complete subspeciality training after gaining fellowship. However, entry into subspecialty training is dependent on the availability of funded training places and Directors of Training (DoTs) are facing pressure to fill vacancies in stretched generalist inpatient and community placements, rather than supporting trainees to become subspecialists.

DoTs are appointed by the RANZCP to coordinate the training programme across five training regions (Auckland, Upper Central North Island (UCNI), Lower Central North Island (LCNI), Canterbury and Dunedin). Training placements occur at a local level within HNZ specialist mental health and addiction services via an apprenticeship model and psychiatry trainees are registered medical practitioners employed by HNZ Districts. Trainees work within multi-disciplinary teams, carry a caseload appropriate to their level of training, and are an integral part of service delivery. Over the course of their placement, trainees work with, and are accountable to, their appointed supervisor who is a consultant psychiatrist working in the same or a similar team.

Training placements and programmes are accredited bi-annually by the RANZCP; the RANZCP training programme itself is accredited jointly by Medical Councils in Aotearoa New Zealand and Australia in alignment with international medical education standards.

Trainees are released one day per week to attend formal education courses (FECs) throughout the period of training to supplement their clinical practice. FECs deliver academic and applied clinical teaching and are provided by university academic departments of psychiatry in all training regions apart from UCNI where it is separate to the University. It is mandatory for trainees to attend at least 75% of FECs.

The psychiatry training programme provides flexibility through Breaks in Training (BIT) and the option to work part-time, with trainees being permitted to take up to 13 years to complete the programme. A detailed overview of the structure of the training programme is detailed in Appendix 2.

Trainee Overview

Table 5 details the number of trainees currently enrolled in the RANZCP fellowship programme. In 2023, there were 228 enrolled trainees, including 194 active trainees and 34 registrars on a BIT. [13] Trainee numbers and new intakes vary substantially across the years, regions, and different stages of training, due to programmes having to assess their capacity for rotations and supervision on a regular basis. Data from 2018 to 2023 (Table 5 and Figure 5) show a steady increase in the overall numbers of trainees in Auckland and LCNI (reflecting improved recruitment into existing positions), while other regions have remained relatively static. [13, 14]

There are slightly more female than male trainees and most trainees are between 25-35 years of age. The majority of trainees are either of New Zealand European or 'other' European ethnicity, 22 (11.5%) identified as Māori, and 79 (41%) are IMGs (Figure 6). [5]

Between 2013 and 2022, 21.5% of trainees withdrew from the programme. However, this may include individuals who started their training in Aotearoa New Zealand but moved to Australia before earning fellowship. [14, 15] Anecdotal reports from DoTs suggest a steady exodus of trainees to Australia for perceived better working conditions and remuneration.

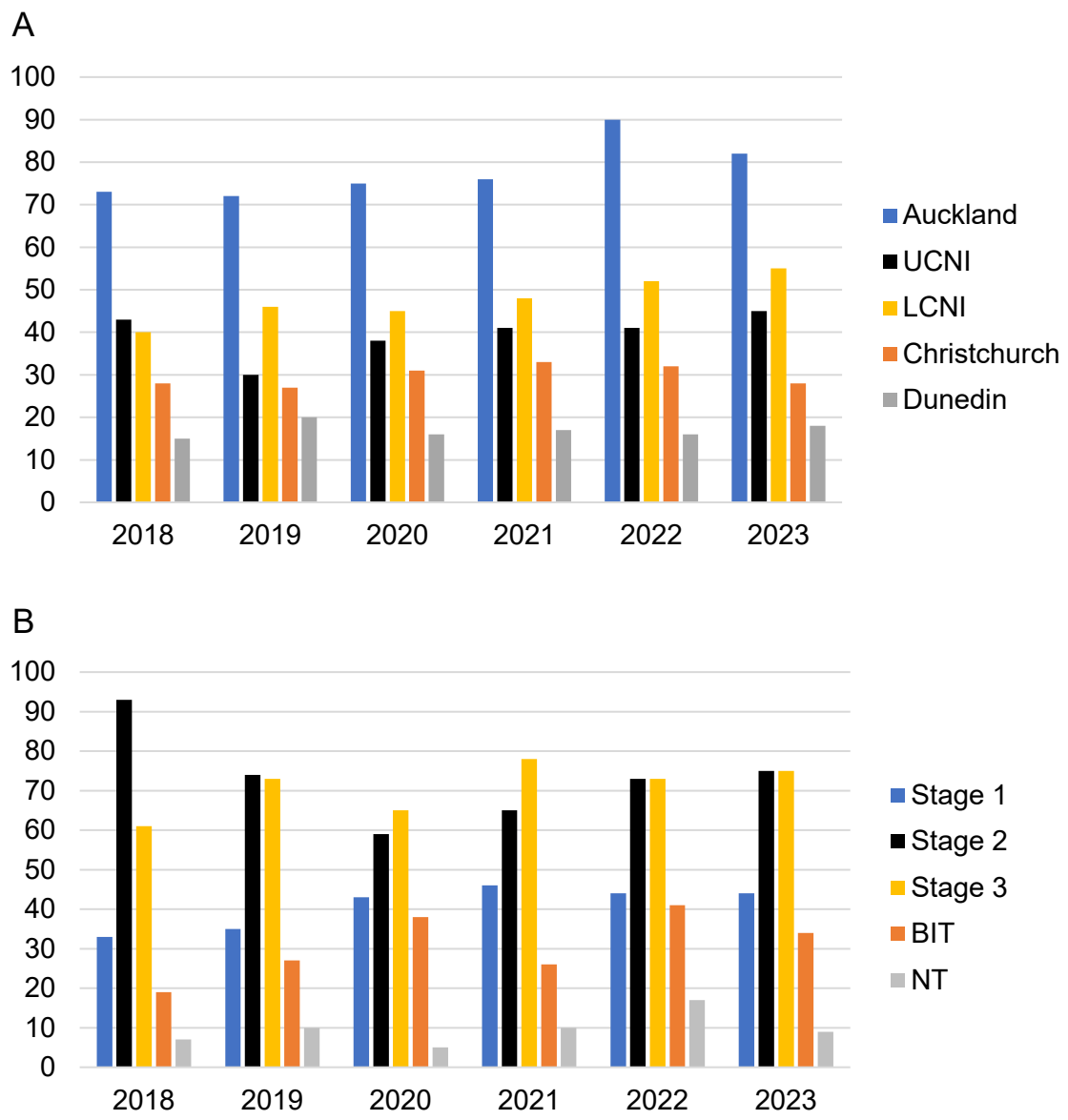
Table 5. Number of Registrars by location (A; HC) and stage (B; HC)

A	Auckland	UCNI	LCNI	Christchurch	Dunedin	Total
2018	73	43	40	28	15	199
2019	72	30	46	27	20	195
2020	75	38	45	31	16	205
2021	76	41	48	33	17	215
2022	90	41	52	32	16	231
2023	82	45	55	28	18	228

B	Stage 1	Stage 2	Stage 3	BIT	Non-training Registrars (NTR)	Total (excluding NTR)
2018	33	93	61	19	7	199
2019	35	74	73	27	10	209
2020	43	59	65	38	5	205
2021	46	65	78	26	10	215
2022	44	73	73	41	17	231
2023	44	75	75	34	9	228

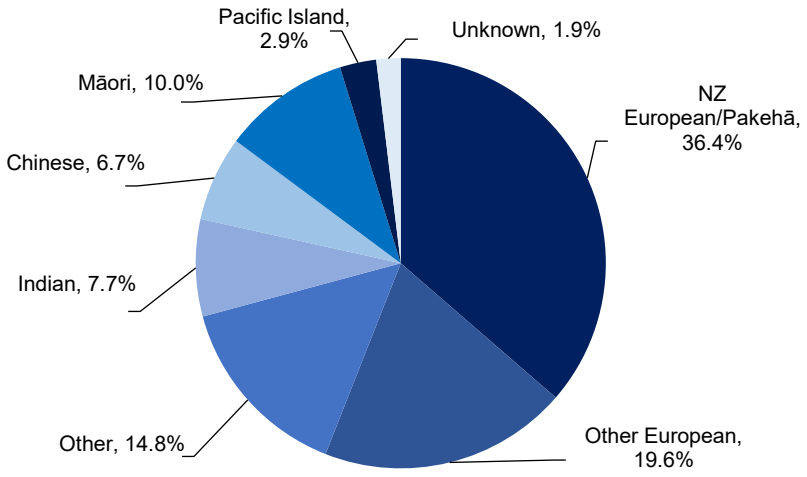
Data from the RANZCP, July 2023. [13]

Figure 5. Trainees by region (A) and stage (B).



Reported by DoTs, 2023. [13, 16]

Figure 6. Trainees by ethnicity.



Source: MCNZ, June 2023. [5]

Current capacity and constraints for psychiatry training in New Zealand

Supervision

Constraints around the availability of supervision is often cited as a factor that limits the growth of the psychiatry trainee pipeline. However, directors of training report supervisory capacity across regions that could potentially support additional trainees (Table 6). Supervisors who are active (are currently supervising a trainee) across the regions can also be augmented by those who are on the register (accredited to supervise) but are currently not supervising a trainee (Table 7).

Table 6. Training numbers by active trainees and potential capacity across regions as of February 2024.

	Auckland	UCNI	LCNI	Christchurch	Dunedin	Total
Active Trainees	70	36	46	26	17	195
Potential additional Trainees	20	12	16	34	19	101

Reported by DoTs, February 2024. [16, 17]

Table 7. Registered and active supervisors as of February 2024.

	Auckland	UNCI	LCNI	Christchurch	Dunedin	Total
In Register	178	110	89	79	24	480
Active	89	71	57	56	16	289

Reported by DoTs, February 2024. [16, 17]

The constraining issue with supervision is not the number, but the distribution, of available supervisors across regions and compulsory rotations such as Child and Adolescent Psychiatry, Consultation-liaison Psychiatry, and inpatient services. This has the potential to hold up the throughput of Stage 1 and 2 trainees and hinder advanced training in those specialty areas. Enhanced coordination and planning, could minimise these issues, revealing capacity for additional trainees while also providing an overview of training that ensures that the workforce is being deployed to areas of greatest need.

However, the increasing vacancy rate and aging workforce in HNZ is a pressing issue as psychiatry training is entirely dependent on supervision within public mental health services. While there is capacity for training now, the availability of accredited supervisors is predicted to become increasingly limited and eventually surpass the need of trainees. To address this, the numbers of trainees need to be increased now.

Regulatory constraints

There is limited flexibility in the training programme to provide adaptations to the models of supervision. The regulations of the RANZCP state that each supervisor can have a maximum of two trainees at a time and must provide four hours of clinical supervision per week over a six-month rotation, plus one hour per week of individual supervision, per trainee. Supervision must include regular direct supervision of the trainee's clinical work as well as specific areas of professional practice. These regulations currently limit innovation such as the use of virtual models of supervision to support training in rural areas or the development of supervision hubs, albeit this could change in time.

Funding for Training

Psychiatry Registrars are employed by HNZ District Mental Health and Addictions services based on allocated FTE and the availability of an RANZCP-accredited supervisor. Vacancy funding is also utilised depending on need and trainee availability. Health Workforce provides registrar training funding to each HNZ District. This contributes to the training costs of registrars of all medical specialties.

HNZ funding made available to psychiatry training covers time out of the workforce to attend a formal education course for approximately one day per week, provision of supervisor time, and decreased caseloads during the early stages of training. The subsidy decreases as training progresses, reflecting the Registrar's increasing seniority and reduced need for training and oversight (Table 8). HNZ Districts meet the remainder of the employment costs.

The programme of formal education that is provided by universities is funded separately. The universities have indicated that this training can be scaled up to include additional trainees.

Psychiatry trainee funds were historically provided to support all training positions but have not grown with the programme since 2007. Currently, there are 107 funded places for 194 active trainees – a shortfall of around 45%. For non-funded trainee registrars, HNZ Districts provide the total salary and associated training costs. While this constrains the employment of registrars in some regions, others have accommodated the total cost, generally from unfilled Senior Medical Officer positions. Many HNZ Districts see this practice as unsustainable and with limited ability to increase the number of training positions any further. This has resulted in a plateau of trainee numbers and geographical inequities. It is clear, though, that when available, the Health Workforce fund provides a strong incentive for HNZ Districts to prioritise positions for registrars. There are currently no clear criteria for which trainees get access to the available funding.

HNZ Districts recruit independently of each other and there is no national oversight or coordination of recruitment, or prioritisation of national workforce priorities either geographically, or in relation to subspecialty training. Furthermore, since July 2022, Health Workforce funds for psychiatry trainees are no longer protected but are distributed to the HNZ Districts to administer according to their priorities for all registrars across all medical specialties. Based on experience, there is a high risk of diversion of existing psychiatry training funding to other medical specialties as they also come under pressure.

The total Health Workforce payment for a funded registrar over their five years of training is $248,204. How and when this funding level was determined is unclear and there is no available analysis of the costs of the training component.

Table 8. Health Workforce Training Funding 2021/2022 (NZD).

	Year 1	Year 2	Year 3	Year 4	Year 5	Total annual cost
HW Fund (per trainee)	62,182	52,293	52,293	40,718	40,718	248,204
Number of trainees funded	26	63	63	15.5	15.5	
Total cost (all trainees)	1,616,732	3,294,459	3,294,459	631,129	631,129	9,467,908

Additional FTE

HNZ services are currently funded for an agreed number of registrar FTE. There is significant workforce vacancy, and ongoing attrition within Mental Health and Addiction services that would absorb initial increases in the psychiatry workforce. Over time and with reduction in vacancy, additional positions may require funding to align FTE/100,000 closer to the OECD average. [18]

Proposed Solutions

The following solutions are proposed for discussion and do not represent policy of HNZ. To realise the goal of an enhanced and sustainable workforce the most urgent areas of focus are as follows:

❖ Increase trainee numbers and fund each trainee equitably.

To ensure the viability of the workforce, to meet demand and to balance the numbers who are exiting the workforce there would need to be an increase in the number of trainees by at least ten percent (of current total trainees) per year for five years. This would necessitate a considerable investment. The following are suggested actions to achieve this goal.

- Fully fund all current training positions (194), not just 107 as per current status.
- Provide additional funding to increase the number of trainees by 10% per year. Over a five-year period, this will increase the number of funded trainees from 194 to 311 (a 60% increase).

These actions will produce an additional 117 NZ-trained psychiatrists per year after ten years. This includes five years of increasing numbers and an additional five for the final increased training cohort to move through their training.

Table 9 shows the trainee numbers over five years with an annual increase of 10% on the preceding year. Assuming an annual cost of $51,178/trainee based on 2021/22 numbers in each training year (Table 8), the annual cost of the training component of funding will be approximately $15,916,358 in five years. This is an increase in investment after five years of approximately $10,440,312 per annum, if funding rates remain the same.

Table 9. Trainee numbers and costs with a 10% increase over five years.

Year	+10%	Number of funded trainees per year	Cost per year (average annual cost per trainee $51,178)
0 (2024)		107 (currently funded)	5,476,046
0 (2024 second half)		194 (total active trainees 2023)	9,928,532 (per annum)
1 (2025)	19	213	10,900,914
2 (2026)	21	234	11,975,652
3 (2027)	23	257	13,152,746
4 (2028)	26	283	14,483,374
5 (2029)	28	311	15,916,358

This proposal is limited in that, over the next ten years, it will achieve no more than 50% of the psychiatry workforce being NZ-trained, merely covering the number of existing vacancies within public services. It will not keep pace with population growth or the pending increased rates of retirement due to the aging workforce, nor will it address the unmet need in sectors other than health.

The other significant factor is that the Health Workforce fund, where available, represents less than one third of the cost to employ and train a trainee. The local service must fund the remainder of the salary. If trainee numbers are to increase, regional funding for registrar positions will also need to be provided.

❖ Protect the funding for psychiatry trainees.

Identifying and protecting the HNZ training funding for psychiatry trainees would ensure it remains available for the exclusive use of psychiatry registrars. The 'one pot' of trainee funding that is provided to the regions, for all medical specialty training, does not guarantee that existing or new resources will be applied to the psychiatry pipeline. Ideally this funding would follow an individual trainee through the training journey and allow for movement across regions if necessary.

❖ Consider national coordination of psychiatry registrar placements.

To manage any new funding and its distribution there is the potential to develop national coordination to have oversight of the training programme and to support DoTs in their roles of recruitment and training. It could also involve coordination of registrar placements along with national coordination of subspecialty training such as Child and Adolescent Psychiatry, Consultation-psychiatry, Forensic Psychiatry, or Old Age Psychiatry. This may also mitigate some of the competition that currently exists across the regions for trainees. While there is concern from DoTs that this could create further bureaucracy, cost money to administer and reduce the ability for local adaptations and solutions, there is merit in exploring this potential.

❖ Increase the focus on recruitment.

A focus on effective recruitment of new trainees is essential. Expansion of programmes such as the PIF should include House Officers as well as senior medical students. Creating additional mental health rotations for House Officers, which is the time when people most commonly decide on areas of specialisation, will assist in promoting enrolment in psychiatry training programmes. NB: some of these were historically available, then disestablished, and could easily be re-instituted with appropriate funding.

Exemplar: A scheme for second year (PGY2) House Officers in Christchurch provides a three-month placement to each of the four-community mental health crisis teams. In one team, instead of four House Officers rotating through every three months, they have two dedicated House Officers for six months each, where they get a good, extended experience in psychiatry. It is a popular attachment with competitive interviews for these positions. So far, all House Officers who have completed one of these placements have converted to psychiatry registrars.

Additionally, development of a Post-graduate Diploma in Mental Health and Psychiatry, preferably with a strong practical emphasis would be valuable to expand the skills of doctors working in specialties such as general practice and attract them to consider undertaking specialist psychiatric training.

❖ Monitor and increase funding for subspecialty training.

It is important to ensure there are enough psychiatrists trained in key subspecialty areas such as Child and Adolescent Psychiatry, Psychiatry of Old Age, Consultation-liaison Psychiatry, Addictions Psychiatry, Neuropsychiatry, Psychiatry of Intellectual Disability, and Forensic Psychiatry. To that end, a larger number of subspecialty training runs should be developed and monitored in a nationally coordinated manner. One-to-two-year training 'Fellow' positions, employed by other specialties such as paediatrics, may be useful to consider as a mechanism of containing funding for these roles.

❖ Consider a review of compulsory training.

A College review of aspects of the training programme is suggested and particularly the compulsory rotations that create bottlenecks. Creating more rotations in different contexts may be an option. For example, currently all Consultation-liaison Psychiatry positions are in an adult context, however child runs could also be utilised to increase capacity. A review may determine that some of the compulsory rotations could become options to ameliorate the bottlenecks. An open-minded perspective and willingness to innovate to manage challenges is essential to ensure the development of an effective and sustainable training pipeline.

❖ Innovate supervision models to better match the pool of existing supervisors with the required training rotations.

While the overall number of supervisors is currently not a limiting factor for increasing trainee numbers, the aging workforce is a portent to this eventuality. Additionally, there are occasions when there are limits on capacity in compulsory runs. This necessitates exploration of how supervision can be adapted to meet growth. It has been suggested to utilise rural placements with virtual supervision, placements in private facilities, or supervision hubs with greater ratios of trainees to supervisor. Remote supervision models have been trialed in Australia recently and may be adapted to the Aotearoa New Zealand context.

❖ Fund improved data collection systems with Te Whatu Ora and the RANZCP.

Data is critical for understanding the need within specialist mental health services and plan for a workforce that serves that need. Therefore, funding of centralised data collection systems, analysis, monitoring, and reporting will be crucial. A centralised data system will inform workforce planning by providing a national perspective regarding the number of trainee positions required to ensure the psychiatry workforce meet the demands of population growth and the specific needs of regions, sectors, and subspecialties.

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Appendices

Appendix 1. Data limitations

Data about the psychiatric workforce is gathered by a range of organisations and is evaluated in Table 10. Unfortunately, there is a lack of comprehensive data and some of it is significantly out of date. This impacts the ability to evaluate and plan effectively. Much of the data analysis of the workforce comes from data gathered from the Medical Council from a survey of its members as part of the annual registration process. Since 2021, doctors cannot opt out of the workforce survey due to new legislation enacted in 2019, but they can decline certain questions, for example ethnicity. However much of the historic data is based on voluntary survey results. Data may vary from year to year and does not provide the complete picture. There is concern about the reporting of FTE figures in the modelling data as the numbers indicate that virtually all psychiatrists are full time when this is (anecdotally) reported as incorrect. These FTE figures are used for modelling, and it is likely that they are significantly overcalculating the true number of psychiatrists both now and in the future.

There is a historic lack of consistency of data across DHBs and some data is reported by financial year, other data by calendar year and published reports from Te Pou are March-March which makes comparisons difficult. There are other issues such as differing levels of precision in the workplace data held for doctors as well as challenges around representing the location of doctors who routinely work across multiple regions.

There are also some issues with the data held by the RANZCP. Data is combined between Australia and Aotearoa New Zealand in some cases, and it is difficult to extract NZ specific data. For example, withdrawals may include some trainees who may have started in, or moved to, Australia. The current shared data does not distinguish between a withdrawal from the Aotearoa New Zealand programme and a transfer to Australia.

Table 10. Available data sources, content, and limitations.

Organisation	Data	Collection Method	Limitations
Te Kaunihera Rata o Aotearoa Medical Council	Overall Number (under vocational scope) Breakdown by age, gender, ethnicity. Retention (not specific to psychiatrists) Vocational Training with breakdown of ethnicity and gender, IMGs	Primary data from the Annual Practising Certificate (APC) questionnaire. Data taken from the register (scope of practice, qualification data and status) as well as non-register data from the annual practising certificate (employment, level of practice, type of medicine, participation in vocational training) and associated workforce survey (ethnicity and other details).	The entire questionnaire is not mandatory. Data only available via Data Dashboard/ no control over what is reported. Not all data is specific to psychiatrists. Annual certificate can be completed four times per year.

Health Workforce Information Programme (HWIP) Te Whatu Ora|Health New Zealand	FTEs and headcounts of psychiatrists practising in the adult public system, breakdown by region, FTE vacancies.	Records Senior Medical Officers (SMOs) holding vocational scope in psychiatry. Information provided by regions (or DHB previously)	Some data is incomplete. Depends on regions reporting accurate data. There is a lack of consistency across regions on how and what data are reported. Only reporting SMOs working in the adult public service. Some SMOs may be counted multiple times (if they work across multiple regions). Some data rounded to ensure anonymity.
Health Workforce New Zealand (HWNZ) Manatū Hauora Ministry of Health	Psychiatrist HC, IMGs, retention and forecasting of psychiatry specialist workforce. More detailed breakdown of MCNZ data including location of primary/secondary degree.	Records movement of SMOs holding psychiatry vocational scope, data as sourced from Medical Council. HWNZ base their information and data provided by the Medical Council.	Currently some data (retention) are based on fiscal year (June-June) and some on calendar year. No regional data or vacancies.
Te Pou Reports	Mental Health Workforce (HNZ, NGOs) Some info on ethnicity and region and type of service. Some break down regarding specialities.	Compiles data from other sources: HWIP and NGOs Data dashboard in development	Information reliant on what is reported/no raw data. Reporting period doesn't align with MCNZ or HW. Some data not specific to psychiatrists.

Whāraurau Reports	ICAYMH/AOD Workforce Some information on ethnicity and region, type of service Provides some information on regional funding.		Relies on report
RANZCP IMis data	Member data Gender, region, training, country of origin, qualifications, age, retirement, information regarding membership and participation in college activities	Information provided voluntarily by psychiatrists through the member data base. psychiatrists may be retired but still be active members)	Voluntary data is incomplete. Reliant on members updates. Data extracts are based on membership and not possible to filter out practising psychiatrists
RANZCP Training committee	Trainee data by region and stage of training – PT and FT. Vacant positions in progress Qualitative information regarding challenges and opportunities/bottlenecks	Based on report by DoTs.	Reliant on subjective reporting. Data only provide a snapshot in time. Inconsistent data across regions.
RANZCP Education committee	Cohort completion and attrition rates, number of graduates. Data is reported via a Cohort Progression Monitor report, released annually.	Each cohort completing the program in six years or less is monitored and reported.	Data relates to commencement zone information, makes tracking challenging/ if a withdrawal it may have taken effect in another jurisdiction.

Appendix 2. Psychiatry workforce modelling

Analysis of workforce data has been provided by Analytics and Intelligence, National People Services within Te Whatu Ora | Health New Zealand for many years. The 2024 modelling that provides for forecasting of psychiatry workforce is based on a limited set of variables and acknowledges the assumption that in the next ten years there will be:

- no changes in technology or models of care
- continuation of age-specific patterns of entry, re-entry and exit based on 2020-2023 trends.
- continuation of age-group-specific working hours
- continuation of historic patterns of entry of new NZ-trained practitioners and fully qualified overseas practitioners

Additional variables and issues that are not factored in this modelling:

- The analysis only considered the over 18 years population whilst including child and adolescent psychiatrists. This has resulted in an estimate of the psychiatry workforce of 18.2 FTE/100,000 (across the whole population the workforce is 13.6 FTE/100,000) which is misleading unless examined carefully in context of the analysis.
- The modelling does not forecast the growth required to remedy the 19% vacancy that currently exists in health.
- Utilising head count data that assumes all psychiatrists work full time; HNZ has a psychiatry workforce of 8.5/100,000.
- Due to shortcomings in the data reporting, FTE may have been conflated with headcount, thereby leading to the numbers of psychiatrists in the workforce being overrepresented (709 psychiatrists were counted as 702.7 FTE – based on anecdotal reporting the FTE number is likely to be substantially less than this).
- The optimal FTE/100,000, determined through consideration of comparable countries is not referenced as a target. Status quo is assumed. The OECD average is 18/100,000.
- It is not known what the level of unmet demand of psychiatrists is in other sectors. A Ministry of Justice (2023) report on the current state of assessment reports pointed to significant shortages of psychiatrists (and other report writers) that may affect the treatment provided to people with serious mental health issues or intellectual difficulties. The report stated that Aotearoa New Zealand health and Justice sectors are facing a challenging situation in the commissioning, arrangement, and delivery of reports.
- The increase in locally trained psychiatrists that will be required to rebalance the reliance on IMGs from over 60% closer to the average in other medical specialties (around 40%) was not considered in the analysis.
- Forecasting considers age related patterns of psychiatrists leaving practice in the years 2020-23. This does not, however, acknowledge the increasing average age of the workforce that will result in a dramatic acceleration in psychiatrists leaving the profession within the next 10 years.

Appendix 3. Structure of the RANZCP training programme.

Table 11. Stages and Rotations of the RANZCP Training Pathway.

Stage 1 (Year 1)	Rotations	Duration
Adult focus	• Adult acute services • Adult non-acute services	6 months 6 months
Stage 2 (Year 2 and 3)	**Rotations**	**Duration**
Variety of settings/diverse populations	• Child and Adolescent Psychiatry • Consultation-liaison Psychiatry	6 months 6 months
	Additional rotation in one or more of the following: • Addiction Psychiatry, • Adult Psychiatry, • Child and Adolescent Psychiatry • Consultation-liaison Psychiatry, • Forensic Psychiatry, • Indigenous psychiatry, psychiatry of old age, • Research (maximum 6 months FTE).	12 months
Stage 3 (Year 4 and 5)	**Rotations**	**Duration**
Trainees can continue in general psychiatry and proceed with elective rotations in a single or multiple area(s) of practice. OR apply to enter training for a Certificate of Advanced Training comprising 24 months of full-time equivalent training in a subspecialty area of practice (Consultation-liaison Psychiatry, Psychiatry of Old Age, Forensic Psychiatry, Addictions Psychiatry, Psychotherapy, and Child and Adolescent Psychiatry).	Four elective rotations: • Addiction Psychiatry, • Adult Psychiatry, • Child and Adolescent Psychiatry • Consultation-liaison psychiatry, • Forensic Psychiatry, • Indigenous Psychiatry, • Psychiatry of Old Age, • Psychotherapies, • Research/medical education/medical administration	6 months each x 4 rotations

Appendix 4. Psychiatry to population ratios

Determining Aotearoa New Zealand relative international comparisons for the psychiatry workforce is not straightforward. In 2022 the OECD/WHO Health at a Glance – Asia/Pacific, states that Aotearoa New Zealand has 20/100,000 psychiatrists, above the OECD average of 18.1. [18] Clearly this is inaccurate, and while the source is not acknowledged, may have arisen from the Medical Councils annual report (2022) that stated there were 962 psychiatrists. [19] This number however, included those who were inactive (have no practicing certificate - e.g., may be overseas or retired) so overestimated the workforce by 36%. These issues are common within workforce data and contribute to the challenge of planning.

Within public-funded health services in 2023 there were 549 FTE positions available for psychiatrists, however 19% (106) of these were vacant. It is not known how many of these were filled by locums. This represents approximately 8.5 psychiatrists employed in public health services per 100,000 population. Again, these figures are considered estimates as it is unclear whether these FTE positions were fully occupied, or whether a head count that included part time employees was utilized. 8.5/100,000 is therefore a best-case scenario estimate and likely overstates the psychiatry workforce in public-funded health services. The Medical Council has recorded in its annual survey that the average hours that each psychiatrist worked was 43.9. [4] This may have led to an assumption that most psychiatrists work full time, though this data did not specify setting and may be across a range of workplaces. Thirty-one percent (173) reported that their main, second or third type of employment was in private practice indicating that a significant proportion of psychiatrists do work across more than one workplace (Te Whatu Ora, 2023).

In 2023, around 16% (88) psychiatrists reported their main employment as private practice. This will include those who privately contract to other sectors such as Justice or ACC. There is scant data on other sectors who utilise the psychiatry workforce.