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Obstetrics and Gynaecology Supply and Demand Compendium Report

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Obstetricians and Gynaecologists in Australia

While the number of obstetricians and gynaecologists continues to grow, significant disparities in workforce distribution persist. Many regional and rural areas remain under-resourced, resulting in limited access to O&G services outside metropolitan areas. This maldistribution contributes to ongoing challenges in ensuring equitable access to O&G care across the country.

Obstetrics and gynaecology (O&G) play a critical role in maternal and child health, making them key areas of focus in medicine. Obstetricians provide medical care before, during, and after childbirth. Gynaecologists diagnose, treat, and aid in the prevention of disorders of the female reproductive system.

Changing fertility rates and increasing average maternal age are driving the demand for O&G services. The latest Australian Institute of Health and Welfare (AIHW) report on Australia's mothers and babies shows that the average maternal age has steadily increased from 30.0 years in 2010 to 31.2 in 2022. The report also highlights a continued rise in caesarean births, from 31.6% in 2010 to 39.2% in 2022.[1]

The O&G workforce is undergoing significant change, driven by increased feminisation and a shift toward part-time work. According to the latest Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Annual Report (2023–24), women now make up 83.2% of college trainees.[2] However, workforce maldistribution remains a challenge, making it difficult to ensure safe and equitable access to women's health services in regional, rural and remote areas. In response, RANZCOG released its *Rural, Regional and Remote Women's Health Strategy* in March 2024, aimed at improving service delivery for women and their families in these geographically dispersed communities.[3]

Another emerging challenge in maternity care is the growing financial pressure on private maternity services. Currently private hospitals manage approximately 25.0% of all births and 70.0% of elective women's procedures. However, decline in child births, high out of pocket costs and high cost of private health insurance products are threatening their financial sustainability. Between 2015–16 and 2022–23, nine private hospitals closed their maternity wards, while 2 hospitals offering maternity services ceased operations entirely. [4,5] As these closures continue, the already overburdened public health system is left to absorb the increased demand, exacerbating pressure on resources and reducing access to timely care.

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[1] Australian Institute of Health and Welfare, Australia's mothers and babies, 2024, accessed 5 March 2025.

[2] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, RANZCOG Activities Report, 2023, accessed 5 March 2025.

[3] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2024, Rural, Regional and Remote Women's Health Strategy aims to ensure equitable access to women's healthcare across Australia, accessed 13 June 2025.

[4] Department of Health, Disability and Ageing, 2024, Private Hospital Sector Financial Health Check – Summary, accessed 5 March 2025.

[5] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2024, Private O&G Services Under Threat in Australia Due to Systemic Gender Bias, accessed 5 March 2025.

The challenges in the O&G workforce offers opportunities to adopt innovative, collaborative models of care. Integrating O&G specialists, midwives and General Practitioners (GPs) with advanced obstetric skills into shared care models, could support the sustainability of private services and improve access to O&G services in rural and remote areas. According to RANZCOG, there were approximately 2,000 GP obstetricians in Australia in 2024. Better integration and utilisation of this workforce could significantly improve service accessibility and reduce pressure on O&G specialists services.

There is also a significant unmet demand for specialist care, particularly for non-urgent gynaecological conditions such as pelvic pain, endometriosis, urinary incontinence and prolapse. However, accurately assessing this demand remains a challenge, as there is no reliable measure to accurately capture and understand the need for gynaecological services.

RANZCOG conducts practice profile survey of the college fellows to understand what proportion of O&G specialists are predominantly working in gynaecology or obstetrics or both. The data for 2024 suggests that around 18.0% of fellows worked exclusively in gynaecology and 10.0% exclusively in obstetrics and remaining 72.0% worked in both gynaecology and obstetrics. This indicates a preference to practise both O&G, however, a sizeable proportion of O&G specialists are working exclusively in gynaecology. Given obstetrics dominates the services delivered across various public health settings (see Appendix), any further shift toward gynaecology would have implications for access to obstetrics services in the public sector.

This study examines the supply of and demand for O&G specialists in Australia, building on the *Australia's Future Health Workforce Report – Obstetrics and Gynaecology 2018* [6], prepared by the Department of Health, Disability and Ageing. Like the 2018 report, General Practitioners (GPs) with advanced skills in obstetrics and gynaecology are not within the scope of the modelling. The 2018 report projected a slight surplus in the O&G workforce throughout the projection period from 2018 to 2030. Using updated data and methodology, this study provides a more refined understanding of the current and future O&G workforce trends, offering insights to support workforce planning and policy development. This study will be presented to the National Maternity Workforce Strategy (NMWS) Steering Committee and will inform the development of the NMWS 2026–36 and the Women-Centred Care Strategy.

[6] Department of Health, 2018, Australia's Future Health Workforce – Obstetrics and Gynaecology, accessed 7 March 2025.

Summary of results

Although the O&G specialist workforce is expected to grow over the next 25 years, the workforce is projected to experience a shortage throughout the projection period.

The national level projections from the O&G model (Figure 1) paint a picture of the future supply and demand trends for O&G specialists over the coming decades.

According to the model, the supply of O&G specialists is expected to grow steadily, rising from 2,262.4 full-time-equivalent (FTE) in 2025 to 3,172.1 FTE by 2048. This growth corresponds to an increase in the number of individual specialists, from 2,186 in 2025 to 3,147 by 2048.

On the demand side, the need for O&G services is also projected to climb, with FTE demand rising from 2,328.0 in 2025 to 3,400.1 by 2048. This translates to a required headcount of 2,265 O&G specialists in 2025 and 3,402 by 2048.

The rising demand is linked to broader demographic trends, including a sustained decline in fertility rates and an increase in the average age of mothers. These shifts, along with evolving population demographics, are associated with greater birth complexity and are therefore likely to drive increased demand for obstetrics and gynaecology (O&G) services. [7]

As a result, the O&G specialists' workforce is expected to remain in shortage throughout the projection period. In 2025, the estimates indicate a shortfall of 65.6 FTE representing a 2.9% gap between supply and demand. This shortage is expected to worsen, reaching 228.0 FTE (7.2%) by 2048.[8] In terms of actual headcount, the gap is estimated at 79 O&G specialists in 2025, increasing to 255 by 2048.

The maldistribution of the O&G workforce remains a significant barrier to equitable access to services in regional, rural, and remote areas. Many of these centres are understaffed and often perceived as less attractive employment locations due to factors such as limited housing, restricted career and employment opportunities for partners and limited childcare options.[9] The public hospital separations data for 2022–23 (financial year)[10] revealed that approximately 34.0% of O&G related public hospital admissions for patients living in Modified Monash Model (MMM) categories 3 to 7 occurred in MMM 1 and 2 locations, requiring patients to travel for care. Similarly, Medicare Benefits Schedule (MBS) data over the same

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[7] Australian Bureau of Statistics, October 2023, Birth rate continues to decline, ABS website, accessed 10 March 2025; Centre for Population, 2023, Australia's future fertility: A quick guide to potential impacts on future population, accessed 12 February 2025; Australian Institute of Health and Welfare, 2024, Australia's mothers and babies, Maternal age, accessed 13 February 2025.

[8] Throughout the document, the percentage shortage is calculated as proportion of the total supply.

[9] NSW Select Committee on Remote, Rural and Reginal Health, 2024, Report 1 - The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health, accessed 13 June 2025.

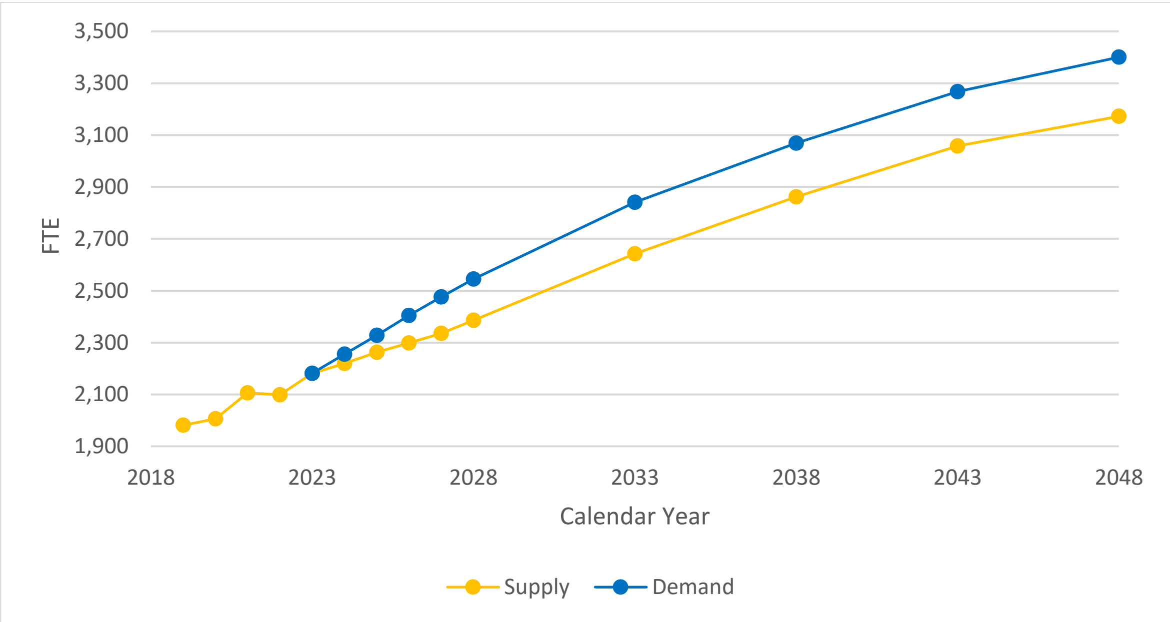
[10] The public hospital separations data is from the AIHW Admitted patient care NMDS (Service Related Groups: 71 and 72). The Medicare Benefits Schedule data is from Medicare Benefits Schedule data collection.

period indicates that 61.0% of MBS funded O&G services received by patients from MMM 3 to 7 areas were delivered by providers located in MMM 1 and 2 regions. [11]

The findings from the study also highlight a continuing trend toward feminisation of the O&G workforce. The proportion of female O&G specialist (headcount) is projected to rise from 60.3% in 2025 to 74.1% by 2048. Accompanying this demographic shift is a decline in the national average FTE per O&G specialist, projected to fall from 1.04 in 2025 to 1.01 by 2048, suggesting changes in work patterns and preferences.

Another notable trend is the ageing of the O&G workforce. The model shows that specialists aged 40-54 are expected to continue providing the highest share of FTE (approximately 50.0%) throughout the projection period. Similarly, those in the 55-64 age cohort are expected to contribute a growing share of FTE, rising from 27.7% in 2025 to 29.1% by 2048. This shift shows a growing reliance on older specialists and suggests future challenges in maintaining workforce sustainability.

Figure 1: FTE National Projections: Supply vs demand, 2018–48



[11] For description of Monash Modified Model please refer to Modified Monash Model.

Workforce Profile

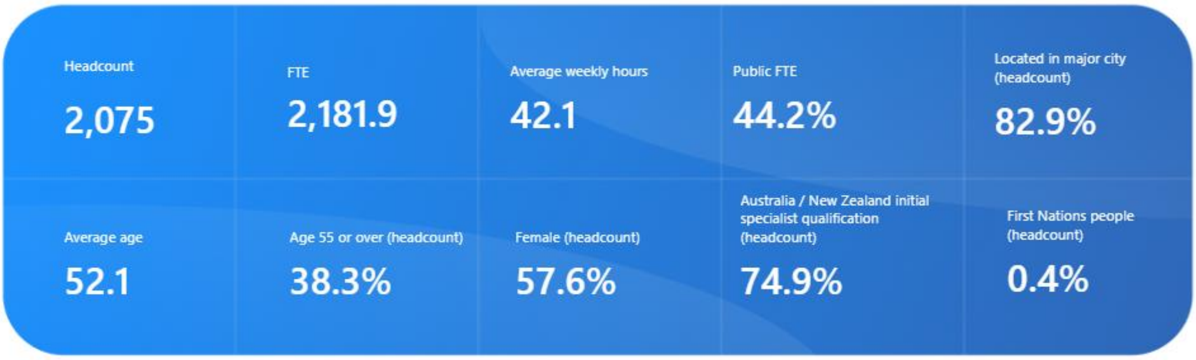
The following section presents a snapshot of the current workforce using the latest available supply data, 2023. It also summarises historical trends observed from 2019–23.

Quick Facts

In 2023, there were:

- 2,075 O&G specialists with average weekly hours of 42.1 that equates to 2,181.9 FTE O&G specialists. This total consists of 1,631.9 FTE Australian/New Zealand medical graduates (those with initial specialist qualification from Australia or New Zealand) and 550.0 FTE international medical graduates (those with initial specialist qualification from overseas).
- 1,195 female and 880 male O&G specialists.

Figure 2: Quick facts on O&G workforce, 2023



Subspeciality

Table 1 provides a summary of the O&G workforce by subspecialty. It shows that in 2023:

- There were 1,879 O&G specialists (headcount) with no registered subspeciality, accounting for 90.6% of the O&G workforce.
- Gynaecological oncology specialists and obstetrics and gynaecological ultrasound specialists each represented 2.4% of O&G workforce. They were followed by maternal-fetal medicine specialists and reproductive endocrinology and infertility specialists, each comprising 2.0%. Urogynaecology specialists made up the smallest portion, accounting for just 1.7% workforce.
- Gynaecological oncology specialists worked the longest average hours at 43.0 per week, followed by urogynaecology specialists, who averaged 42.7 hours per week.
- Overall, 44.2% of the FTE O&G specialists were employed in the public sector. A significant majority of maternal-fetal medicine specialists (76.1%) worked in the public sector, while most reproductive endocrinology and infertility specialists (93.7%) were employed in the private sector.

Table 1: Summary statistics by subspeciality, 2023

Subspeciality	Headcount	Average weekly hours	FTE	Public FTE %	Private FTE %
Gynaecological oncology	50	43.0	53.7	44.2	55.8
Maternal-fetal medicine	42	41.6	43.7	76.1	23.9
Obstetrics and gynaecological ultrasound	50	35.5	44.4	24.8	75.2
Reproductive endocrinology and infertility	41	40.2	41.2	6.3	93.7
Urogynaecology	35	42.7	37.3	26.5	73.5
Specialist obstetrician and gynaecologist	1,879	41.8	1,961.5	45.1	54.9
Total[12]	**2,075**	**42.1**	**2,181.9**	**44.2**	**55.8**

Workforce Trends and Distribution

Table 2 provides the O&G workforce trends, with key highlights as follows:

- The number of O&G specialists increased from 1,865 in 2019 to 2,075 in 2023 reflecting a Compounded Annual Growth Rate (CAGR) of 2.7%. However, FTE workforce grew at CAGR of 2.4% during the same period, driven by a slight decrease in the average hours worked.
- Overall, the average weekly hours worked decreased slightly from 42.5 in 2019 to 42.1 in 2023, reflecting a 0.2% CAGR decline.
- The proportion of FTE O&G specialists employed in the public sector has increased from 41.4% in 2019 to 44.2% in 2023, reflecting a CAGR of 1.7%.

Table 2: Workforce trends, 2019–23

Year	2019	2020	2021	2022	2023	CAGR (%)
Headcount	1,865	1,916	1,980	1,996	2,075	2.7
Average weekly hours	42.5	41.9	42.6	42.1	42.1	-0.2
FTE	1,981.1	2,006.8	2,106.3	2,099.2	2,181.9	2.4
Public FTE (%)	41.4	43.3	42.3	42.7	44.2	1.7
Private FTE (%)	58.6	56.7	57.7	57.3	55.8	-1.2

[12] The total headcount differs from the sum of subspecialty headcounts because some O&G specialists are counted under multiple subspecialties.

Demographics

Key highlights from Table 3 are as follows:

- Overall, the proportion of female FTE O&G specialists increased from 50.2% in 2019 to 56.9% in 2023.
- O&G specialists aged 40–54 contributed the highest share of FTEs over the period, though their contribution declined slightly from 51.9% in 2019 to 50.1% in 2023. The FTE contribution of O&G specialists aged 55-64 increased from 25.5% in 2019 to 27.7% in 2023.

Table 3: FTE by sex and age-groups, 2019 and 2023

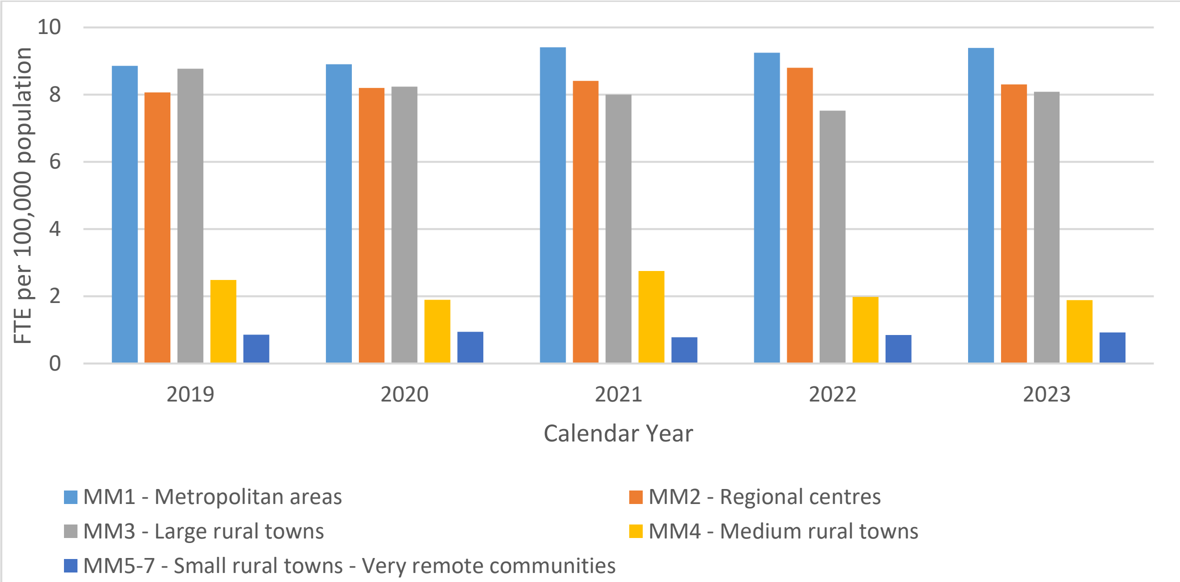
	2019			2023		
Age group	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Under 40	61.8	189.7	251.5 (12.7%)	61.2	223.2	284.4 (13.0%)
40–54	434.2	593.4	1,027.6 (51.9%)	380.0	712.7	1,092.8 (50.1%)
55–64	323.1	182.1	505.2 (25.5%)	344.5	259.5	604.0 (27.7%)
65+	168.0	28.8	196.8 (9.9%)	155.5	45.2	200.7 (9.2%)
Total	987.1	994.0	**1,981.1 (100%)**	941.3	1,240.6	**2,181.9 (100%)**

Full-Time Equivalent (FTE) O&G specialists by Modified Monash Model (MMM) 2023[13]

There is maldistribution of O&G specialists between rural and remote areas compared with metropolitan areas. In 2023, the FTE O&G specialists per 100,000 population in metropolitan areas (Monash Modified – Category 1 (MM1)) was 9.4, compared to only 0.9 in small rural towns to very remote communities (MM4 – 7), see Figure 3.

[13] For description of Monash Modified Model please refer to Modified Monash Model.

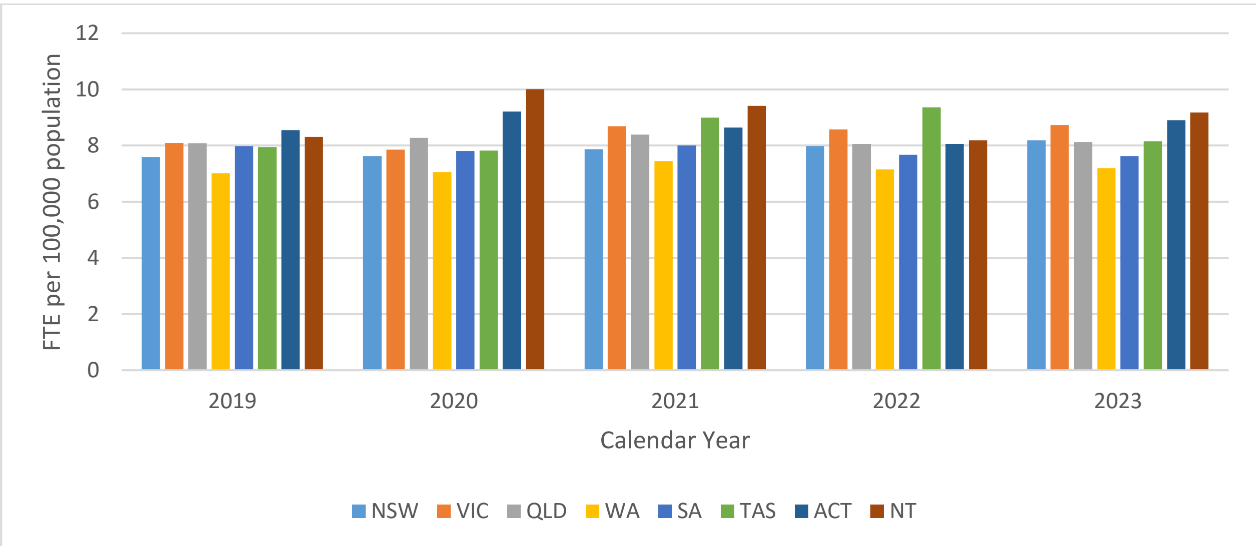
Figure 3: FTE O&G specialists per 100,000 population by Modified Monash Model (2023), 2019–23



Full-Time Equivalent (FTE) O&G specialists by state and territories

In 2023, across jurisdictions, Northern Territory (NT) had the highest FTE O&G specialists per 100,000 population at 9.2, while Western Australia (WA) had the lowest at 7.2, see Figure 4.

Figure 4: FTE O&G per 100,000 population by states and territories, 2019–23



For more details on trends in FTE and average hours worked by sex, place of initial specialist qualification and practitioner type, please refer to Obstetrics and Gynaecology Supply Profile Dashboard.

What is supply and demand modelling?

Supply and demand modelling is a tool used to understand how much of something is available (supply) and how much is needed (demand).

Effective health workforce planning is a key instrument for a resilient and sustainable health system. Health workforce modelling provides insights into the current and projected health workforce, playing an integral role in workforce planning to ensure we have the workforce we need and where they are most needed.

This supply and demand study provide valuable insights into the O&G workforce, helping to identify potential workforce gaps. By quantifying the projected supply and demand for O&G specialists from 2025 to 2048, using data collected from several sources between 2014 and 2023, the study provides important evidence to guide policy decisions on regulating O&G specialist training places and the distribution of Specialist International Medical Graduates (SIMGs) across Australia.

Methodology for the O&G supply and demand model

To enable detailed scenario modelling of the O&G workforce, a combination of microsimulation and time series regression modelling approaches for supply and demand is used. Microsimulation is a technique for modelling the behaviour of individuals according to predetermined probabilistic rules. Time series regression is a statistical method for predicting future values based on the response history and the influence of relevant predictors.

The microsimulation approach provides maximum flexibility for adapting the model to different populations and unique supply and demand scenarios. This enhances our understanding of the effects of existing policies and helps identify ways to improve them.

For detailed information on the methodology, refer to the Obstetrics and Gynaecology Supply and Demand Model – Methodology Paper.

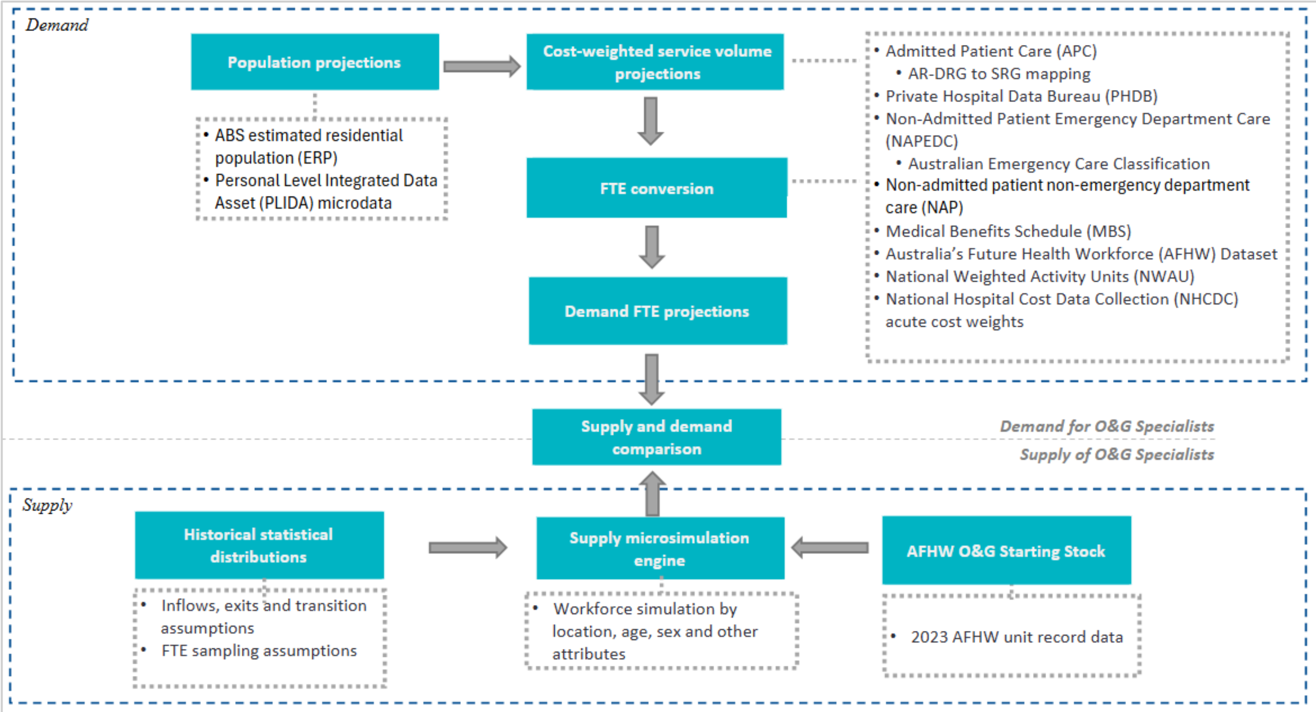
Overview

This study models the supply of and demand for O&G specialist who are currently working clinical hours and not currently trainees. O&G trainees are modelled as part of the training pipeline analysis (see section under 'Supply').

Modelling has been undertaken at the Statistical Area 4 (SA4) geography (where data availability permitted). However, results will be published at State and Territory level, with their aggregation forming the National results.

Figure 5 presents a summary of the process used in modelling the O&G specialist workforce.

Figure 5: Overview of the modelling process



Supply

The supply model uses the Australia's Future Health Workforce (AFHW) [14] data on O&G specialists from 2014 to 2023.

The supply model uses the microsimulation approach where attributes such as entries and exits to the workforce and practitioner FTE are modelled distinctly. The supply methodology begins by identifying the current stock of O&G specialists, analysing their demographic profile and historically observed work patterns. Statistically significant predictors of future O&G workforce supply (such as age, sex, etc.) are selected, and their historical distributions are measured to allow the development of a microsimulation model.

The supply model includes a **training pipeline module** that models O&G trainees in the RANZCOG Fellowship and SIMG pathways. This module projects the number of new O&G fellows entering the workforce each year over the projection period, see Table 4.

[14] The Australia's Future Health Workforce (AFHW) datasets are created from the National Health Workforce Datasets (NHWDS) for modelling purposes. A sequence of rules (supply criteria) is applied to each NHWDS to determine which practitioners meet the definition of supply for each profession (and sub-groups where applicable). The headcount and workload of these practitioners, along with other variables required for modelling, are included, derived or imputed in the AFHW datasets.

Table 4: Projected number of new fellows entering workforce each year[15], selected years 2025–48

New Fellow type	2025	2026	2027	2028	2029	2030	2035	2040	2045	2048
Domestic	75	78	77	79	83	85	91	91	91	91
SIMG	38	33	33	33	33	33	33	33	33	33
Total	**113**	**111**	**110**	**112**	**116**	**118**	**124**	**124**	**124**	**124**

Demand

Demand is measured in terms of observed utilisation of medical services. This method captures expressed (observed) service demand for O&G services across a variety of care settings. Historical patterns of usage are examined and used to estimate the future demand for O&G specialists, accounting for differences in service demand across various age groups and geographies.

This approach does not directly capture the population's need for services, particularly for individuals who require O&G care but cannot access it due to factors such as affordability or availability.

The demand is projected assuming the supply of O&G specialists is equal to the demand in the base year, 2023. The following key data sources are used to capture service utilisation:

1. Medical Benefits Schedule (MBS) data
2. AIHW Admitted Patient Care (APC) NMDS
3. Private Hospital Data Bureau (PHDB)
4. National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD)
5. National Non-Admitted Patient Database (NNAPD)
6. National Hospital Cost Data Collection (NHCDC)

Different services or separations require varying workforce effort based on severity of conditions, complexity of procedures, or degree of medical input required. Therefore, services and separations are cost-weighted to adjust for these differences, enabling accurate comparison of resources use by converting them to units of demand activity.

To compare demand to supply and identify the workforce gap, demand activity projections are converted to FTE O&G specialists by comparing the demand values against the supply FTE from the AFHW dataset for a specified reference year (2023). Specifically, the base year supply FTE is divided by the base year demand activity to yield an FTE-to-activity ratio, which is then multiplied by the demand projections for each forecast year.

[15] The inflow assumptions for supply modelling does not account for the increase in overseas trained O&G specialists due to expedited specialist pathway.

Limitations

- The model forecasts are based on analysis of historical trends in the AFHW dataset. As such, the projections are limited to extending existing trends observed in the workforce data. Any changes during the projection period, such as shifts in models of care and technological improvements that could impact workforce FTE requirements in delivering medical services, are not considered in the modelling.
- The primary source of supply modelling data, the AFHW, is a longitudinal survey of medical practitioners. The survey has 3 notable limitations:
  1. all supply FTE/hours are self-reported and therefore subject to measurement errors, response bias and potential inaccuracies due to memory recall and misinterpretation of questions.
  2. the survey only captures the primary work location of medical practitioners, and
  3. medical practitioners without general registration, such as provisional registrants, do not complete the survey and therefore most of their data is imputed.
- The inflow assumptions for supply modelling does not account for the increase in overseas trained O&G specialists due to expedited specialist pathway.[16]
- The model does not capture the unmet demand for O&G care due to accessibility or affordability challenges. There is no reliable data on unmet demand for O&G services such as non-urgent gynaecological conditions.
- The model does not explicitly account for changes in complexity of O&G care in measuring demand.
- The model does not account for Primary Health Network (PHN) commissioned health services and the Department of Veteran Affairs funded health services.
- Technological advancement during the projection period that may affect workforce productivity and how care is delivered is not considered.

GP obstetricians

- GP obstetricians are GPs who have undertaken specialized training in women's health and obstetrics through RANZCOG.[17] They often work within shared care models, collaborating with O&G specialists and midwives to deliver comprehensive maternity services. Their role is especially vital in rural and remote areas, where access to O&G specialists may be limited.

[16] Medical Board Ahpra, 2024, Medical Board of Australia - Expedited Specialist pathway, accessed 2 March 2025.

[17] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), 2024, Certificate and Procedural Training, accessed 2 March 2025.

- GP obstetricians are not within the scope of this model due to data limitations, however, they were included as part of the department's GP Supply and Demand Study – 2024.
- The hospital demand data used in this study includes services provided by GP obstetricians. However, the data does not allow for distinguishing between services delivered by GP obstetricians and those by O&G specialists. Consequently, the demand estimation method accounts for the activities performed by GP Obstetricians in hospitals, even though they are not included in the supply.
- All O&G services within the MBS data claimed by GPs are excluded from demand estimation for this study.

Key findings and insights

The main outputs of the O&G model are projections of the number (headcount) and FTE O&G specialists. Based on these, the model produces one supply estimate and baseline demand estimates.

What is baseline demand?

Baseline demand is the number of O&G specialists that are needed to meet the current and future demand for O&G services based on observed utilisation and assuming the supply of O&G specialists is equal to demand in the base year, 2023.

National projections

While both the supply of and demand for O&G specialists are estimated to increase in the future, the workforce is expected to experience a shortage throughout the projection period.

The O&G model projections at national level (Table 5 and Figure 6) indicate that:

- The supply of O&G specialists is expected to increase from 2,262.4 FTE in 2025 to 2,642.5 FTE in 2033 and to 3,172.1 FTE by 2048. In terms of headcount, this corresponds to 2,186 O&G specialists in 2025, 2,579 in 2033 and 3,147 in 2048.
- Demand is projected to increase from 2,328.0 FTE in 2025 to 2,841.2 FTE in 2033, reaching 3,400.1 FTE by 2048.
- The FTE O&G specialists are expected to be in shortage throughout the projection period.[18]
    - The estimates indicate a current shortfall of 65.6 FTE (2.9%) in 2025, projected to increase to 198.7 FTE (7.5%) by 2033. The total shortfall is estimated to be 228.0 (7.2%) FTE in 2048.
- In terms of headcount, the estimates indicate a shortfall of 79 O&G specialists in 2025, increasing to 218 by 2033 and will reach 255 by 2048.

The national supply projections show that:

- The national average FTE per O&G specialist is projected to decline from 1.04 in 2025 to 1.01 by 2048, highlighting a trend toward declining hours worked[19].
- The total entry rate (headcount) including re-entries is expected to decline throughout the projection period from 7.3% of total supply in 2025 to 6.2% by 2048.

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[18] Throughout this paper, the percentage shortage/oversupply is calculated as proportion of the supply.

[19] Average FTE per O&G specialist is calculated by dividing the total FTE by the total headcount of O&G specialist in a given year (i.e. Average FTE = Total FTE ÷ Total headcount).

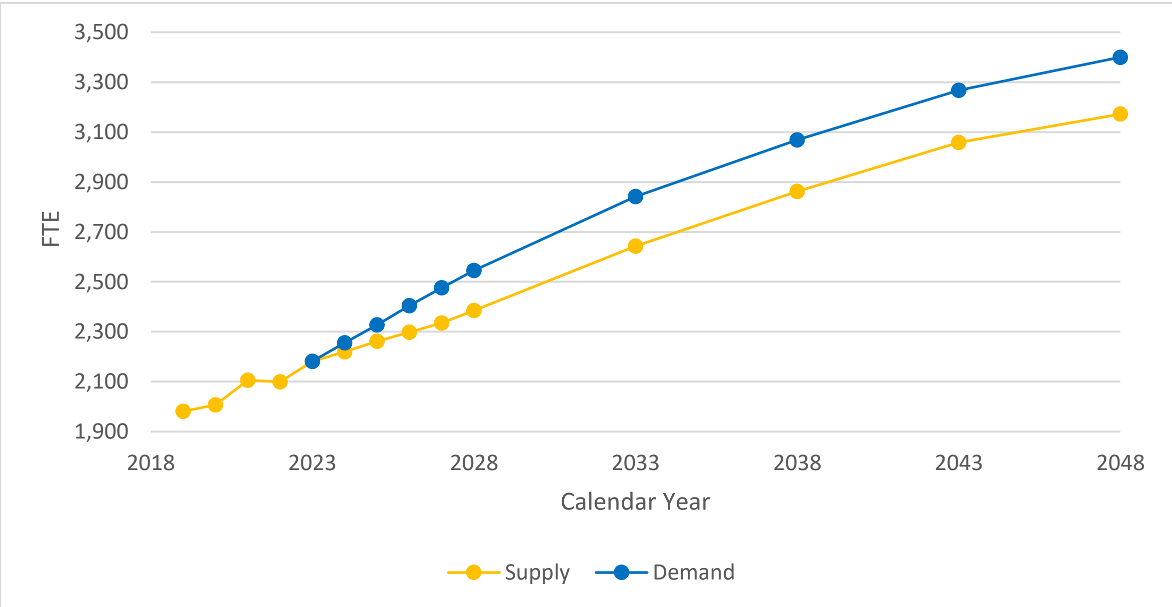
- The total exit rate (headcount) including temporary exits is expected to increase over the projection period from 5.2% of total supply in 2025 to 5.7% in 2048. Exit rates are expected to remain lower than entry rates, consistent with historical trends.
- New entries into the O&G workforce include individuals entering through the domestic Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) Fellowship Program, as well as those entering via the RANZCOG international pathways. The key assumptions about the number of new fellows each year are:
    - The model assumes a constant number of new entries for both pathways throughout the projection period. For domestic trainees, the number of new entries is held constant at 2024 level. For international trainees, the model uses the average number of new entries over the past 3 years (2022–2024).[20]
    - The rate of transition between each stage of the training program (and to becoming a new fellow) remain constant using the average transition rates observed between 2020 and 2024.
- The number of new domestic fellows entering the O&G workforce (headcount) is projected to rise from 75 in 2025 to 91 in 2035 and remaining steady at that level for the remainder of the projection period. In contrast, the number of SIMGs entering the O&G workforce is expected to decrease from 38 in 2025 to 33 in 2026 and then remain constant thereafter.

[20] During consultations, RANZCOG confirmed that they do not intend to change the current number of trainees. As a result, the number of new domestic trainees for 2024 is held constant throughout the projection period. For the SIMG pathway, international trainee numbers were impacted by COVID-19, so the model uses the average number of new entries over the past three years (2022–24) to determine new entries.

Table 5: National Projections, selected years 2025–48

	2025	2026	2027	2028	2033	2038	2043	2048
Full-time equivalent (FTE)								
Supply	2,262.4	2,297.9	2,335.8	2,385.5	2,642.5	2,862.1	3,058.4	3,172.1
Entries	146.8	144.2	144.0	147.8	158.9	165.4	171.2	171.6
New Entries	115.2	113.3	109.3	113.3	121.8	125.4	124.0	122.4
Re-entries	31.5	30.9	34.7	34.6	37.1	40.0	47.2	49.3
Exits	81.3	84.0	83.2	84.8	98.4	99.5	110.7	123.2
Permanent Exits	40.4	45.7	42.2	43.1	47.6	54.1	57.9	69.9
Temporary Exits	40.8	38.4	41.0	41.7	50.8	45.3	52.8	53.3
Demand	2,328.0	2,405.1	2,476.1	2,544.9	2,841.2	3,069.3	3,267.3	3,400.1
Surplus / Shortfall	-65.6	-107.2	-140.3	-159.4	-198.7	-207.2	-208.9	-228.0
Headcount								
Supply	2,186	2,230	2,277	2,325	2,579	2,811	3,000	3,147
Entries	160	159	162	162	176	182	191	196
New Entries	118	116	115	117	128	129	129	129
Re-entries	42	43	47	45	48	53	62	67
Exits	114	115	113	118	135	139	156	179
Permanent Exits	67	71	66	70	77	86	95	115
Temporary Exits	47	44	47	49	58	53	61	64
Demand	2,265	2,350	2,438	2,502	2,797	3,049	3,227	3,402
Surplus / Shortfall	-79	-120	-161	-177	-218	-238	-227	-255

Figure 6: FTE O&G specialists: National supply versus demand, 2018–48



Age profile of O&G specialists

- O&G specialists aged 40-54 are projected to remain the largest segment of the workforce and continue contributing the highest average FTE throughout the projection period (around 1.1).
- The proportion of O&G specialists aged 55-64 is expected to increase from 26.8% in 2025 to 28.4% by 2048, while their average FTE is expected to decline from 1.07 in 2025 to 1.03 by 2048 over the same period.

Table 6: Age profile of O&G specialists, 2025 and 2048

Age groups	2025		2048	
	Headcount	Average FTE	Headcount	Average FTE
Under 40	285 (13.0%)	1.00	308 (9.8%)	0.99
40-54	1,064 (48.7%)	1.08	1,466 (46.6%)	1.07
55-64	585 (26.8%)	1.07	893 (28.4%)	1.03
over 65	251 (11.5%)	0.81	479 (15.2%)	0.79
Total	2,186 (100%)	**1.04**	3,147 (100%)	**1.01**

Projected workforce outcomes under an alternative scenario

Scenario: Higher exit rate

Supply scenario: Double permanent exits for O&G specialists aged 65 and over, from 2026 onwards

In 2023, the average age of O&G specialists was 52.1 (see Figure 2). During consultations, stakeholders raised concerns about the ageing workforce. In response, the permanent exit rate for specialists aged 65 and over was doubled from 2026 onwards to assess its impact on the O&G workforce projections.

The findings (Table 7) reveal that there will be 39 fewer O&G specialists (headcount), equivalent to a reduction of 35 FTE in 2027, compared to the baseline results (see Table 5). By 2048, this gap in workforce supply grows to 177 fewer O&G specialists and the baseline reaches 117.1 FTE.

When comparing projected shortfalls, the FTE shortage increases from 140.3 under the baseline to 175.3 in 2027, and from 228.0 FTE to 345.1 FTE by 2048.

Table 7: National Projections - Higher exit rates scenario, selected years 2027–48

	2027	2028	2033	2038	2043	2048
Full-time equivalent (FTE)						
Supply	2,300.8	2,325.0	2,542.2	2,747.8	2,922.6	3,055.0
Demand	2,476.1	2,544.9	2,841.2	3,069.3	3,267.3	3,400.1
Surplus / Shortfall	- 175.3	-219.9	-299.0	-321.5	-344.7	-345.1
Headcount						
Supply	2,238	2,259	2,455	2,649	2,841	2,970
Demand	2,433	2,486	2,765	2,980	3,200	3,333
Surplus / Shortfall	-195	-227	-310	-331	-359	-363

State and Territory Projections

Throughout the projection period (2024 to 2048), most states and territories are expected to have a shortfall of O&G specialists. For New South Wales, Western Australia, South Australia and Tasmania, the shortfall peaks around 2033 and then the gap is projected to decline gradually. These projections reflect the anticipated decline in fertility rates across these states. By 2048, Northern Territory is projected to have the highest shortfall at 24.9%, followed by Australian Capital Territory at 19.6%.

Table 8 presents a summary of O&G workforce projections by state and territory for selected years.

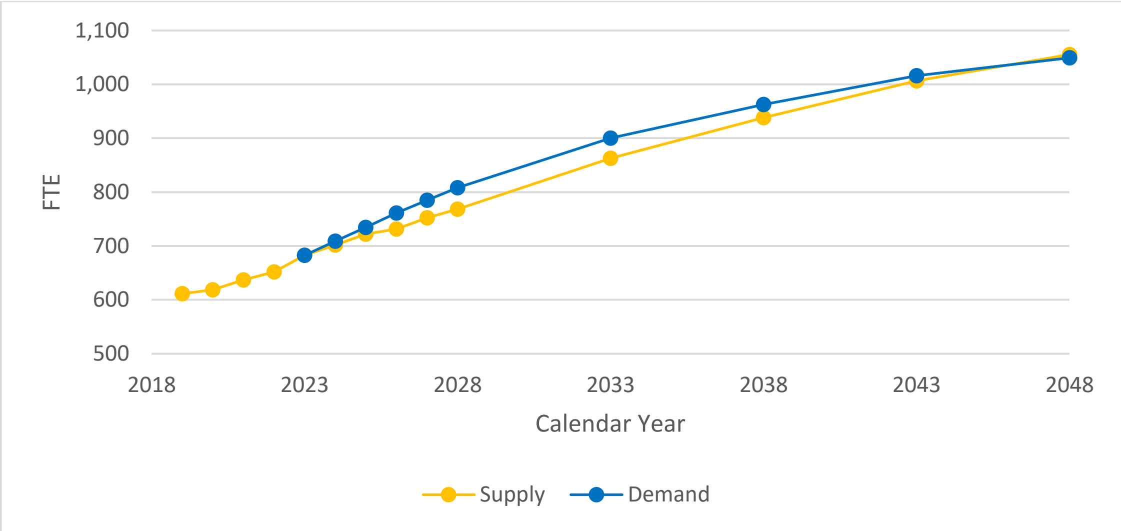
Table 8: Summary of State-level projections - Projected under/oversupply of FTE O&G specialists and % under/oversupply, selected years 2025–48

State/Territory	Workforce Surplus / shortfall (FTE)					
	2025	2028	2033	2038	2043	2048
NSW	-12.4 (-1.7%)	-39.7 (-5.2%)	-37.5 (-4.3%)	-24.6 (-2.6%)	-9.4 (-0.9%)	6.1 (0.6%)
VIC	-19.3 (-3.1%)	-46.8 (-7.0%)	-64.6 (-8.5%)	-92.9 (-11.3%)	-99.2 (-11.0%)	-140.8 (-15.4%)
QLD	-5.6 (-1.2%)	-22.5 (-4.7%)	-25.0 (-4.7%)	-32.8 (-5.7%)	-57.8 (-9.7%)	-69.7 (-11.2%)
WA	-13.3 (-6.5%)	-23.9 (-11.2%)	-32.7 (-14.4%)	-27.3 (-11.1%)	-18.3 (-6.9%)	-14.8 (-5.5%)
SA	-5.4 (-3.8%)	-12.4 (-8.6%)	-15.8 (-10.5%)	-5.1 (-3.1%)	-0.2 (-0.1%)	9.6 (5.0%)
TAS	-8.4 (-21.3%)	-12.6 (-33.6%)	-15.5 (-44.0%)	-9.4 (-23.0%)	-7.0 (-16.8%)	-2.6 (-5.9%)
ACT	-0.5 (-1.3%)	0.8 (1.7%)	-4.2 (-8.7%)	-11.3 (-24.8%)	-12.3 (-25.7%)	-10.2 (-19.6%)
NT	-0.7 (-3.1%)	-2.3 (-9.9%)	-3.3 (-13.9%)	-3.8 (-15.7%)	-4.7 (-20.0%)	-5.7 (-24.9%)
National	**-65.6 (-2.9%)**	**-159.4 (-6.7%)**	**-198.7 (-7.5%)**	**-207.2 (-7.2%)**	**-208.9 (-6.8%)**	**-228.0 (-7.2%)**

New South Wales (NSW)

- The supply of O&G specialists in NSW is expected to increase from 722.2 FTE in 2025 to 862.6 FTE in 2033, and reach 1,055.4 FTE by 2048, see Figure 7.
- The demand estimates indicate NSW currently has a shortfall of 12.4 FTE in 2025, with the shortage expected to reach 37.5 FTE in 2033. By 2048, NSW is expected to shift to a surplus of 6.1 FTE.

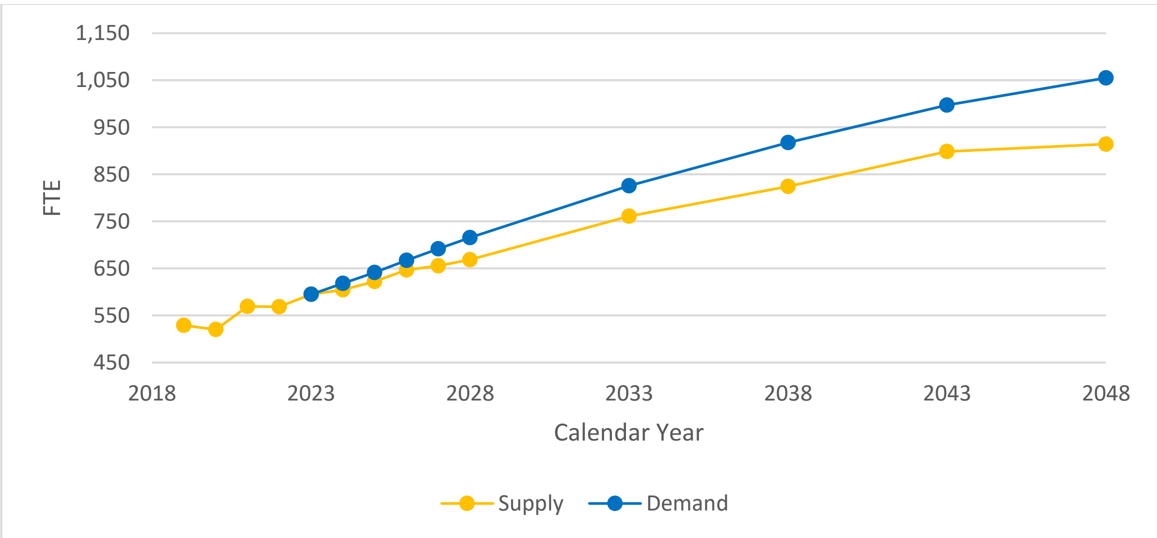
Figure 7: FTE O&G specialists: NSW supply versus demand, 2018–48



Victoria (VIC)

- The supply of O&G specialists in VIC is expected to increase from 622.1 FTE in 2025 to 761.2 FTE in 2033 and reach 914.3 FTE by 2048, see Figure 8.
- The demand estimates indicate VIC currently has a shortfall of 19.3 FTE in 2025, with the shortage expected to reach 64.6 FTE in 2033. By 2048, the total undersupply is estimated to be 140.8 FTE.

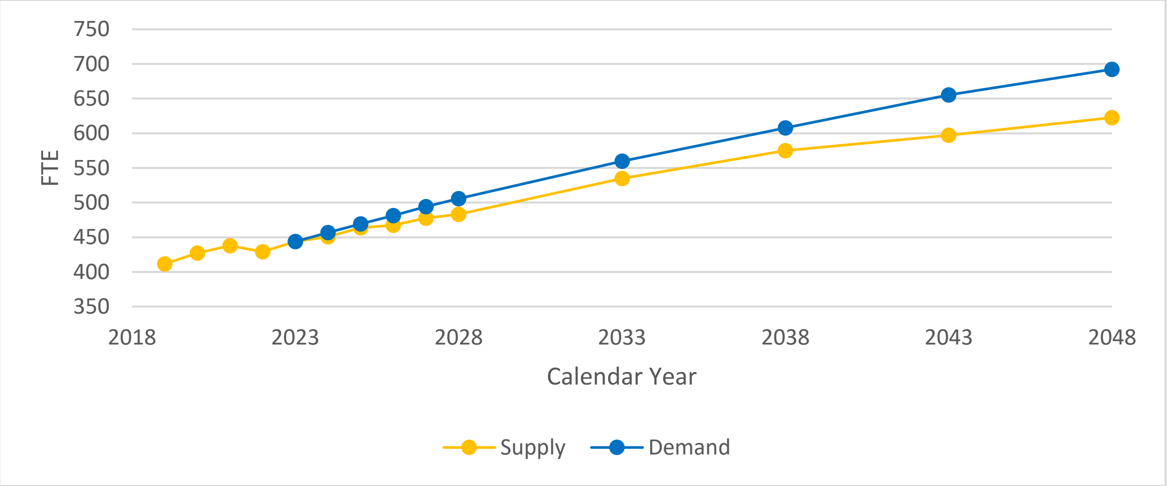
Figure 8: FTE O&G specialists: VIC supply versus demand, 2018–48



Queensland (QLD)

- The supply of O&G specialists in QLD is expected to increase from 463.5 FTE in 2025 to 534.7 FTE in 2033 and reach 622.6 FTE by 2048, see Figure 9.
- The demand estimates indicate QLD currently has a shortfall of 5.6 FTE in 2025, with the shortage expected to reach 25.0 FTE in 2033. By 2048, the total undersupply is estimated to be 69.7 FTE.

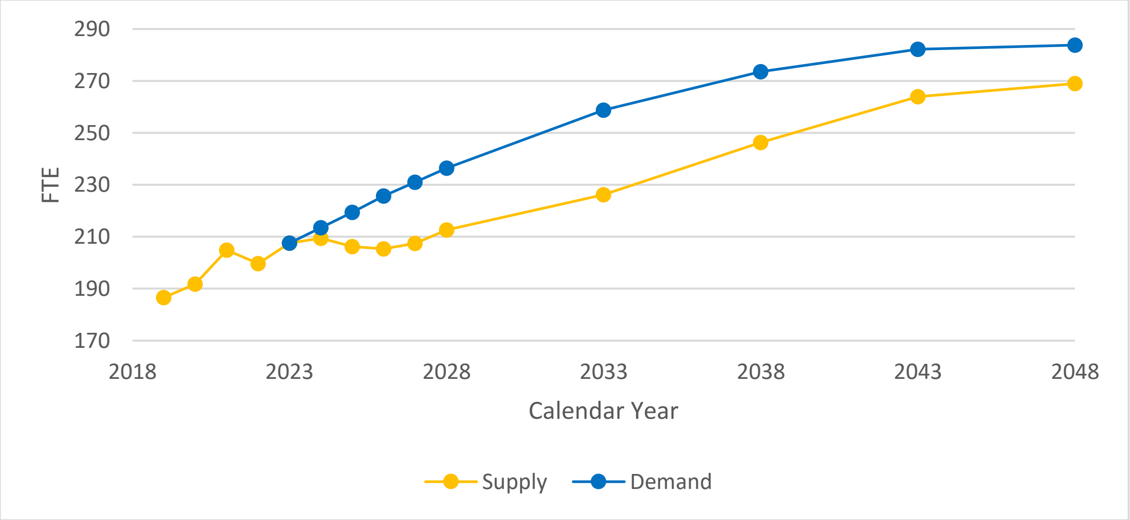
Figure 9: FTE O&G specialists: QLD supply versus demand, 2018–48



Western Australia (WA)

- The supply of O&G specialists in WA is expected to increase from 206.2 FTE in 2025 to 226.2 FTE in 2033 and reach 269.0 FTE by 2048, see Figure 10.
- The demand estimates indicate WA currently has a shortfall of 13.3 FTE in 2025, with the shortage expected to reach 32.7 FTE in 2033. By 2048, the total undersupply is estimated to decline to 14.8 FTE.

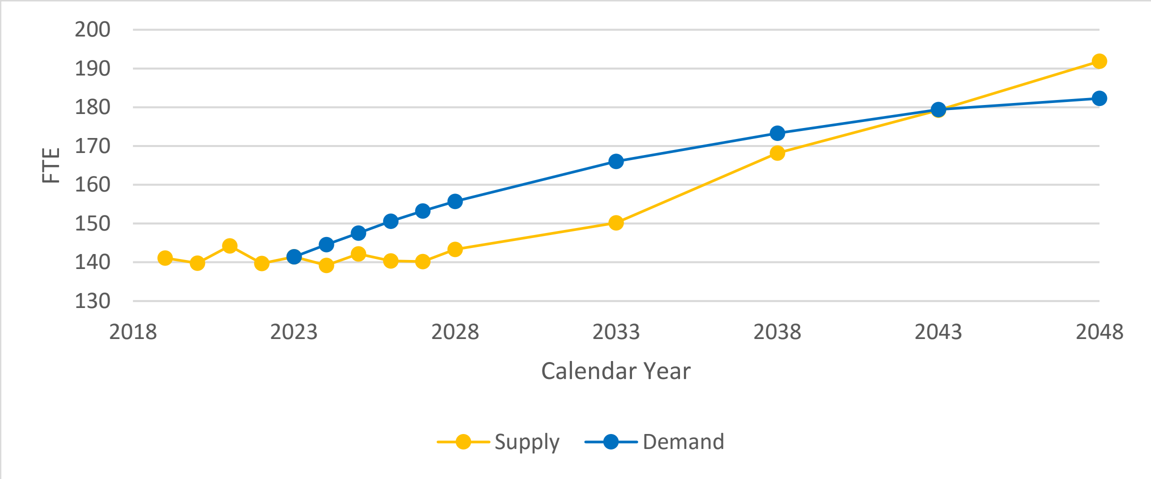
Figure 10: FTE O&G specialists: WA supply versus demand, 2018–48



South Australia (SA)

- The supply of O&G specialists in SA is expected to increase from 142.2 FTE in 2025 to 150.2 FTE in 2033 and reach 191.9 FTE by 2048, see Figure 11.
- The demand estimates indicate SA currently has a shortfall of 5.4 FTE in 2025, with the shortage expected to reach 15.8 FTE in 2033. By 2048, SA is expected to shift to a surplus of 9.6 FTE.

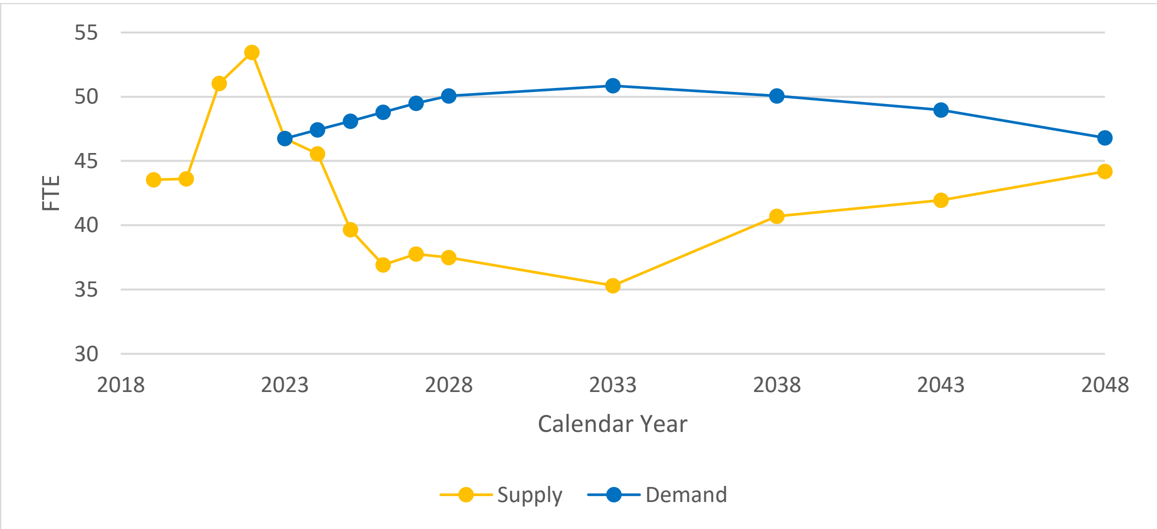
Figure 11: FTE O&G specialists: SA supply versus demand, 2018–48



Tasmania (TAS)

- The supply of O&G specialists in TAS is expected to decrease from 39.7 FTE in 2025 to 35.3 FTE in 2033 and then increase to reach 44.2 FTE by 2048, see Figure 12.
- The demand estimates indicate TAS currently has a shortfall of 8.4 FTE in 2025, with the shortage expected to reach 15.5 FTE in 2033. By 2048, the total undersupply is estimated to decline to 2.6 FTE.

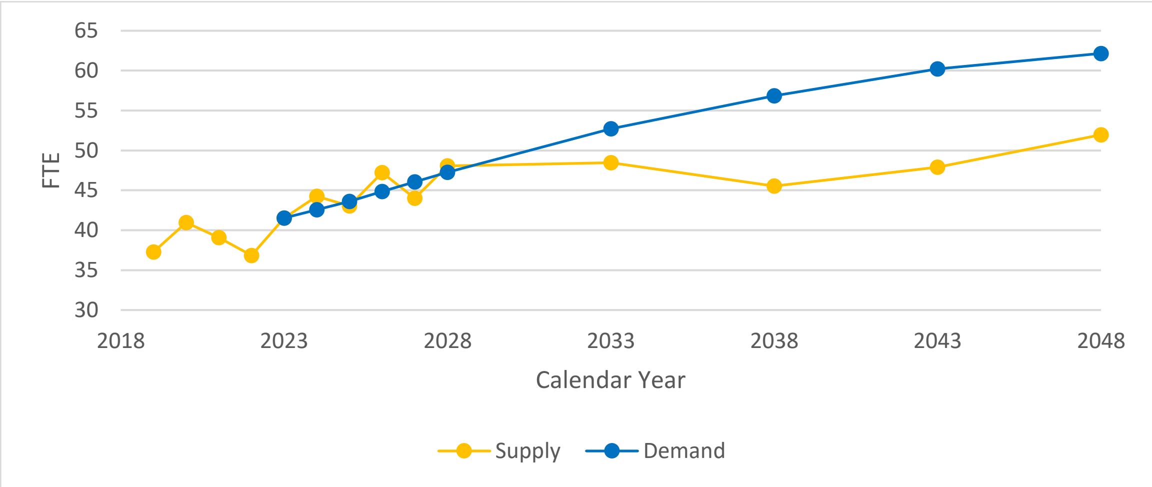
Figure 12: FTE O&G specialists: TAS supply versus demand, 2018–48



Australian Capital Territory (ACT)

- The supply of O&G specialists in the ACT is expected to increase from 43.1 FTE in 2025 to 48.5 FTE in 2033 and reach 52.0 FTE by 2048, see Figure 13.
- The demand estimates indicate the ACT currently has a shortfall of 0.5 FTE in 2025, with the shortage expected to reach 4.2 FTE in 2033. By 2048, the total undersupply is estimated to be 10.2 FTE.

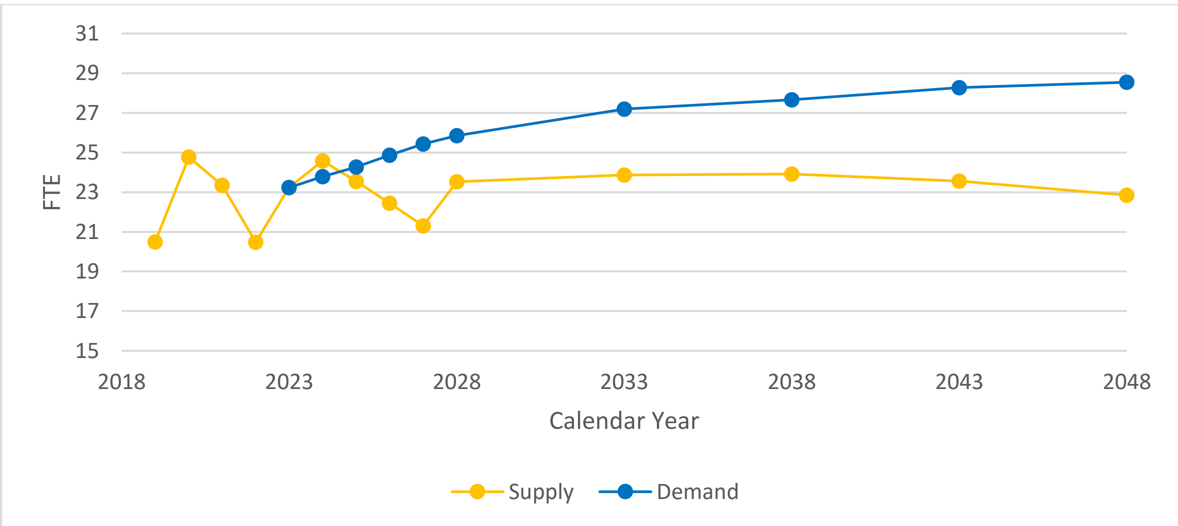
Figure 13: FTE O&G specialists: ACT supply versus demand, 2018–48



Northern Territory (NT)

- The supply of O&G specialists in the NT is expected to increase marginally from 23.5 FTE in 2025 to 23.9 FTE in 2033, and then decrease to 22.8 FTE in 2048, see Figure 14.
- The demand estimates indicate the NT currently has a shortfall of 0.7 FTE in 2025, with the shortage expected to reach 3.3 FTE in 2033. By 2048, the total undersupply is estimated to be 5.7 FTE.

Figure 14: FTE Midwives: NT supply versus demand, 2018–48



What do the results indicate?

The O&G model projections suggest a shortage of O&G specialists over the next 25 years (2025–48). Inequitable access to O&G services remains a key issue for Australian communities, largely driven by geographic maldistribution of O&G specialists.

The study forecasts a growing gap between supply and demand for O&G specialists, indicating that Australia's O&G workforce is likely to remain in shortage over the next 25 years. In FTE terms, a workforce shortage of 2.9% is projected for 2025, increasing to 7.2% by 2048. Despite a gradual increase in the number of specialists entering the workforce, this growth is not expected to keep pace with rising demand.[21]

Over the past 15 years, there has been a significant rise in female participation in O&G training programs in Australia. The proportion of female trainees rose from 68.4% in 2010 to 83.2% in 2023.[22, 23] This trend is projected to reshape the workforce, with women expected to comprise 74.0% of O&G specialists by 2048.

The results also suggest a reduced working hours trend among O&G specialists. Average FTE is projected to decline slightly from 1.04 in 2025 to 1.01 in 2048. The 40–54 age group is expected to contribute the largest share of FTE (approximately 50.0%), driven by headcount. However, the impact of an ageing workforce is increasingly evident as the proportion of FTE contributed by the 55–64 years old cohort is expected to rise from 27.7% in 2025 to 29.1% by 2048.

The maldistribution of the O&G workforce remains a significant barrier to equitable access to services in regional, rural, and remote areas. Many of these centres are understaffed and often perceived as less attractive employment locations due to factors such as limited housing, restricted career and employment opportunities for partners and limited childcare options.[24] The public hospital separations data for 2022-2023 (financial year)[25] revealed that approximately 34.0% of O&G related public hospital admissions for patients living in Modified Monash Model (MMM) categories 3 to 7 occurred in MMM 1 and 2 locations, requiring patients to travel for care. Similarly, Medicare Benefits Schedule (MBS) data over the same

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[21] Please note that this study does not account for the increase in overseas-trained O&G specialists resulting from the expedited specialist pathway.

[22] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2019, RANZCOG Activities Report 2018-2019, accessed 20 March 2025 RANZCOG Activities Report 2023

[23] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2023, RANZCOG Activities Report 2023, accessed 20 March 2025.

[24] NSW Select Committee on Remote, Rural and Reginal Health, 2024, Report 1 - The implementation of recommendations relating to workforce, workplace culture and funding for remote, rural and regional health, accessed 13 June 2025.

[25] The public hospital separations data is from the AIHW Admitted patient care NMDS (Service Related Groups: 71 and 72), accessed 13 July 2025.

period indicates that 61.0% of MBS funded O&G services received by patients from MMM 3 to 7 areas were delivered by providers located in MMM 1 and 2 regions. [26]

It is important to note that these projections do not capture unmet demand for O&G services, as there is no reliable measure for non-urgent gynaecological conditions such as pelvic pain, endometriosis, urinary incontinence and prolapse. The study also does not explicitly account for increasing complexity of O&G care in measuring demand. As such, the actual workforce shortage is likely underestimated.

The challenges facing the broader maternity workforce is well known. The ongoing closure of private maternity units raises concerns about the sector's viability, driven by persistent difficulties in attracting and retaining specialised staff - including O&G specialists, midwives, nurses, paediatricians and anaesthetists – as well as high out of pocket costs, the rising cost of private health insurance, and a declining fertility rate. Private hospitals currently manage approximately 25.0% of all births and 70.0% of elective women's procedures. Between 2015–2016 and 2022–2023, nine private hospitals closed their maternity wards, while two hospitals offering maternity services ceased operations entirely.[27, 28] The trend places increasing pressure on the public health system, driving up costs and exacerbating capacity issues. Over the past decade, the volume of obstetric services in the private sector declined by 12.0%, while it rose by 15.0% in the public sector.[29]

These challenges in the O&G workforce offers opportunities to adopt innovative, collaborative models of care. Integrating O&G specialists, midwives and General Practitioners (GPs) with advanced obstetric and gynaecological skills into shared care models, could support the sustainability of private services and improve access to O&G services in rural and remote areas. According to RANZCOG, there were approximately 2,000 GP obstetricians in Australia in 2024. Optimising the integration and utilisation of this workforce has the potential to significantly improve service accessibility and reduce pressure on specialist O&G services. While some progress has been made in this area, further efforts are needed to fully realise the benefits of a more integrated care approach.

With an ageing O&G workforce and declining average working hours, addressing future workforce shortages will require systemic reforms. These include changes to training pathways and investment in multidisciplinary models of care. Such reforms are critical to ensuring the O&G workforce is equipped to meet the evolving needs of the Australian community.

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[26] The Medicare Benefits Schedule data is from Medicare Benefits Schedule data collection. For description of Monash Modified Model please refer to Modified Monash Model.

[27] Department of Health, Disability and Ageing, 2024, Private Hospital Sector Financial Health Check – Summary, accessed 20 March 2025

[28] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2024, Private O&G Services Under Threat in Australia Due to Systemic Gender Bias, accessed 20 March 2025

[29] The hospital separations data is from the AIHW Admitted patient care NMDS. The Enhanced Service-Related Groups (ESRGs) included within the obstetrics services are ante-natal admission, caesarean delivery, post-natal admission and vaginal delivery.

Consultations

During development of the medical model, the department consulted with the following stakeholders:

- Australian Institute of Health and Welfare
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- State and Territory workforce planners

Next steps

The O&G model will be updated every two years with latest available data across all data sources.

We welcome stakeholder feedback to support the continuous improvement of the model, enhancing its value as a tool for effective health program delivery and workforce planning.

If you require further information regarding the medical model or the results as published contact us at healthworkforcedata@health.gov.au.

Appendix

Breakdown of services into obstetrics and gynaecology

This study uses combined data on O&G services to estimate the overall demand for O&G services. It then compares this demand with the supply of O&G specialists to project workforce gap.

To distinguish the demand for obstetrics and gynaecology individually, Table 5 provides a breakdown of each demand dataset for 2021–22 (financial year).

Table 5: Breakdown of services into obstetrics and gynecology for 2021–22

Dataset	Variables used for breakdown	Inferred proportions
MBS data	Derived major specialty (DMS) of the provider and MBS group and sub-group of the services provided.[30]	64.2% obstetrics 35.8% gynaecology
Admitted patient care data (both public and private separations)	Service-related group (SRG) of hospital separations.[31]	55.6% obstetrics 44.4 gynaecology
NNAPEDCD data	EDDG code and ECC description of emergency presentations[32]	54.0% obstetrics 46.0% gynaecology
NNAPD	Tier 2, Clinic type and usual provider description[33]	65.9% obstetrics 44.1% gynaecology

[30] The proportion of obstetrics-related MBS services delivered by O&G specialists is inferred from individual provider billing patterns. MBS services are classified according to their Group and Sub-group, which are used to calculate the proportion of obstetrics-related services at the provider level. It is then assumed that general professional attendances delivered by each provider follow the same obstetrics-related proportion. Most obstetrics-related services are captured under MBS Group T4 – Obstetrics.

[31] The proportion of gynaecology separations is determined based on cases classified under Service-Related Group (SRG) 71 ‘Gynaecology’. Similarly, the proportion of obstetrics separations is derived from cases classified under SRG 72 ‘Obstetrics’.

[32] The proportion of obstetrics-related presentations is determined based on cases classified under the ‘Obstetrics and Gynaecology’ specialty that are assigned Emergency Department Diagnosis Group (EDDG) codes E1410 (‘Postpartum and post-abortion conditions’) and E1420 (‘Antenatal and other obstetric conditions’). All other presentations within the same specialty are considered gynaecology related.

[33] The proportion of obstetrics-related outpatient services is determined based on services where the usual provider is an ‘Obstetrician and Gynaecologist’ and the service is classified under Tier 2 categories 20.40 (‘Obstetrics – management of pregnancy without complications’) and 20.53 (‘Obstetrics – management of complex pregnancy’). All other services provided by an ‘Obstetrician and Gynaecologist’ are considered gynaecology related.

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All information in this publication is correct as at April 2026