

Gap in child and adolescent psychiatrists in Chile's public health network: estimate of service supply and requirements for 2025

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INTRODUCTION

Mental health disorders during childhood and adolescence are a significant cause of suffering, disability, and service utilization. Furthermore, timely intervention can alter clinical, educational, family, and social trajectories [1]. Specialized care does not replace the role of primary care or interdisciplinary teams, but it remains a critical component of care networks for the most complex cases, continuity of care, and clinical support at other levels of care.

The availability of child and adolescent psychiatrists is limited in many countries and is often concentrated in large cities, in the private sector, or in referral centers. In Latin America, this distribution compounds regional inequalities in mental health services, transportation, referral systems, and the availability of specialized teams [1,2]. In Chile, the situation is particularly acute due to persistent waiting lists for new appointments in child and adolescent psychiatry. The ministry's database recorded nearly 14 000 people on the waiting list and a national median wait time of 306 days in 2024 [3].

The number of specialists alone does not reflect the network's care capacity, as it does not indicate how many hours of care they can actually provide or how that supply compares to an explicit scenario of population needs. This distinction is relevant when part-time schedules, non-clinical duties, shared contracts, and a heterogeneous geographic distribution are present.

This brief paper presents a technical estimate of the available care supply and the potential demand for specialized care in child and adolescent psychiatry for the population aged 4 to 19

covered by the National Health Fund (FONASA). The estimate was conducted by region and at the national level for the year 2025. Its purpose is to clarify the planning assumptions and to quantify the magnitude and geographic distribution of the gap. This study does not aim to estimate expressed demand, observed utilization of services, or establish a definitive number of specialists required.

ESTIMATION METHOD

A technical estimate of health care planning was conducted using secondary administrative records. The number of registered specialists nationwide was obtained from the National Registry of Individual Providers of the Superintendency of Health, as of April 2025 [4]. Regional information on active contracts in the public healthcare network was obtained through a request for information submitted to the Undersecretariat of Healthcare Networks, pursuant to Law No. 20 285 (Transparency Law). The target population consisted of beneficiaries of the National Health Fund aged 4 to 19 years, disaggregated by region, based on institutional open data [5]. The national rate of specialists per 100 000 inhabitants was calculated based on the population reported in the 2024 Census [6].

Healthcare supply was calculated based on contracted hours, rather than the number of individuals. For each region, the weekly contracted hours were multiplied by 45.86 effective working weeks per year and by a care dedication rate of 80%, an assumption consistent with ministerial guidelines for the mental health network [7]. The result was expressed in annual care hours and in full-time equivalent care days. One full-time equivalent in care equals 44 hours per week $\times$ 45.86 weeks/year $\times$ 80% care time; that is, 1614.3 annual care hours. This conversion allows a distinction between the number of contracted specialists and the actual care capacity reflected in their work hours.

Potential care demand was estimated by multiplying, for each region, the National Health Fund population aged 4 to 19 by a prevalence of mental disorders of 22.5% [8], a proportion of 30% of cases requiring specialized care, ten annual consultations per



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MAIN MESSAGES

- This brief paper uses administrative records and explicit assumptions to estimate the available supply of care and the potential demand for specialized care by region.
- The estimate does not measure expressed demand, actual service delivery, infrastructure, or the timeliness of care. It should be interpreted as a planning scenario, not as a rigid hiring target.
- The shortage and uneven distribution of child and adolescent psychiatrists limit the public health system's ability to respond to the mental health needs of children and adolescents.

person, and an average duration of 45 minutes per consultation [9]. The referral assumption aims to represent a tiered care scenario and does not imply that all individuals with mental disorders must be treated exclusively by psychiatrists. The gap was defined as the difference between the potential demand and the available care supply. Coverage was calculated as $(\text{supply}/\text{demand}) \times 100$. To examine the dependence of the result on the referral assumption, a unidirectional sensitivity analysis was conducted by modifying that proportion to 20% and 40%. No inferential tests were performed, nor was the correlation with waiting lists analyzed, because such relationships would be strongly influenced by regional population size and exceed the descriptive scope of the estimate.

RESULTS

In April 2025, 613 specialists in child and adolescent psychiatry were identified nationwide, equivalent to 3.32 per 100 000 inhabitants [4.6]. Of these, 330 had active contracts in the public healthcare system. The care provision resulting from these contracts totaled 395 607 annual care hours, equivalent to 245 full-time-equivalent workdays of care.

In the baseline scenario, the potential demand was 1 253 367 annual care hours, equivalent to 776 full-time-equivalent workdays of care. The national gap amounted to 857 760 hours, or 531 full-time equivalent workdays of care, and the estimated coverage was 32% (Table 1). The Metropolitan Region accounted for 39% of the national potential demand. However, it provided only 28% of the available care supply, resulting in the largest absolute gap: 232 full-day equivalents of care. The regions of Valparaíso, Maule, and O'Higgins had additional deficits of 57, 36, and 33 full-day equivalents of care, respectively. In contrast, proportional coverage was lowest in the Antofagasta (6%) and Tarapacá (13%) regions. Meanwhile, Aysén and Magallanes showed coverage rates of 75% and 83%, respectively, although with small absolute levels of care provision; therefore, even minor variations in staffing could substantially alter their response capacity.

The sensitivity analysis did not alter the main conclusion. If 20% of cases required specialized care, national coverage would increase to 47%, and a gap of 273 full-day equivalents in care would persist. Assuming a 40% rate, coverage would drop to 24%, and the gap would increase to 790 full-day equivalents of care. Therefore, even under a more conservative referral

scenario, the mismatch between care supply and potential demand remains significant.

DISCUSSION

The estimate shows that the contracted public care supply is insufficient given a reasonable scenario of potential demand for specialized care. Its main contribution is not to establish an exact number of psychiatrists per region, but rather to demonstrate that the problem combines an overall shortage with regional inequality. National coverage of one-third of the estimated need suggests that the gap cannot be resolved solely through marginal redistributions among regions. At the same time, the regional results show that a one-size-fits-all strategy would be insufficient. In areas with lower proportional coverage, measures are needed to attract professionals, provide professional support, establish referral networks, and ensure working conditions that reduce clinical isolation. Meanwhile, in areas with higher concentrations of care, the challenge lies in organizing care supply to support continuity of care and regional networks.

Nor should the gap be interpreted as the need to hire one additional professional for every full-time equivalent of missing care. Human resources planning in mental health must integrate training, staffing, working conditions, and retention with the strengthening of primary care, community mental health centers, interdisciplinary consultation, clinical supervision, and telepsychiatry. Tiered care models and interdisciplinary teams enable more appropriate use of specialized time and reduce avoidable referrals, while acknowledging that some clinical situations require evaluation and follow-up by child and adolescent psychiatry [1,7–10]. Thus, expanding the supply of specialists must be accompanied by a network strategy, not replace it.

This estimate has significant limitations. It does not measure actual consultations, expressed demand, timeliness, waiting lists, productivity, available infrastructure, or the problem-solving capacity of other professionals. Contract hours do not allow for a precise distinction between clinical and non-clinical duties, absenteeism, teaching or administrative activities, dual public-private employment, or variations within the same region. Nor did it incorporate the contributions of psychology, nursing, occupational therapy, social work, and other members of mental health teams. Furthermore, the parameters for prevalence, referral rates, frequency, and duration of

Table 1. Healthcare provision, potential demand, and estimated gap in child and adolescent psychiatry within the public healthcare system.

Region ¹	Healthcare Services (JCE) ³	Potential requirement (JCE)	Gap (JCE)	Coverage (%)
Arica y Parinacota	4	12	8	33
Tarapacá	2	18	16	13
Antofagasta	2	30	28	6
Atacama	4	15	11	25
Coquimbo	14	37	23	38
Valparaíso	20	77	57	26
Metropolitana	68	300	232	23
O'Higgins	9	42	33	20
Maule	11	47	36	24
Ñuble	10	20	10	50
Biobío	46	69	23	66
La Araucanía	26	45	19	58
Los Ríos	6	17	11	34
Los Lagos	16	38	22	43
Aysén	4	5	1	75
Magallanes	6	7	1	83
National total ²	245	776	531	32

Abbreviations: JCE, full-time equivalent annual care hours.
1 Regional figures are rounded to the nearest JCE. 2 Totals were calculated using unrounded values. 3 One JCE is equivalent to 44 hours per week × 45.86 weeks/year × 80% of care time = 1,614.3 care hours per year.
Data for each region of Chile for the year 2025.
Source: Compiled by the authors based on data from the study.

consultations are derived from available evidence and planning standards, rather than from a comprehensive local validation. Therefore, the gap should be interpreted as an indicator of the magnitude and distribution of the problem, rather than as a rigid hiring target.

The usefulness of this exercise increases if it is periodically updated and supplemented with information on production, referrals, population-adjusted waiting lists, infrastructure, telemedicine, and professional retention rates.

CONCLUSION

According to the estimates presented here, in the baseline scenario, the available healthcare supply covers 32% of the estimated demand. The Antofagasta and Tarapacá regions have the lowest proportional coverage. Furthermore, even under a more conservative referral scenario, the mismatch between healthcare supply and potential demand remains significant.

Improving the traceability of contracted hours and healthcare activities would allow for a shift from aggregate estimates to more detailed, transparent, and geographically equitable planning for child and adolescent mental health.

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Ethics The study used secondary, aggregated data that did not contain personally identifiable information and did not involve human subjects. Therefore, it did not require review by an ethics committee.

Data sharing statement The aggregated data, the calculation matrix, and the assumptions used are available upon reasonable request to the corresponding author. Individual contract information is not included in the manuscript and is protected in accordance with applicable regulations.

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REFERENCES

1. In: World Health Organization, United Nations Children's Fund. Mental health of children and young people: service guidance [Internet]. Geneva: World Health Organization; 2024. <https://iris.who.int/handle/10665/376643>
2. Defensoría de la Niñez. In: Estudio de políticas de salud mental: hacia un nuevo modelo de garantías para la salud mental de niños, niñas y adolescentes en Chile [Internet]. Santiago: Defensoría de la Niñez; 2022. https://www.defensorianinez.cl/estud_y_consultas/estudio-de-politicas-publicas-relacionadas-con-la-salud-mental-de-ninos-ninas-y-adolescentes/
3. Ministerio de Salud de Chile. In: Visor de casos en espera: consulta nueva médica, psiquiatría infantil y de la adolescencia [Internet]. Santiago: Ministerio de Salud de Chile; 2025. <https://public.tableau.com/app/profile/minsal>.

- qa2/viz/Visor-CNE-Mdica_17442110425110/VisorCasosenEspera-Tiempo
4. In: Superintendencia de Salud de Chile. Registro Nacional de Prestadores Individuales [Internet]. Santiago: Superintendencia de Salud; 2025. <https://rnpi.superdesalud.gob.cl/>
 5. Fondo Nacional de Salud. In: Datos abiertos: distribución de beneficiarios por tramo de edad y región [Internet]. Santiago: FONASA; 2024. <https://datosabiertos.fonasa.cl/>
 6. In: Instituto Nacional de Estadísticas. Censo 2024: población censada [Internet]. Santiago: INE; 2024. <https://censo2024.ine.gob.cl/>
 7. Ministerio de Salud de Chile. In: Modelo de gestión de la red temática de salud mental en la red general de salud [Internet]. Santiago: Ministerio de Salud de Chile; 2018. https://dipol.minsal.cl/wp-content/uploads/2022/03/Modelo-de-Gestion-de-la-Red-Tematica-de-Salud-Mental_digital.pdf
 8. Flora De La Barra M, Benjamin Vicente P, Sandra Saldivia B, Roberto Melipillán A. Estudio de epidemiología psiquiátrica en niños y adolescentes en Chile. Estado actual. Revista Médica Clínica Las Condes. 2012;23: 521–529. [https://doi.org/10.1016/S0716-8640\(12\)70346-2](https://doi.org/10.1016/S0716-8640(12)70346-2)
 9. Rey JM, Martin A, editors. IACAPAP e-textbook of child and adolescent mental health. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions. 2018; Available from. <https://iacapap.org/>
 10. Ministerio de Salud de Chile. In: Dotación de personal en el Sistema Nacional de Servicios de Salud: brechas por Servicio de Salud y especialidad [Internet]. Santiago: Ministerio de Salud de Chile; 2022. <https://www.minsal.cl/wp-content/uploads/2023/01/Dotacion-de-personal-en-el-SNSS-brechas-por-servicio-y-especialidad.pdf>

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