Te Kaunihera Rata o Aotearoa
Medical Council of New Zealand

Pūrongo ā-Tau
Annual Report
2022-2023

Pūrongo ā-Tau 2023

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand is pleased to submit this report, for the year ending 30 June 2023, to the Minister of Health.

The report is presented in accordance with section 134 of the Health Practitioners Competence Assurance Act 2003.

He Tirohanga Whānui o te Tau
Our Year at a Glance

1 July 2022 to 30 June 2023

19,344

Upward trend in the number of registered doctors

2022/2023 saw an upward trend in the number of registered doctors. In comparison to the previous year the number of practising doctors on the register increased by 2.98%, rising from 18,784 to 19,344.

33%

New Zealand trained doctors registered

In the 2022/2023 year, New Zealand-trained doctors accounted for 33% of new registrations (559), representing a slight decrease (4%) compared to the previous year.

769

New specialists registered

In the 2022/2023 period, the number of new specialists registered increased by 2.8% (21) compared to the previous year.

272

Notifications related to doctors' performance and conduct

Notifications related to doctors' performance and conduct totaled 272 in the 2022/2023 period, reflecting a 14.7% increase compared to the previous year.

67%

International medical graduates (IMGs) registered

In the 2022/2023 year, IMGs accounted for 67% of new registrations (1,134), marking an increase (7%) in comparision to the previous year.

99%

IMG applications processed in 20 working days

Consistent with the previous year IMG applications were processed within 20 working days. Our commitment to service standards resulted in 99% of applications from IMGs seeking registration in the general or special purposes scopes of practice being processed within this timeframe.

39

Notifications referred to a Professional Conduct Committee (PCC)

Notifications referred to a PCC reflect the Medical Council's commitment to prioritise public health and safety in every decision about individual doctors. In the 2022/2023 period, the Medical Council referred 39 notifications to a PCC, up from 33 in the previous year.

Kia whakawhirinakitia ngā Rata katoa i Aotearoa

A medical profession all New Zealanders can trust

Mai i te Tumuaki
From the Chairperson

E ngā rau rangatira mā, e ngā tāngata o te motu, tēnā koutou katoa

E rau ringa, e oti ai – many hands get the work done.

In the 2022/2023, as international borders and travel re-opened and vaccinations and antiviral medicines against COVID rolled out, we have moved into a new normal. Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand (the Medical Council) is in a strong position to deliver on its purpose to regulate the medical profession. Some of the old challenges remain, in particular workforce pressures.

40%

Registered doctors who were trained overseas

The Medical Council has initiated new registration processes to provide more timely and efficient pathways to registration for locally trained and overseas trained doctors. With forty percent of doctors registered in the past year having been trained overseas, this will continue to be a vital area for Council to support.

Partnerships across health are our strength and I want to acknowledge our close working relationships with national and international organisations such as the Australian Medical Council and Medical Board and the International Association of Medical Regulators, where we have collaborated to improve right touch regulation across the globe and within Aotearoa.

Our work in cultural safety in support of health equity has continued to develop and resulted in a new training framework for colleges, developed by Te ORA and the Council of Medical Colleges.

We have reviewed how we better support notifiers who report sexual boundary breaches and this work will continue into 2024. We have established a committee to look at our notification processes and how we can respond to the harm identified by the Royal Commission of Inquiry into Abuse in State Care when it reports in 2024.

Our prevocational accreditation system for intern training in years 1-3 is also undergoing an overhaul in response to the health system reforms. In particular the coming together of the 20 District Health Boards into Te Whatu Ora have necessitated a review of accountabilities for training and quality assurance and improvement in the intern training experience, including a greater emphasis on community-based ttachments.

Finally, I would like to acknowledge that this is the last Annual Report that I will sign off as Chair. It has been a privilege to serve as Chair since February 2019, and a member of of the Medical Council for the past 9 years. I would like to recognise the many Medical Council members I have served alongside as well as all staff, they are dedicated professionals who serve with wisdom and hard work to protect the public.

Tēnei te mihi whakahirahira ki a koutou. Nāku te honore.

Dr Curtis Walker
Tumuaki | Chairperson

Mai i te Manukura
From the Chief Executive Officer

Tēnā koutou katoa, ngā mihi mahana ki a koutou.

Our focus has continued to be on the Medical Council's primary purpose of protecting the health and safety of the public by ensuring doctors are competent to practise. At the same time we are cognisant of our environment and the worldwide shortage of healthcare professionals and the additional stress that places on our medical workforce. In addition, we are mindful of the inequities in the healthcare outcomes of some of our communities. These are some of the strategic issues that are laid out in the pou of Te Mahere Rautaki, our Strategic Plan 2022-2027 that guide our work.

Te Tiriti o Waitangi

The Medical Council's commitment to Te Tiriti o Waitangi was a key focus over the year. Te Kāhui Whakamana Tiriti, is supporting the development of our Te Tiriti strategy. We also continue to strengthen and embed cultural safety, cultural competence and te ao Māori in all our regulatory work. Training provided for Medical Council and committee members, staff, agents and key stakeholders has given us an important foundation for our ongoing cultural capability development.

Workforce

The Medical Council's commitment to taking a leadership role, supporting growth of the workforce in a highly competitive global environment, has been welcomed by the profession and policy-makers.

An important initiative completed during the year was a review of the criteria for comparable health systems which streamlined registration for international medical graduates (IMGs). We also reviewed other pathways to registration to ensure they were fit for purpose and do not pose barriers for IMGs seeking registration. We continue to work with stakeholders to explore the issues relating to the retention of IMGs, once they have gained registration in Aotearoa | New Zealand.

We continue to register almost double the number of IMGs each year, in comparison to New Zealand graduates. We have some of the most flexible pathways to registration, and have the highest percentage of IMGs in our workforce of any country in the Western world.

Collaborative working

Strong relationships are at the heart of all we do. We are grateful for the collegial relationships we have across the sector that enable us to jointly consider challenges for the profession and react with agility and responsiveness.

We continued our collaboration with Te Whatu Ora | Health New Zealand, Te Aka Whai Ora, Manatū Hauroa | Ministry of Health, medical colleges and other key stakeholders and responsible authorities on areas relating to workforce, health equity, education and training.

An important aspect of our role is international collaboration regarding regulatory best practice. During the year we held discussions with medical regulators from Australia, US, UK and Canada regarding our comparable health system pathway to registration for IMGs. The Medical Council is regarded as leading regulatory practice in this area.

Our senior staff represent the Medical Council internationally in strategic health practitioner regulation, and I have the privilege of sitting on the Board of Directors of the International Association of Regulatory Authorities. This supports us to stay up to date with international developments and regulatory approach.

Our data to inform

We are due to launch our data dashboard on our website. The dashboard will provide timely, relevant information about the medical workforce in Aotearoa | New Zealand. The dashboard will be updated every quarter with registration information, and annually where data from the Workforce Survey is used to show the hours worked, and the location of doctors by local health region. It will include trends over time about the number of doctors as well as information around the breakdown of doctors who are vocationally registered in each specialty with a breakdown of age, gender, and ethnicity, and the change in number of doctors working in the specialty over the last 5 years.

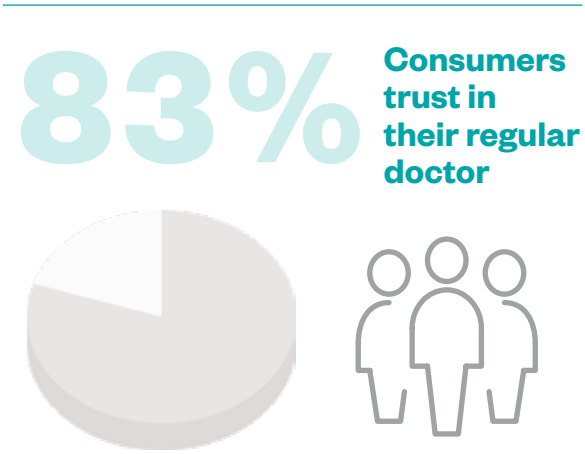
The data dashboard will improve transparency and will provide information to employers and policy-makers of our work. This an important part of the Medical Council's Te Pou Tuatahi – demonstrating accountability to the public, the profession, and stakeholders.

Consumer Advisory Group

We are grateful to continue to engage with an outstanding Consumer Advisory group and we are grateful to the Health and Disability Commissioner for allowing us to share this group with them. This group provides valuable insights that inform all our regulatory work.

Stakeholder, doctor, and consumer surveys

The doctor-patient relationship lies at the heart of health care, and patient trust is a fundamental aspect of that relationship. Trust in the medical profession remains high and this is demonstrated in baseline data in our surveys of the public, which showed that trust in the medical profession was 76%. Consumers reported that trust in their own regular doctor was 83%.



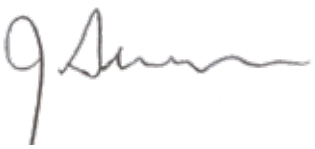
We are encouraged by this high level of confidence; however we also note that that trust comes with a corresponding responsibility on doctors. We note the increasing expectations of the regulator by the public, especially when we are considering conduct matters, for example breaches of sexual boundaries. The Medical Council and others within the healthcare regulatory space, have a significant responsibility to maintain public trust.

Our team

I am incredibly proud of the dedication and professionalism of our team, and all that they have achieved over the past year.

Finally, would like to acknowledge the Medical Council members who have contributed to our work this year, particularly Dr Luisa Fonua-Faemani, whose term has ended. We thank Luisa for her insightful contribution to our work.

Ngā manaakitanga



Joan Simeon
Manukura | Chief Executive

He Rārangi Upoko
Contents

4. Mātauranga | Ngā Whakamatautau

Education and Examinations

- Education Committee Report
- Key Achievements – Education
- Key Achievements – Examinations

Page 38–41

5. Te Hauora

Health

- Health Committee Report
- Workforce Data

Page 42–44

6. Te Āheinga me te Whanonga

Performance and Conduct

- Workforce Data
- Principal Activities
- Notifications
- Performance
- Performance Outcomes
- Conduct
- Conduct Outcomes

Page 46–50

7. Te Pūrongo Pūtea ā-Tau

Annual Financials

- Audit and Risk Committee Report
- Financial Statements and Notes

Page 52–72

8. He Raraunga Kaimahi

Workforce Data

Page 76–95

Mō Mātou
About Us

The Medical Council's primary purpose is to protect the public health and safety of Aotearoa New Zealand by ensuring doctors are competent and fit to practise.

Whether it's assessing a doctor's performance or promoting good medical practice that reflects the expectations of Aotearoa New Zealand communities, all our decisions are based on the principles of right-touch regulation. This is an internationally tried and tested decision-making model for regulators.

How we make our decisions

Proportionate
- We will identify risk. Decisions will be proportionate to the risk posed.

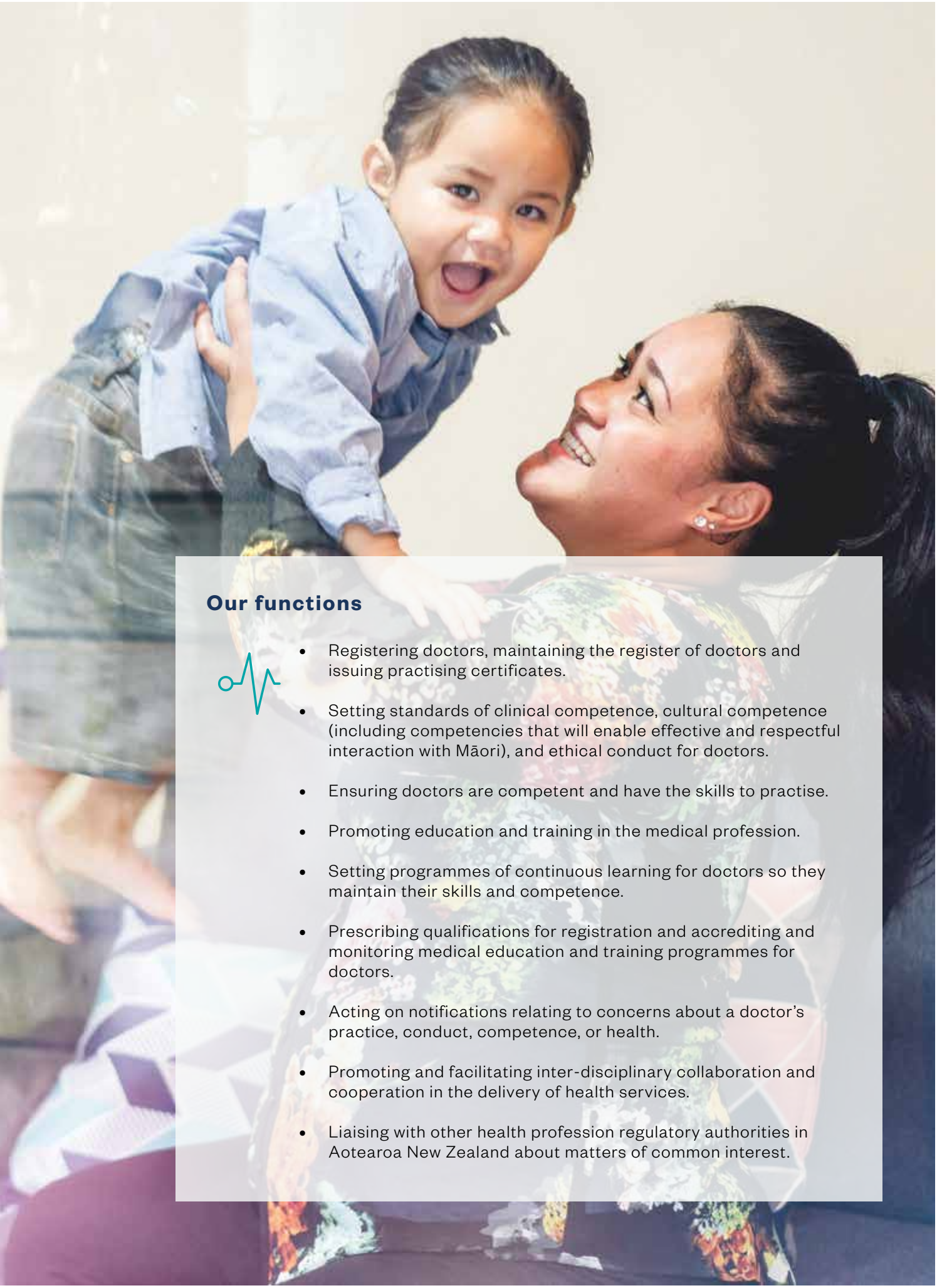
Consistent
- Our policies, standards and decisions will be based on the principles of fairness and consistency.

Targeted
- We will focus on the problem and minimise the side effects.

Transparent
- We will be open and transparent and keep our regulations simple and user-friendly.

Accountable
- We make sure our decisions and actions are robust and stand up to scrutiny.

Agile
- We will be forward thinking and adapt to and anticipate change.



Our functions

- Registering doctors, maintaining the register of doctors and issuing practising certificates.
- Setting standards of clinical competence, cultural competence (including competencies that will enable effective and respectful interaction with Māori), and ethical conduct for doctors.
- Ensuring doctors are competent and have the skills to practise.
- Promoting education and training in the medical profession.
- Setting programmes of continuous learning for doctors so they maintain their skills and competence.
- Prescribing qualifications for registration and accrediting and monitoring medical education and training programmes for doctors.
- Acting on notifications relating to concerns about a doctor's practice, conduct, competence, or health.
- Promoting and facilitating inter-disciplinary collaboration and cooperation in the delivery of health services.
- Liaising with other health profession regulatory authorities in Aotearoa New Zealand about matters of common interest.

Ngā Tumu o Te Kaunihera
Medical Council Members

Dr Stephen Child
MD 1986 Ottawa, FRCP(C) 1991, FRACP 1995

Dr Kenneth (Ken) Clark
MB ChB 1981 Otago, FRANZCOG 1989, FRACMA 2012

Dr Ainsley Goodman
MB ChB 1994 Otago, FRNZCUC 2006, FRNZCGP 2017

Dr Pamela Hale
MBChB Otago 1982, FRACP 1991

Dr Charles Hornabrook
MBChB Otago 1985, FRANZCP 1999

Dr David Ivory
Phd, MEd (Leadership), MEd, LLB, BA (Hons)

Dr Rachelle Love
MB ChB 2002 Auckland, FRACS 2017

Giselle McLachlan
LLB, CFInstD

Kim Ngārimu
BBS
Tumuaki Tuarua | Deputy Chair

Dr Curtis Walker
MB ChB 2007 Auckland, FRACP 2015
Tumuaki | Chair

Mr Simon Watt
LLB (Hons), BA (VUW) LLM (London)

Ms Joan Simeon
MPM
Manukura | Chief Executive Officer

Mr David Dunbar
LLB, B.Com
Pouroki | Registrar

Te Mahere Rautaki
Strategic Plan 2022-2027

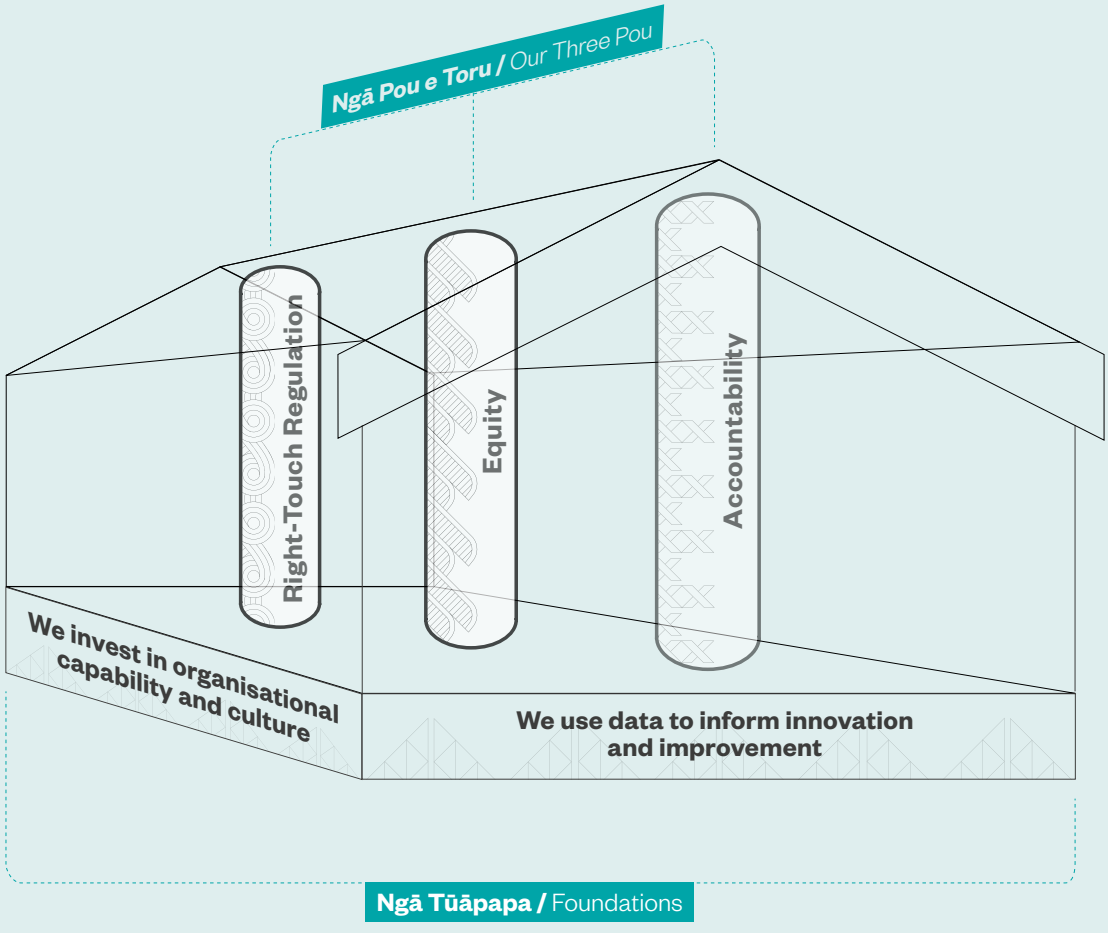
Te Moemoeā / Vision

Kia whakawhirinakitia ngā rata katoa i Aotearoa.
A medical profession all New Zealanders can trust.

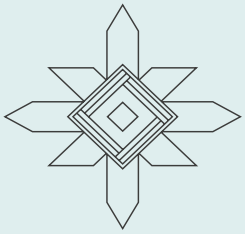
Tō Mātou Kaupapa / Our Purpose

Kia tūhauora, kia haumaru ai te iwi, mā te whakatū, whakatuarā ngā paerewa mo ngā rata i Aotearoa.

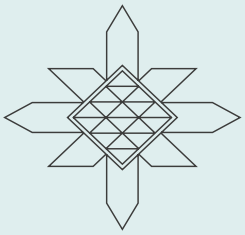
We serve Aotearoa New Zealand by protecting public health and safety through setting and promoting standards for the medical profession.



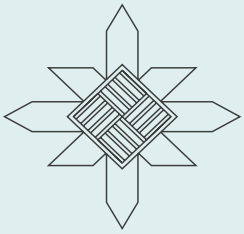
Ā Mātou Uara
Our Values



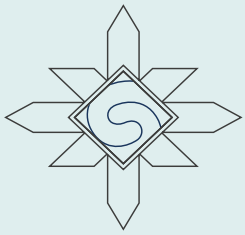
Whakapono
We act with integrity



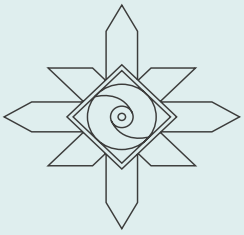
Whakamārama
We lead by listening



Kotahitanga
We are a team



Manaakitanga
We support each other



Kaitiakitanga
We protect the public

'Mā ēnei whakaarotau rautaki, me whakatutuki te moemoeā, me whakamahia te kaupapa, me whakamana Te Tiriti o Waitangi, a, kia toitū te rōpū.'

'We will achieve our vision, deliver on our purpose, uphold the mana of Te Tiriti o Waitangi, and be a sustainable organisation through our strategic priorities.'

He Paetae Matua
Key Achievements

He Paetae Matua / Key Achievements

The Annual Report broadly focuses on operational and financial performance, whereas the Statement of Service Performance in the following pages is focused on the delivery of the outcomes of Te Mahere Rautaki, our Strategic Plan for 2022/2027. Our strategic priorities, informing our strategic plan, comprise three pou: accountability, equity and right-touch regulation.

The Statement of Service Performance reflects activities undertaken in 2022/2023 and demonstrates our progress against the short-term outputs that, over time, will help us reach our medium-term intentions and long-term outcomes.

Te Pou Tuatahi

Demonstrate accountability to the public, profession and stakeholders

A highlight this year was the completion of foundational work for this first pou, as we established baseline data about public trust, public understanding and the profession's knowledge of standards. We engaged with a range of health consumers, doctors, and key stakeholders through surveys and focus groups, providing important insight into the public's view of key components of good medical care. It also sparked new workstreams for the Medical Council. For example work has begun to strengthen doctors' understanding of certain standards, as research revealed that not all of the Medical Council's standards are understood to the same extent.

Te Pou Tuarua

Promote equity of health outcomes

In 2022/2023, we conducted an evaluation of a series of online interactive workshops for international medical graduates (IMGs) that were held in May last year. The workshops were designed to support IMGs to practise safely in Aotearoa | New Zealand by ensuring they understood the standards expected of them. This included the standards of professional and ethical conduct that the Medical Council sets for the profession and obligations around cultural safety.

Evaluation of the workshops showed that participants achieved the intended learning outcomes and applied the learning to their practice. All respondents to the 3-month follow-up survey stated that they were familiar with the Medical Council's role and standards, and had gained confidence in providing culturally safe care. Nearly all respondents stated they understood their obligations about informed consent and safe prescribing. 73% of respondents had fully or mostly embedded what they learned into their practice, with the remaining 27%, having somewhat embedded their learning.

Te Pou Tuatoru

Demonstrate proactive right-touch regulation in all we do

Our registration pathways and processes are acknowledged internationally as flexible and enabling. The Medical Council is committed to maintaining pathways that are fit-for-purpose and protect public safety, and given Aotearoa | New Zealand's reliance on IMGs, that avoid adding unnecessary barriers to registration. Developments this year included the addition of one new and one alternative registration pathway, and a reduction in the requirements for another. A key achievement was the revision of our criteria for recognition of comparable health systems, and the subsequent assessment of five new countries against the criteria. This resulted in Hong Kong being approved as a comparable health system, enabling doctors who have practised in Hong Kong to gain registration more easily.

Te Tiriti o Waitangi

Our obligations under Te Tiriti o Waitangi

The Medical Council has progressed work related to its responsibilities under Te Tiriti o Waitangi over the past year.

- The Medical Council has a primary goal of upholding the mana of Te Tiriti o Waitangi (Te Tiriti) in our work; cultural safety, cultural competence, and health equity are key focus areas of our approach as we activate that goal.
- We have established the oversight group Te Kāhui Whakamana Tiriti to provide guidance and advice about how we continue to embed Te Tiriti into the Medical Council's work.
- We have continued our focus by applying the principles of Te Tiriti, cultural safety, cultural competence, and health equity across a range of functions.

  As an example, we have provided training to the Medical Council agents who support our regulatory functions, including Professional Conduct Committee members, Prevocational Education Supervisors, Vocational Practice Assessors and Performance Assessment Committee members.
- We have also continued our engagement with key stakeholders, including Te Ohu Rata o Aotearoa | Māori Medical Practitioners Association (Te ORA), other responsible authorities, the Council of Medical Colleges (CMC), Manatū Hauora | Ministry of Health, medical education providers, employers, and professional associations. The Medical Council has also supported related external developments, including the cultural safety training framework for vocational medicine launched this year by Te ORA and CMC.
- To enable our work, the Medical Council continues to strengthen its own internal organisational capability in the understanding of Te Tiriti, cultural safety, cultural competence, health equity, and te ao Māori.

Ngā Tohu Whakatutuki Statement of Service Performance

1 July 2022 to 30 June 2023

Entity information

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand is established under the Health Practitioners Competence Assurance Act 2003. The Medical Council's primary purpose is to protect the public health and safety of Aotearoa | New Zealanders by ensuring doctors are competent and fit to practise. Whether it's assessing a doctor's performance or promoting good medical practice that reflects the expectations of Aotearoa | New Zealand communities, all our decisions are based on the principles of right-touch regulation – an internationally tried and tested decision-making model for regulators. For more on our functions and how we make decisions see pages 12-13.

Disclosure of judgements

The performance measures used in this report are based on the Medical Council's strategic priorities as shown in Te Mahere Rautaki 2022-2027, the Strategic Plan of the Medical Council for 2022-2027.

1. Te Pou Tuatahi–Demonstrate accountability to the public, the profession and stakeholders	
Long term (enduring) Ngā Hua | Outcomes	Medium term (3–5 years) Ngā Aronga | Intentions
The public have increased trust in the medical profession. The profession, stakeholders and government have increased trust in us as the medical regulator.	By 2027, we will achieve: » an increase* in the public's trust in doctors, relative to other professions and international benchmarks. » an increase* in the public's understanding of how to make a notification. » an increase* in the profession's knowledge of the Medical Council standards. *targets will be established once baseline data has been collected.

	Fully achieved by 30 June 2023
	On track for completion by 30 June 2024
	Scheduled for commencement 2023/2024
	Partial completion expected by 30 June 2024
	Unlikely to be achieved by 30 June 2024

The short-term outputs (1-2 years) were deliberately developed to be measurable in order to minimise subjectivity in reporting. Work has commenced on the outputs that are identified as 'On track for completion by 30 June 2024' and we have subjectively judged these as likely to be achieved by that date.

Comparative information

This is the first service performance report prepared by the Medical Council. Where comparative information is available it has been included against those specific performance measures. As several performance measures were set in accordance with the recently updated strategic plan (see above), providing comparative information was not always possible or appropriate due to the characteristics of these measures.

	Short term (1–2 years) Ngā Mahi Rautaki | Outcomes	Commentary	Progress
1.1	Short video guides, a chatbot to answer questions, and spot surveys are available to the public on our website.	We developed a video guide on 'Making a notification as a patient' that was published on our website in April 2023. At least one more video guide will be created in the coming year. A chatbot to help our website visitors find the information they need is under development.	
1.2	Feedback from the Consumer Advisory Group has informed, and is embedded into, at least four standards for the profession.	We sought input from the Consumer Advisory Group (CAG) on these draft standards for the profession: » 'Doctors and health-related commercial organisations' » 'Medical certification' » 'Principles for quality and safe prescribing practice'. In the coming year we will seek CAG feedback on further draft standards and close the loop with the group as to how their input has been incorporated into the final published versions.	

1. Te Pou Tuatahi–Demonstrate accountability to the public, the profession and stakeholders	
Long term (enduring) Ngā Hua | Outcomes	Medium term (3–5 years) Ngā Aronga | Intentions
We demonstrate increased accountability to Māori under Te Tiriti o Waitangi.	New systems identified in the plan that we will set in partnership with Te Kāhui Whakamana Tiriti will be embedded across our work – demonstrating our accountability to Māori in all aspects of our work.
We are efficient and transparent in our registration, professional standards and doctors' health processes.	We will meet our published service standards for timeliness.

	Short term (1–2 years) Ngā Mahi Rautaki | Outcomes	Commentary	Progress
1.3	Baseline data about public trust, public understanding, and the profession's knowledge of standards is captured for use in future evaluations to measure progress towards our medium and long-term goals.	We collected baseline data from health consumers and doctors in November/ December 2022 through a survey conducted for us by a market research company. In brief, we found that: » Public trust in medical profession was 76%. » Public trust in their regular doctor was 83%. » Just under half (47%) of health consumers were unsure of who to contact if they had a concern about a doctor. » Only 12% of health consumers surveyed would contact us. Doctors reported their level of understanding of key standards for the profession as follows: » Sexual boundaries – 82% » Informed consent – 75% » Providing care to yourself – 65% » Good prescribing practice – 58% » Cultural safety – 53% Now that baseline data has been collected, we will set 2027 targets for improvement.	
1.4	Te Kāhui Whakamana Tiriti is established, provides Māori input to our work, and sets our plan around how we will fulfil our responsibilities under Te Tiriti o Waitangi.	We established a new advisory group, Te Kāhui Whakamana Tiriti, which met for the first time in July 2023. Over the coming months it will help us develop a framework and plan to ensure we fulfil our responsibilities to Māori under Te Tiriti o Waitangi.	
1.5	95% of general registration applications will be processed within 20 working days of receipt of completed application.	We achieved this service standard by processing 99% of general registration applications within 20 working days. (In 2021-2022, we also processed 99% of general registration applications within 20 working days). The number of general (new doctor) registrations is available on the public data dashboard on our website.	

1. **Te Pou Tuatahi–Demonstrate accountability to the public, the profession and stakeholders**	
Long term (enduring) Ngā Hua | Outcomes	Medium term (3–5 years) Ngā Aronga | Intentions

2. **Te Pou Tuarua–**Promote equity of health outcomes	
Long term (enduring) Ngā Hua | Outcomes	Medium term (3–5 years) Ngā Aronga | Intentions
Māori receiving health services from doctors have an improved experience of cultural safety. Our regulatory and non-regulatory levers support the achievement of health equity for Māori, Pasifika, disabled people and other groups who currently experience inequitable health outcomes. The medical workforce is diverse and inclusive.	An improvement in the current experience of cultural safety amongst Māori receiving health services from doctors, as demonstrated in an evaluation against the September 2020 report 'Baseline data capture: Cultural safety, partnership and health equity initiatives'.

	Short term (1–2 years) Ngā Mahi Rautaki | Outcomes	Commentary	Progress
1.6	90% of applications for assessment of eligibility for provisional vocational registration (international medical graduates) will be completed in 6 months.	We processed 83% of vocational registration applications within 6 months. The 7% shortfall from target levels was due to delays with medical college processes. (In 2021-2022, we also processed 83% of vocational registration applications within 6 months.) Over this coming year we will be working closely with colleges to support improved timeliness. The number of new vocational scope registrations is available on the public data dashboard on our website.	

	Short term (1–2 years) Ngā Mahi Rautaki | Outcomes	Commentary	Progress
2.1	The effectiveness of the 'Welcome to Practice in Aotearoa New Zealand' trial workshops for international medical graduates delivered in 2021–22 is determined through evaluation.	Evaluation showed that the 'Welcome to Practice in Aotearoa | New Zealand' workshops were effective in achieving the intended learning outcomes, useful in educating international medical graduates (IMGs) on key aspects of good medical practice and cultural safety in Aotearoa | New Zealand, and successful in influencing changes to the doctors' practice. The workshops were attended by 71 IMGs. The evaluation of the workshops was considered by the Medical Council in September 2022. The Medical Council recommended that delivery of this content should continue through a mechanism that is sustainable and scalable to reach a larger cohort of IMGs. Discussion with Te Whatu Ora on the continuation of the workshops is underway.	

2. **Te Pou Tuarua**–Promote equity of health outcomes	
Long term (enduring) Ngā Hua | Outcomes	Medium term (3–5 years) Ngā Aronga | Intentions

	Short term (1–2 years) Ngā Mahi Rautaki | Outcomes	Commentary	Progress
2.2	Accreditation standards for training providers across the medical education continuum are strengthened to demonstrate commitment to Te Tiriti o Waitangi and health equity, including: » all training providers demonstrate commitment to Te Tiriti o Waitangi through documented strategic priorities » all training providers include Māori on their governance and decision-making bodies » all vocational providers have policies in place that facilitate and support entry to training programmes for Māori trainees.	Scheduled to commence 2023/2024.	
2.3	Cultural safety is embedded in the Medical Council's systems and processes for all regulatory functions (including PACs and PCCs).	We delivered cultural safety and health equity training for the doctors and lay people who form the panels and committees that are fundamental to our regulatory processes. Between February and June 2023, we provided training for: » 65 panel members who undertake performance assessments when the Medical Council has questions about a doctor's competence. » 49 committee members who undertake conduct investigations when the Medical Council has concern about a doctor's conduct. » 94 doctors who are intern supervisors for the prevocational medical training programme.	

2. **Te Pou Tuarua**–Promote equity of health outcomes

Long term (enduring) Ngā Hua | Outcomes	Medium term (3–5 years) Ngā Aronga | Intentions

3. **Te Pou Tuatoru**–Demonstrate proactive, right-touch regulation in all we do

Long term (enduring) Ngā Hua | Outcomes	Medium term (3–5 years) Ngā Aronga | Intentions
Medical education and training prepares and supports a medical profession fit for practice in a transformative health care environment.	Accreditation systems and standards are responsive to a modern workforce and a transformative healthcare environment. Systemic themes arising from accreditations are reported annually and inform the Medical Council's strategic response.

	Short term (1–2 years) Ngā Mahi Rautaki | Outcomes	Commentary	Progress
2.4	Doctors' responsibilities under Te Tiriti o Waitangi are defined and incorporated in the Medical Council's statement on cultural safety and our health equity guidance document.	Scheduled to commence 2023/2024.	
2.5	A cultural safety and health equity symposium is delivered, to further advance the movement from understanding to action across the profession and stakeholders.	Scheduled to commence 2023/2024.	
2.6	Training providers are required to report on trainees' ethnicity and gender/gender identity.	Scheduled to commence 2023/2024.	

	Short term (1–2 years) Ngā Mahi Rautaki | Outcomes	Commentary	Progress
3.1	There are explicit national, regional and local level requirements in a strengthened prevocational medical training accreditation framework, increasing the accountability of training providers.	We set up a project to review the processes for the accreditation of training providers who provide education and training to interns in their first two years of practice (prevocational medical training). This was to ensure that these would remain effective given the health sector restructure. This project has been delayed while external decisions are made as part of the Te Whatu Ora establishment phase.	
3.2	Four training providers are assessed against this framework, their accreditation reports are published, and their progress is monitored against required actions.	Due to the external delays described in 3.1 above, the Medical Council agreed to resume accreditation in 2023/2024 using its current accreditation processes. Consequently, the short-term output for 3.2 was revised as follows.	

3. **Te Pou Tuatoru**–Demonstrate proactive right-touch regulation in all we do	
Long term (enduring) Ngā Hua | Outcomes	Medium term (3–5 years) Ngā Aronga | Intentions
The principles of right-touch regulation are used in all the Medical Council's decision-making.	Right-touch regulatory impact analyses are routinely considered in the Medical Council's strategic, policy and operational decisions.
There is a demonstrated increase in inter-professional collaboration and cooperation in the regulation of health professionals and the delivery of health services.	At least three joint strategic initiatives with other Responsible Authorities (RAs) are carried out each year.

	Short term (1–2 years) Ngā Mahi Rautaki | Outcomes	Commentary	Progress
		'A regional network of prevocational training providers undergoes accreditation'. Accreditation of the Northern Region is scheduled for 2023/2024.	
3.3	A right-touch impact analysis methodology is developed and trialled.	We are developing a structured approach to applying the principles of right-touch regulation in our decision-making. These principles are that regulation should be: » Proportionate » Targeted » Accountable » Consistent » Transparent » Agile	
3.4	Right-touch regulation is embedded in the Medical Council's briefing papers through systematic use of right-touch impact analysis methodology.	This will build on the right-touch regulation approach being developed in 3.2 above. This work is scheduled to commence in 2023/2024.	
3.5	Completion of a joint RA prescribing statement.	We have actively participated with other RAs in developing a draft standard for all health professions that undertake prescribing. This is so that patients experience a consistent and high-quality approach to prescribing, no matter which health professional is involved. Consultation with the prescribing professions and their stakeholders was underway as at 30 June 2023.	
3.6	The framework for our 'Welcome to Practice in Aotearoa New Zealand' IMG workshops is used for consideration of joint workshops with other RAs and other health professions.	We shared the format, content and evaluation findings from our 'Welcome to Practice in Aotearoa New Zealand' workshops with the CEs and Registrars of the other Responsible Authorities, to support the work they are doing with their international practitioners.	

3. **Te Pou Tuatoru**–Demonstrate proactive right-touch regulation in all we do	
Long term (enduring) Ngā Hua | Outcomes	Medium term (3–5 years) Ngā Aronga | Intentions
Our registration policies are fit for purpose and responsive to the changing nature of the medical workforce.	The IMG application process is streamlined to ensure that applicants are provided outcomes within the shortest possible time, and within a maximum of 6 months.

	Short term (1–2 years) Ngā Mahi Rautaki | Outcomes	Commentary	Progress
3.7	Completion of at least one initiative that promotes RA alignment on cultural safety and health equity.	In order to support the governance members of all the RAs in their cultural learning, we hosted an interactive workshop on the history of bicultural relations in Aotearoa | New Zealand. Two of our senior staff who are Māori are active members of the Inter-RA Māori Advisors and Influencers Network. This group met approximately monthly to discuss and share RA activities related to Te Tiriti o Waitangi, health equity and cultural safety, promoting collaboration and alignment.	
3.8	The criteria for recognition of Comparable Health Systems (CHSs) are revised to ensure fit for purpose and appropriate thresholds.	The Medical Council adopted revised criteria for the recognition of Comparable Health Systems (CHSs) in December 2022. The aim of the review was to ensure the criteria were fit for purpose and did not provide any unnecessary barriers to registration.	
3.9	Four additional jurisdictions and all current CHSs are assessed against the new criteria.	We assessed five countries against our new criteria for CHSs. These countries were South Africa, Argentina, Brazil, Cuba and Hong Kong. Hong Kong was approved as a comparable health system country, and the other four were assessed as not comparable. Countries currently recognised under the comparable health system pathway will undergo review in 2023/2024.	

Te Whakaurunga
Registration

He Paetae Matua
Key Achievements

1 July 2022 to 30 June 2023

Principal activities

All doctors who practise medicine in Aotearoa | New Zealand must be registered by the Medical Council and hold a practising certificate. This ensures that a doctor is competent and fit to practise safely.

Practising doctors must comply with the Medical Council's recertification requirements including continuing professional development to demonstrate that they are up to date and maintaining competence.

The Medical Council registration team considers applications, renews practising certificates (PCs), issues certificates of professional status (COPS), and develops registration policy.

Registration Committee

The Registration Committee (the Committee) was established in November 2019. Its role was to consider applications for registration from medical students identified by medical schools' Fitness to Practise Committees as having issues requiring Medical Council consideration. The Committee did not meet during this reporting period.

99%

IMG general scope applications were processed in 20 working days

Service standards

99% of international medical graduates' (IMGs) general and special purpose registration applications were processed within the 20 working day timeframe. We are committed to processing applications for registration in the general and special purpose scopes within 20 working days of receiving a complete application.

> Applications were processed within 20 working days.

- We have achieved this goal in 99 percent of cases during the 2022/2023 reporting period.
- Applications for registration in the vocational scope of practice take longer to process, because they require more detailed assessment.
- As part of the assessment, we seek advice from the relevant specialist medical college. On average, it takes four to six months to confirm a doctor's eligibility for registration.
- We processed 83% of applications within our six-month service standard in the 2022/2023 reporting period.
- 61 individuals who passed the NZREX Clinical gained registration in the provisional general scope of practice via the Examinations pathway between 1 July 2022 and 30 June 2023.

> Further development of online and automated processes.

- Applications can now be made online for special purpose locum tenens registration applications, and changes for IMGs under supervision and also changes to scopes of practice. This has increased efficiency and saved processing time for approximately 100 locum tenens applications and 650 variation applications each year.
- We have automated the processing of Practising Certificates and Certificates of Professional Status for the vast majority of applications. Automation streamlines the process and allows us to focus on other priorities.

38% **IMGs retained after 2 years**

Retention rates

> Many IMGs come to Aotearoa | New Zealand for a very short time.

We register a significant number of IMGs each year, however many only stay in Aotearoa | New Zealand for a short period.

- 43% have left Aotearoa | New Zealand one year after gaining registration.
- 62% have left Aotearoa | New Zealand two years after gaining registration.

99% **New Zealand graduates retained after 2 years**

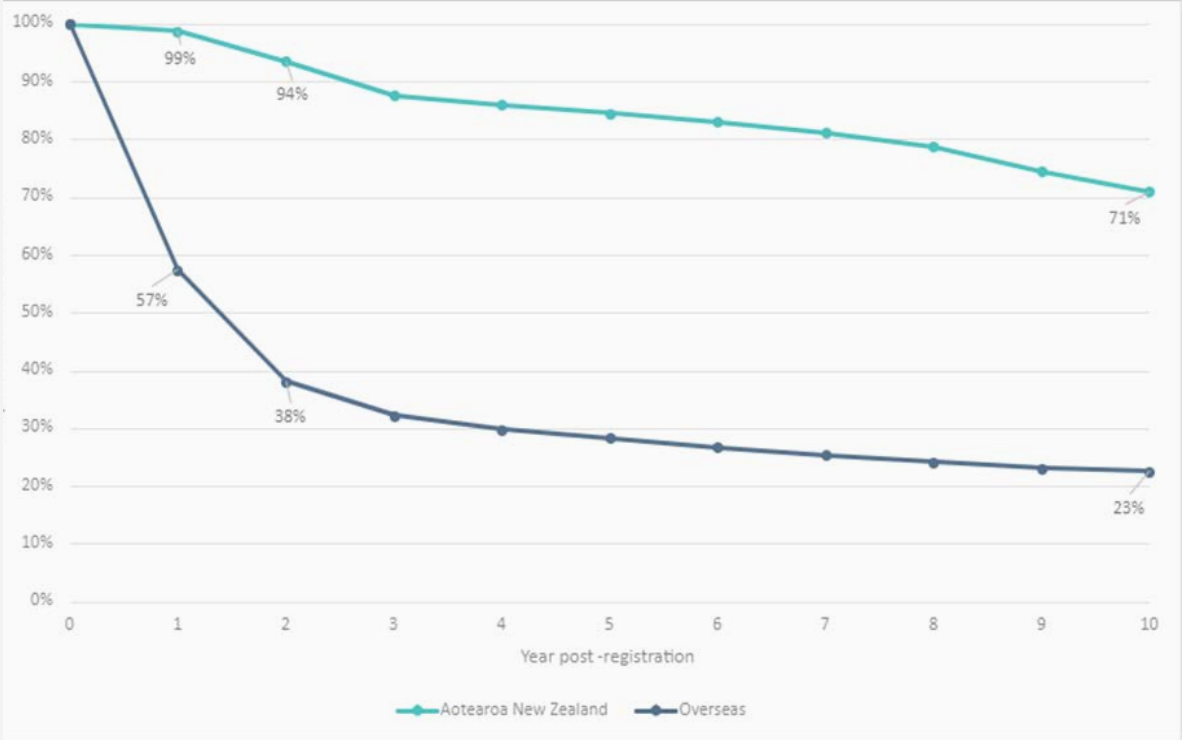
> Retention of NZ graduates remains very high, 5 years after gaining registration.

Retention of New Zealand graduates is significantly higher.

- 98.9% remain in Aotearoa | New Zealand 2 years after gaining registration.
- 90% remain in Aotearoa | New Zealand 5 years after initial registration (for 2015, 2016, 2017, and 2018 cohorts).

Retention over 10 years

Retention rate of IMGs and NZ graduates after initial registration over 10 years



Registrations by year and scope

Registrations issued by year and scope (1 July 2018 to 30 June 2023)

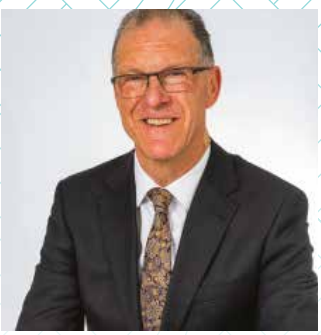
	2018/19	2019/20	2020/21	2021/22	2022/23
General	90	88	75	91	87
Provisional general (IMGs)	742	679	499	630	741
Provisional general (NZ and Australian graduates)	508	521	527	569	548
Provisional vocational (IMGs)	103	110	154	199	168
Special purpose	178	178	132	110	160
Vocational (VOC1)	421	481	491	465	576
Vocational (VOC2)	46	80	91	111	56
Total	**2,088**	**2,137**	**1,969**	**2,176**	**2,327**

- The number of provisional general registrations (IMGs) has increased and is now comparable to pre-COVID levels.
- The number of provisional vocational registrations (IMGs) has declined since last year but remains higher than pre-COVID levels.
- The number of special purpose scope of practice pathway registrations has increased. Locum tenens registrations have returned to pre-COVID levels. Visiting expert registrations have significantly increased and are higher than pre-COVID levels.

See more workforce data at pages 76 - 97.

Mātauranga | Ngā Whakamatautau
Education | Examinations

Te Rōpū Mātauranga Education Committee



Dr Kenneth (Ken) Clark (Chair)
MB ChB 1981 Otago, FRANZCOG 1989, FRACMA 2012

Te Rōpū Mātauranga | Education Committee is a standing committee of the Medical Council. Its primary purpose is to accredit and monitor medical education providers, including medical schools, prevocational medical training providers and vocational training providers (medical colleges).

This ensures students and doctors receive high-quality education and training across the education continuum for their primary medical qualification, prevocational training as interns, and vocational training.

Our mahi over the last 12 months has focused on the continued monitoring and promotion of medical education while changes in the Aotearoa | New Zealand health system are implemented.

We have continued with our mahi to develop a new accreditation framework for prevocational medical training, with the following aims.

- Ensuring the accreditation system aligns with the changes to the new health system, reflecting Te Whatu Ora | Health New Zealand, Te Aka Whai Ora | Māori Health Authority and the other new health structures.
- Using the opportunity to further develop and emphasise key aspects of prevocational medical training, for example cultural safety, health equity and community-based clinical attachments.
- Ensure that interns continue to receive high-quality medical education and training.

This work that will continue into the 2023-2024 financial year.

Over the last year, we have welcomed two new members to the Education Committee: Dr David Ivory, as a lay member of the Medical Council and Dr Jacob Ward as an intern member.

We farewelled Dr Emma Espiner (intern member) and Ms Kim Ngārimu (Deputy Chair), both of whom were also valued members on several accreditation assessment panels.

I am pleased to have been involved in the working group constructing the Australian Medical Council's (AMC's) *Standards for Assessment and Accreditation of Primary Medical Programs,* which have now been approved for use by medical schools in Aotearoa | New Zealand and Australia.

These standards are strengthened in key areas of importance such as cultural safety and student wellbeing. The Medical Council has a long history of working collaboratively with the AMC on medical schools accreditation, to ensure a trans-Tasman approach.

In the coming financial year, we are resuming accreditations for prevocational training providers against our current standards.

I would like to recognise the ongoing contribution made by all those committed to medical education in Aotearoa | New Zealand.

He Paetae Matua
Key Achievements

1 July 2022 to 30 June 2023

59% **Interns undertaking community placements**

The percentage of interns undertaking community placements increased from 48% in 2021-2022 to 59% in 2022-2023.

Education

> 91 new or changed accredited clinical attachments.

- Two organisations were assessed against the *Accreditation standards for training providers of vocational medical training and recertification programmes:* the New Zealand Dermatological Society and the New Zealand College of Sexual and Reproductive Health.
- We accredited 91 new or changed clinical attachments, 24 were community-based. PGY1 and PGY2, interns undertake a series of clinical attachments for a range in experience. Each attachment is accredited by the Medical Council to ensure quality supervision and assessment.
- The number of doctors completing prevocational training programmes who had undertaken at least one community-based clinical attachment rose from 48% in 2021-2022 to 59% in 2022-23.

29 **New prevocational educational supervisors**

148 **Current prevocational educational supervisors**

> An enhanced monitoring exercise with Te Whatu Ora Bay of Plenty was conducted.

- We appointed 29 new prevocational educational supervisors from 15 regions. We now have a total of 148. These supervisors, who are vocationally registered doctors, are appointed by the Medical Council to offer educational guidance, pastoral care, and support to groups of up to 10 interns. Each intern is assigned a supervisor at the start of their PGY1 year.
- We conducted an enhanced monitoring exercise with Te Whatu Ora - Hauora aToi Bay of Plenty for ongoing quality of training while prevocational accreditation visits were paused due to health system reforms.

> We celebrated our Intern of the Year and Clinical Educator of the Year award winners.

- We considered the first set of prevocational training provider annual reports at the August Education Committee meeting. Key themes were progression in embedding cultural safety and health equity into programmes, ongoing resilience in Covid-19 response, and implementation of valued community based clinical attachments.
- The new annual monitoring process demonstrated that prevocational medical training in Aotearoa New Zealand remains safe and effective.
- We collaborated with the Australian Medical Council to conduct accreditations for two Australasian vocational training providers, the Australian and New Zealand College of Anaesthetists, and the Royal Australian and New Zealand College of Psychiatrists.
- We celebrated our 2022 Aotearoa | New Zealand Intern of the Year and Clinical Educator of the Year award winners, Dr Emma Espiner and Dr Joshua Manukonga respectively. Dr Joshua Manukonga was also the winner of the overall 2022 Confederation of Post-graduate Medical Education Councils of Australia and New Zealand Clinical Educator of the Year award.
- We ran a series of clinics for prevocational educational supervisors, providing support on interns in difficulty.
- We participated in the 2022 Australian and New Zealand Prevocational Medical Education Forum. Plenary speakers at the forum included: Tumuaki | Chair of the Medical Council Dr Curtis Walker, Poutoko | Chair of the Education Committee Dr Ken Clark, Manukura | Chief Executive Officer Ms Joan Simeon, Jane Dancer, Kaitiaki Rautaki Kaupapa Here | Manager, Strategy and Policy and intern member on our Education Committee Dr Karleigh O'Connor.
- We hosted the annual prevocational educational supervisor meetings in September 2022, May 2023 and June 2023, resuming face-to-face meetings; a valuable opportunity for strengthened peer-to-peer collaboration and networking. The meetings provided continuing professional development for prevocational educational supervisors across several areas of interest, including:

  - embedding cultural safety in medical education
  - supporting interns in difficulty
  - promoting the health and wellbeing of interns.

69%

Passed the NZ Registration Examination

(NZREX Clinical)

Examinations

- The New Zealand Registration Examination (NZREX Clinical), held in September 2022 and March 2023, saw 53 candidates sitting the examination. 69% passed the examination.
- We increased diversity in actor casting for NZREX Clinical, reflecting the diversity of Aotearoa | New Zealand's population and to better assess candidates' ability to provide equitable health care.
- We recognised Examination Director Dr Steven Lillis and Assistant Examination Director Dr Malcolm Stuart as they stepped back from this role after 17 and 13 years of successfully conducting NZREX Clinical.

See more workforce data at pages 76 - 97.

Te Hauora Health

Te Rōpū Hauora Health Committee

Dr Pamela Hale (Chair)
MBChB Otago 1982, FRACP

The Health Committee (Te Rōpū Hauora) acts on behalf of the Medical Council by reviewing all notifications about a doctor's health that may affect their ability to safely practise medicine. It comprises up to five members of the Medical Council representing different medical specialties, including a minimum of one lay person. Ideal medical members include a psychiatrist, GP and a hospital specialist to get a broad understanding of the work undertaken by different types of doctors.

This year saw a change in our membership. We were sorry to lose Kim Ngārimu – she has been a real asset as our lay person. New into the role is Simon Watt. We were also very sorry to lose Dr Lu'isa Fonua-Faeamani whose term on the Medical Council ended. Her compassion, and insight into busy GP work has been invaluable.

We received 50 notifications of doctors with health problems, in the year ending 30 June 2023 – see page 44.

Our role is to decide whether the doctor's health condition could adversely impact their work. If concerns are raised, we will arrange for treatment team reports, and often an assessment by an independent practitioner in a specialty relevant to the illness of concern.

This independent assessor is nominated by the Committee, and we do liaise with the referred doctor. The assessors' conclusions and advice, particularly around any oversight we may need to put in place to enable the doctor to work safely, informs our decision making. We are grateful for the quality of these assessments and the professionalism of our assessors.

It is unusual that a doctor may be required to stop work, usually this is just until their health improves.

We meet approximately monthly to discuss doctors who have been referred, and to regularly review the progress of doctors under our supervision.

We carefully balance any risks to patient safety with compassionate management of the doctor, encouraging and facilitating treatment of their health condition.

Conditions most likely to require the Committee's oversight include mental illnesses such as severe depression and bipolar illness, drug and alcohol dependence, neuropsychiatric conditions such as dementia, head injuries, and progressive physical conditions such as Parkinson's disease.

The Committee also considers applicants' health disclosures on applications for registration, as well as practising certificates, and gives advice to the Medical Council's Registrar and the Medical Council on these. In total, there were 251 disclosures reviewed.

The Medical Council referred 2 doctors who had been convicted of alcohol-related offences. The Committee arranged health assessments to inform the Medical Council's decision making on whether there was an underlying health condition contributing to the offence.

We are fortunate to have a skilled team in the office to support us. They perform their work with sensitivity, compassion, and professionalism. The work can be stressful especially when dealing with vulnerable and distressed doctors, anxious to maintain their careers.

Last year, the Committee oversaw over 250 decisions made under delegation by the Health Team. They liaise directly with the doctors, organising assessments, coordinating treatment and any work supervision needed. They may need to arrange drug and alcohol screening, respond to any concerns or health crises; and keep the Committee informed on actions taken.

Only a few meetings have been held face-to-face over the last year. The rest occurred by video conferencing, which is functional but does not facilitate the same level of rapport. We have had fewer doctors attending the committee meeting in person than previous years. We look forward to more face-to-face time going forward.

Our fundamental role is public safety, ensuring doctors are not impaired at work, but it is also very rewarding when we can enable doctors to continue working safely whilst managing their underlying health condition.

He Raraunga Kaimahi
Workforce Data

1 July 2022 to 30 June 2023

50

48 Health referrals plus 2 S67A cases

Notifications of inability to perform required functions due to mental or physical health condition (1 July 2019 to 30 June 2023)					
Source	2019	2020	2021	2022	2023
Health service	2	2	2	-	-
Health practitioner	29	29	31	20	28
Employer	7	7	16	6	8
Medical Officer of Health	-	-	-	-	-
Other person	2	2	-	1	2
Person involved with education	2	2	2	12	-
The Medical Council	-	-	-	5	8
Ordered health evaluation	-	-	-	3	8
Treating doctor	-	-	-	4	2

Disclosures

> There were 251 disclosures in total.

- 37 New graduate disclosures
- 155 Practising Certificate disclosures
- 59 Registration disclosures

14 of the 37 new graduates were notifications from the deans. 81 independent assessments were completed. Of the 56 new referrals 28 were self notifications, 8 were from employers, 8 were from the Medical Council, 2 were from treating doctors, 2 were from other sources, and 2 were S67A cases that were notifications from legal counsel and the Medical Council's Notifications Triage Team.

Reason for referral :

- 3 Dual diagnosis
- 25 Psychiatric
- 3 Drug
- 5 Alcohol
- 12 Physical
- 2 S67A

See more workforce data

Te Āheinga me te Whanonga Performance and Conduct

He Raraunga Kaimahi
Workforce Data

Principal activities

The Professional Standards Team:

- receive notifications and referrals of concerns
- support the Notifications Triage Team (NTT)
- maintain assessment tools and policy on performance assessment
- establish Performance Assessment Committees (PACs) and Professional Conduct Committees (PCCs)
- establish individual education programmes and recertification programmes, following performance assessments
- monitor doctors who are subject to conditions arising from competence and conduct concerns and disciplinary action.

Notifications

Notifications are broadly categorised into whether they relate to a doctor's competence or conduct. Some cases will include a combination of competence and conduct concerns.

272 Notifcations received about doctors

142 Doctors' performance

120 Doctors' conduct

10 Mix - conduct and performance

Total notifications received by type [1] (1 July to 30 June of the year)					
Type	2019	2020	2021	2022	2023
Performance	-	130	146	103	142
Conduct	-	59	104	132	120
Mixed	-	-	-	2	10

[1] This only includes matters where the Medical Council processes were commenced. It does not include queries outside the Medical Council's jurisdiction or internally managed inquiries that did not proceed to NTT or the Medical Council.

Competence and conduct processes ordered (1 July to 30 June of the year)					
Process	2019	2020	2021	2022	2023
Performance assessment (PAC)	12	23	18	19	17
Preliminary competence inquiry (PCI) [2]	-	9	21	8	16
Professional conduct committee (PCC)	27	36	30	33	39

[2] The Medical Council only holds data for PCIs ordered from partway through the 2019-2020 FY.

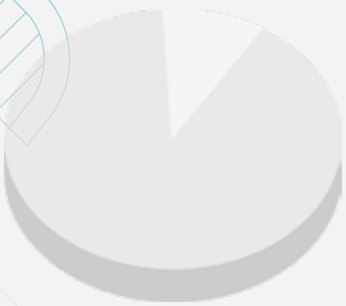
Performance

When receiving notifications or referrals that relate to a doctor's competence to practise, the Medical Council considers whether the circumstances raise questions about deficiencies in the doctor's competence.

Where questions are raised about a doctor's competence, we will investigate through either a Preliminary Competence Inquiry (PCI) or Performance Assessment Committee (PAC).

10.5%

Notifications referred to a PCI or PAC



Of the total number of notifications received in 2022/23 the Medical Council referred 16 performance related notifications to a PCI and 17 notifications to a PAC.

> There is some overlap between the role of the Medical Council and the HDC.

- The Health and Disability Commissioner (HDC) is responsible for investigating specific incidents in the first instance, but sometimes notifications are made to both organisations. In these cases, we will often await the outcome of the HDC's investigation.
- This outcome occurred for 35 performance-related notifications in 2022-2023.
- Tables 1-3 (page 53) shows the number of cases considered by the Medical Council during the year that related to a doctor's competence to practise, and our decisions as to how those cases should be addressed. The table shows the number of processes during the year rather than the number of individual doctors, as many doctors may have been the subject of more than one decision or process.

> There were 152 notifications about performance/ mixed related matters from 8 sources.

- 9 ACC
- 13 Colleague
- 3 DHB/GP
- 6 Employer
- 81 HDC
- 3 Internally / MedicalCouncil
- 36 Notifier
- 1 Health professional

56%

of the total number of notifications related to performance received.

13%

Performance related notifications referred to HDC

Of the total number of notifications received 35 were about performance were referred to the HDC.

Outcomes

> 8 educational programmes were ordered as a result of PACs.

2022/2023	
1. PAC Outcomes	
Doctors met the required standard of competence (Category 1).	4
Doctors did not meet the required standard of competence (Category 2 or 3).	8
Educational programmes were ordered in relation to the above.	8

2022/2023	
2. Performance and mixed notification outcomes	
No further action after first consideration	25
Educational letter after first consideration	32
No further action or educational letter	57
Awaiting outcome from HDC after first consideration	35
Request for PCI	12

2022/2023	
3. PCI Outcomes	
Refer to NTT	3
Refer to the Medical Council	2
No further action	5
Educational letter	1
Pending decision	1

Conduct

The Medical Council's Conduct team handles notifications that relate to the appropriateness of a doctor's conduct, or the safety of a doctor's practice.

The Medical Council refers these notifications to a Professional Conduct Committee (PCC) where further investigation is required. Among PCCs ordered in 2022/2023, were prescribing concerns, and unprofessional behaviour.

As with performance-related notifications there is some overlap between the Medical Council's role and that of the HDC.

With conduct-related notifications the Medical Council is not legally allowed to take action against a doctor under Part 4 of the Act (conduct-related action) while the Health and Disability Commissioner is conducting an investigation.

The Medical Council may take interim action where it considers the doctor poses a risk of harm to the public while an HDC, PCC or criminal investigation is undertaken. This can include imposing conditions on the doctor's practice or suspending the doctor's practising certificate.

> There were 121 notifications about conduct related matters from 15 sources.

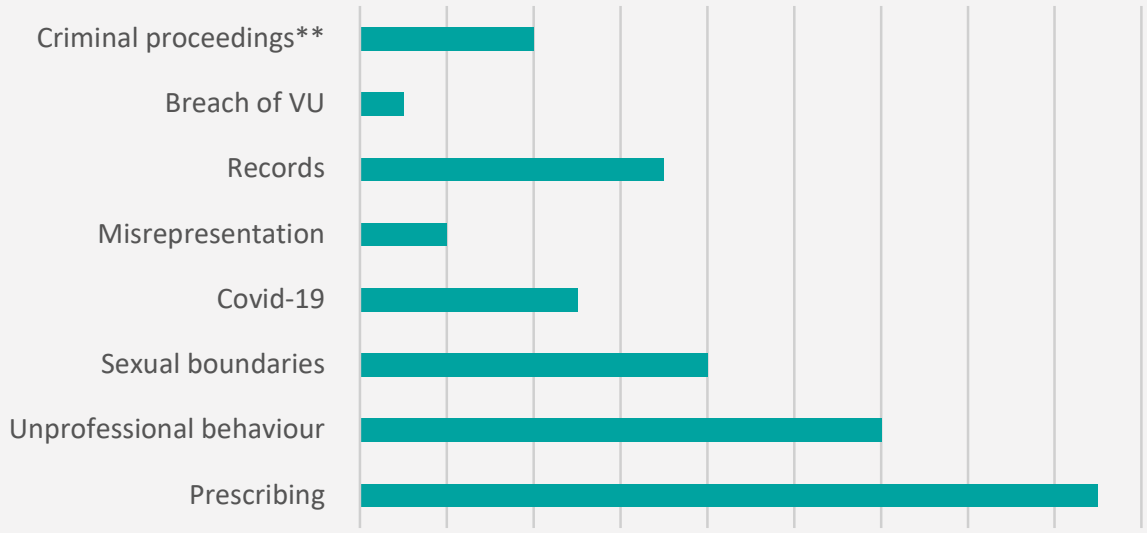
- 25 Colleague
- 4 Employer
- 1 DHB/GP
- 12 HDC
- 4 Internally / Medical Council
- 2 Legal counsel
- 3 Media/Public information
- 6 Ministry of Health
- 26 Notifier
- 2 Health agency
- 20 Health professional
- 2 PAC
- 2 PCC
- 1 Police
- 11 Self-disclosed

44%

Of the total Number of notifications received related to conduct.

Outcomes

PCC's investigations ordered by type.*



*Some investigations involve multiple types of concerns.

> Of the 39 PCCS ordered in 2022/2023, 36 were completed.

2022/2023	
PCC investigation outcomes	
Counselling	27
Competence review	4
Fitness to practise review	3
Referral to Health Practitioners Disciplinary Tribunal	5
No further steps	3

2022/2023 prosecution outcomes*	
HPDT	
HPDT hearings held	12
HPDT charges proved	10
HPDT Outcome TBC	2
Censure**	10

2022/2023 prosecution penalties'	
HPDT	
Fine	3
Conditions	10
Suspension	3
Cancellation	3

* Includes some matters currently under appeal.
** All proved matters resulted in censure.

See more workforce data at pages 76 - 97.

Te Pūrongo Pūtea ā-Tau
Annual Financials

Te Rōpū Arotake Pūtea me te Tūraru
Audit and Risk Committee

Dr Rachelle Love
MB ChB 2002 Auckland, FRACS 2017

The Audit and Risk Committee is a standing committee of the Medical Council and meets regularly throughout the year to assist the Medical Council in discharging its responsibilities relative to financial accountability and risk management. The Committee consists of four members of the Medical Council and one independent member with audit and accounting experience.

In November 2022, the Committee farewelled Roy Tiffin, who served as the independent member for over 12 years. We express our heartfelt thanks to Roy for his dedicated service and for instilling a lasting legacy of diligence and integrity. Succeeding him, Phillip Jacques was appointed in early 2023, bringing a wealth of experience that will ensure the Committee's continued excellence in overseeing our financial and risk management.

Notable mahi over the last 12 months includes:

Budget and fees

Consideration of the 2022/2023 annual budget and recommending this to the Medical Council for final approval. Balancing the Medical Council's operational and strategic needs, and financial position meant that all of the Medical Council's existing fees were able to remain unchanged with the exception of college advice fees.

Risk management

The Committee continued to monitor key risks, allowing both the Medical Council, management and staff to anticipate, proactively mitigate and manage issues. Significant contributions during the year include:

- Continuing to take an active role in seeking to be informed about health, safety and wellbeing issues.
- We continue to prioritise our privacy programme and foster a culture of privacy awareness as an organisation.
- Implementing a legislative compliance tool to support the Medical Council's compliance programme.
- Undertaking an independent review of the Medical Council's cyber risk and IT systems to ensure these are resilient and fit-for-purpose.

Annual financial statements

The Committee reviewed the annual financial statements prepared by management and liaised with the external auditors during the audit process. An unqualified audit opinion was issued by the external auditors.

I would like to acknowledge the excellent contribution of the Committee and the Medical Council staff in presenting these annual financial statements.

Statement of Comprehensive Revenue and Expenses

For the year ended 30 June 2023

	Notes	2023 (000's)	2022 (000's)
Revenue from non-exchange transactions			
Practising certificate (PC) fees and disciplinary levies		16,055	14,897
Disciplinary recoveries		413	251
Total non-exchange revenue		**16,468**	**15,148**
Revenue from exchange transactions			
Fees received		3,904	3,737
Interest income		326	67
Other income		583	726
Total exchange revenue		**4,813**	**4,530**
Total revenue		**21,281**	**19,678**
Expenses per schedules	6		
Administration expenses		12,424	10,980
Council and profession expenses		3,757	3,639
Disciplinary expenses		3,278	2,119
Examination expenses		144	101
Total expenses		**19,603**	**16,839**
Total surplus for the year		**1,678**	**2,839**
Other comprehensive revenue and expense for the year		-	-
Total comprehensive revenue and expense for the year		**1,678**	**2,839**

These financial statements should be read in conjunction with the notes to the financial statements.

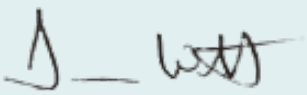
Statement of Changes in Net Assets				
For the year ended 30 June 2023				
	General Reserve (000's)	**Disciplinary Reserve (000's)**	**Examination Reserve (000's)**	**Total Equity (000's)**
Opening equity balance 1 July 2022	8,552	3,321	139	12,012
Total surplus / (deficit) for the year	857	794	27	1,678
Closing equity balance 30 June 2023	**9,409**	**4,115**	**166**	**13,690**
Opening equity balance 1 July 2021	6,730	2,154	289	9,173
Total surplus for the year	1,822	1,167	(150)	2,839
Closing equity balance 30 June 2022	**8,552**	**3,321**	**139**	**12,012**

These financial statements should be read in conjunction with the notes to the financial statements.

Statement of Financial Position
As at 30 June 2023

	Notes	2023 (000's)	2022 (000's)
Current assets			
Cash and cash equivalents		1,441	1,707
Short term investments		9,000	7,000
Prepayments		829	194
Receivables from exchange transactions	**8**	312	252
Receivables from non-exchange transactions	**8**	43	36
Total current assets		**11,625**	**9,189**
Non-current assets			
Intangible assets	**9**	3,024	3,520
Work in progress	**10**	-	40
Property, plant and equipment	**11**	1,372	1,563
Total non-current assets		**4,396**	**5,123**
Total assets		**16,021**	**14,312**
Current liabilities			
Payables	**12**	1,350	1,231
Employee entitlements	**13**	566	511
Revenue received in advance		350	500
Total current liabilities		**2,266**	**2,242**
Non-current liabilities			
Employee entitlements	**13**	65	58
Total non-current liabilities		**65**	**58**
Total liabilities		**2,331**	**2,300**
Net assets		**13,690**	**12,012**
Equity			
General reserve		9,409	8,552
Disciplinary reserve		4,115	3,321
Examination reserve		166	139
Total Equity		**13,690**	**12,012**

Authorised for issue for and on behalf of the Council on 5 December 2023.



Curtis Walker
Chair

Simon Watt
Deputy Chair

These financial statements should be read in conjunction with the notes to the financial statements.

Statement of Cash Flows
For the year ended 30 June 2023

	2023 (000's)	2022 (000's)
Cash flows from operating activities		
Receipts		
Receipts from PC fees (non-exchange)	11,378	11,009
Receipts from disciplinary levies (non-exchange)	4,677	3,888
Receipts from other non-exchange transactions	212	566
Receipts from exchange transactions	4,440	4,596
GST	-	41
Payments		
Payments to suppliers and employees	(18,412)	(15,777)
GST	(57)	-
Net cash flows from operating activities	**2,238**	**4,323**
Cash flows from investing activities		
Receipts		
Interest received	176	30
Redemption of investments	9,000	5,250
Payments		
Purchase of property, plant and equipment	(145)	(199)
Purchase of intangible assets	(535)	(540)
Investments in short term deposits	(11,000)	(9,250)
Net cash flows from investing activities	**(2,504)**	**(4,709)**
Net (decrease)/increase in cash and cash equivalents	**(266)**	**(386)**
Cash and cash equivalents at 1 July	1,707	2,093
Cash and cash equivalents at 30 June	**1,441**	**1,707**
Represented by:		
ANZ Bank Account - General	1	-
ASB Bank Account - General	440	107
ASB Bank Account - Call	1,000	1,600
	1,441	**1,707**

These financial statements should be read in conjunction with the notes to the financial statements.

Notes to the financial statements

For the year ended 30 June 2023

1. Reporting entity

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand (the Council) is a body corporate constituted under the Health Practitioners Competence Assurance Act 2003.

These financial statements and the accompanying notes summarise the financial results of the activities carried out by the Council. To protect the health and safety of the New Zealand public, the Council provides mechanisms to ensure that medical practitioners are competent and fit to practise in their professions. The Council is a charitable organisation registered under the Charities Act 2005.

These financial statements have been approved and were authorised for issue by the Council on 5 December 2023.

2. Statement of compliance

The financial statements have been prepared on the going concern basis and have been prepared in accordance with generally accepted accounting practice in New Zealand (NZ GAAP). They comply with public benefit entity international public sector accounting standards (PBE IPSAS) and other applicable financial reporting standards as appropriate that have been authorised for use by the New Zealand External Reporting Board for public sector entities. For the purposes of complying with NZ GAAP, the Council is a public sector public benefit entity and is eligible to apply Tier 2 Public Sector PBE IPSAS RDR on the basis that it does not have public accountability and is not defined as large.

The Council has elected to report in accordance with Tier 2 public sector PBE accounting standards and, in doing so, has taken advantage of all applicable reduced disclosure regime (RDR) disclosure concessions.

3. Changes in accounting policies

Adoption of PBE IPSAS 41 Financial instruments

The Council has adopted PBE IPSAS 41 *Financial Instruments* with effect from 1 April 2022. In accordance with the transitional provisions of PBE IPSAS 41, the Council has elected not to restate previous years to comply with PBE IPSAS 41. The comparative information continues to be reported under PBE IPSAS 29. No adjustments arising from the adoption of PBE IPSAS 41 are recognised in opening accumulated comprehensive revenue and expenses as the impact of adoption is considered immaterial.

Accounting policies have been updated to comply with PBE IPSAS 41. The main updates are:

- *Note 4.6 Short term Investments.* Investments in term deposits policy has been updated to explain that a loss allowance for expected credit losses is recognised only if the estimated loss allowance is material.
- *Note 4.4 Receivables from exchange transactions and non-exchange transactions.* The policy has been updated to reflect that the impairment of short-term receivables from exchange and non-exchange transactions is now determined by applying a lifetime expected credit loss model.

On the date of the initial application of PBE IPSAS 41, the classification of financial instruments under PBE IPSAS 29 and PBE IPSAS 41 are as follows:

	Measurement category	
	Previous PBE IPSAS 29 category	**New PBE IPSAS 41 category**
Cash and cash equivalents	Loans and receivables	Amortised cost
Short term investments	Loans and receivables	Amortised cost
Receivables from exchange and non-exchange transactions	Loans and receivables	Amortised cost

Carrying amounts for financial assets have not changed between the closing of 31 March 2022 and opening at 1 April 2022 as a result of the transition to PBE IPSAS 41 as the impact is immaterial.

The measurement categories and carrying amounts for financial liabilities are unchanged between the closing of 31 March 2022 and the opening of 1 April 2022 as a result of the transition to PBE IPSAS 41.

4. Summary of Accounting Policies

The significant accounting policies used in the preparation of these financial statements, as set out below, have been applied consistently to both years presented in these financial statements.

Notes to the financial statements

For the year ended 30 June 2023

4.1 Basis of measurement

These financial statements have been prepared on the basis of historical cost.

4.2 Functional, presentational currency and rounding

The financial statements are presented in New Zealand dollars ($), which is the Council's functional currency. All amounts disclosed in the financial statements have been rounded to the nearest thousand dollars unless otherwise stated.

4.3 Revenue

Revenue is recognised to the extent that it is probable that the economic benefit will flow to the Council and revenue can be reliably measured. Revenue is measured at the fair value of the consideration received. The following specific recognition criteria must be met before revenue is recognised.

Revenue from non-exchange transactions

Practicing certificate (PC) fees and disciplinary levies

PC fees are recognised in full upon the commencement of the practising year to which it relates. Revenue from the provision of other services is recognised when the service has been provided. Where provision of services is extended over a period of time the stage of completion is estimated and revenue recognised when the degree of service has been provided.

Disciplinary recoveries

Disciplinary recoveries represent fines and costs awarded to the Council by the Health Practitioners Disciplinary Tribunal (HPDT). The amount awarded represents a percentage or a portion of the Professional Conduct Committees (PCC) and HPDT costs.

Once awarded by the HPDT, disciplinary recoveries are reflected in the accounts at the time those costs were incurred and at the amount determined by the HPDT.

Revenue from exchange transactions

Fees received

Fees received include application and registration fees for general, vocational and special scopes of practice, examinations, certification and assessment related activities. All fees are recognised when invoiced except for:

- New Zealand registration examination fees which are recognised when the examination is held.
- Vocational registration income is recognised at the time of invoicing, however a portion equivalent to 3 months (2022: 3 months) is assessed and held as payments in advance.

Interest income

Interest income is recognised as it accrues, using the effective interest method.

Other income

All other income from exchange transactions is recognised when earned and is reported in the financial period to which it relates.

4.4 Financial instruments

Financial assets and liabilities are recognised in the statement of financial position when the Council becomes party to the contractual provisions of the financial instrument.

The Council ceases to recognise a financial asset or, where applicable, a part of a financial asset or part of a group of similar financial assets, when the rights to receive cash flows from the asset have expired or are waived, or the Council has transferred its rights to receive cash flows from the asset or has an assumed obligation to pay the received cash flows in full without material delay to a third party; and either:

- the Council has transferred substantially all the risks and rewards of the asset; or
- the Council has neither transferred nor retained substantially all the risks and rewards of the asset but has transferred control of the asset.

4.4 Financial instruments (continued)

Financial assets

Financial assets within the scope of PBE IPSAS 41 *Financial Instruments* are initially recognised at fair value plus transaction costs unless they are measured at fair value through surplus or deficit, in which case the transaction costs are recognised in the surplus or deficit. The Council classifies financial assets as subsequently measured at amortised cost, fair value through other comprehensive revenue and expense, or fair value through surplus or deficit based on requirements as per PBE IPSAS 41 *Financial Instruments*.

The Councils financial assets include cash and cash equivalents, short-term investments, receivables from non-exchange transactions and receivables from exchange transactions.

Receivables from exchange and non-exchange transactions

Short term receivables from exchange and non-exchange transactions are recorded at the amount due, less an allowance for credit losses. Council applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables.

In measuring expected credit losses, short-term receivables have been assessed collectively as they share credit risk characteristics. They have been grouped based on the days past due on the following basis:

Age of debt	Rate
1 month or less	0%
2 months	2%
3 months	5%
4 months	10%
5 months	20%
6 months	40%
7 months	60%
8 months	80%
9 months or more	100%

Short-term receivables from the exchange and non-exchange transactions are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery included the debtor being in liquidation.

The previous year's allowance for credit losses was based on the incurred credit loss model. An allowance loss was recognised only when there was objective evidence that the amount would not be fully collected.

Impairment of financial assets

During the year $215k was written off from the provision for doubtful debts. Additional amounts were recovered from specific debtors during the year which were previously doubtful. There were no other impairments of financial assets for the year.

Financial liabilities

The Council's financial liabilities include trade and other creditors (excluding GST and PAYE) and employee entitlements.

All financial liabilities are initially recognised at fair value (plus transaction costs for financial liabilities not at fair value through surplus and deficit) and are subsequently measured at amortised cost using the effective interest method except for financial liabilities at fair value through surplus or deficit. Such liabilities are subsequently measured at fair value.

4.5 Cash and cash equivalents

Cash and cash equivalents are short term, highly liquid investments that are readily convertible to known amounts of cash and which are subject to an insignificant risk of changes in value. Cash and cash equivalents are held for the purpose of meeting short term cash commitments rather than for investment or other purposes. Cash and cash equivalents are subject to the expected credit loss requirements of PBE IPSAS 41, no loss allowance has been recognised because the estimated credit losses is trivial.

4.6 Short term investments

Short term investments in term deposits are initially measured at the amount invested, as this reflects fair value for these market-based transactions. Interest is subsequently accrued and added to the investment balance. A loss allowance for expected credit losses is recognised if the estimated loss allowance is not trivial.

Short term investments are held with the intention of investing and comprise term deposits that have a maturity within 12 months of reporting date. Long term investments comprise term deposits that have a term of greater than 12 months.

4.7 Property, plant and equipment

Items of property, plant and equipment are measured at cost less accumulated depreciation and impairment losses. Cost includes expenditure that is directly attributable to the acquisition of the asset. Where an asset is acquired through a non-exchange transaction, its cost is measured at its fair value as at the date of acquisition.

Depreciation is charged on a straight-line basis over the useful life of the asset. Depreciation is charged at rates calculated to allocate the cost of valuation of the asset less any estimated residual value over its remaining useful life:

- Equipment, furniture and fittings 0% - 20% p.a.
- Office alterations 10% p.a.
- Computer hardware 33% p.a.

Depreciation methods, useful lives and residual values are reviewed at each reporting date and are adjusted if a change occurs in the expected pattern of consumption of the future economic benefits or service potential embodied in the asset.

4.8 Intangible assets

Intangible assets acquired separately are measured on initial recognition at cost. The cost of intangible assets acquired in a non-exchange transaction is their fair value at the date of the exchange.

Following initial recognition, intangible assets are carried at cost less any accumulated amortisation and impairment losses. Internally generated intangibles, excluding capitalised development costs, are not capitalised and the related expenditure is reflected in surplus or deficit in the period which the expenditure is incurred.

The useful lives of intangible assets are assessed as either finite or indefinite.

Intangible assets with finite life are amortised over the useful economic life and assessed for impairment whenever there is an indication that the intangible asset may be impaired.

The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each reporting period. Changes in the expected useful life or the expected pattern of consumption of future economic benefits or service potential embodied in the asset are considered to modify the amortisation period or method, as appropriate, and are treated as changes in accounting estimates.

The amortisation expense on intangible assets with finite lives is recognised in surplus or deficit as the expense category that is consistent with the function of the intangible assets.

The Council does not hold any intangible assets that have an indefinite life. The useful life and associated amortisation rates for the Council's assets are as follows:

	Useful life	*Amortisation rate*	*Remaining useful life (average)*
• Medsys (Practitioner registration database and workflows)	5 to 10 years	10% - 20% p.a.	3.1 years
• MyMCNZ (Practitioner & Council agent portal)	5 to 10 years	10% - 20% p.a.	3.4 years
• Document management system	5 years	20% p.a.	1.5 years
• Website	5 years	20% p.a.	1 month
• Purchased software	10 years	10% p.a.	3.8 years

4.9 Leases

Payments on operating lease agreements, where the lessor retains substantially the risk and rewards of ownership of an asset, are recognised as an expense on a straight-line basis over the lease term.

4.10 Work in progress

Work in progress is stated at cost and not depreciated or amortised. Depreciation or amortisation on work in progress starts when assets are ready for their intended use.

4.11 Employee entitlements

Short term employee entitlements

Employee entitlements expected to be settled within 12 months of reporting date are measured at nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to reporting date, annual leave earned but not yet taken at reporting date and long service leave entitlements expected to be settled within 12 months.

Long term employee entitlements

Employee entitlements that are due to be settled beyond 12 months after the end of the reporting period in which the employee renders the related service, such as long service leave, are calculated on an actuarial basis where practical. The calculation is based on:

- likely future entitlement accruing to employees, based on years of service, years to entitlement, the likelihood that employees will reach the point of entitlement and contractual entitlements information; and
- the present value of the estimated future cash flows.

Expected future payments are discounted, factoring inflation and the expected long term increase in remuneration for employees.

4.12 Provisions

A provision is recognised for future expenditure of uncertain amount or timing when:

- there is a present obligation (either legal or constructive) as a result of a past event;
- it is probable that an outflow of future economic benefits will be required to settle the obligation; and
- a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditures expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense.

4.13 Income tax

The Council is exempt from Income Tax. The Council was registered as a charitable entity under the Charities Act 2005 on 30 June 2008 to maintain its tax exemption status.

4.14 Goods and services tax (GST)

These financial statements have been prepared on a GST exclusive basis except for receivables and sundry creditors which include GST.

The net amount of GST recoverable from, or payable to, the Inland Revenue is included as part of receivables or payables in the Statement of Financial Position.

Cash flows are included in the Statement of Cash Flows on a net basis, and the GST component of cash flows arising from investing and financing activities, which is recoverable from, or payable to, the Inland Revenue is classified as part of operating cash flows.

4.15 Equity

Equity is the professions' interest in the Council and is measured as the difference between total assets and total liabilities. Equity is classified into the following categories which fulfil a specific purpose:

General reserve

General reserves are used to separate all funding and expenditure related to the operational activities of the Council and excludes any disciplinary and examination activities.

4.15 Equity (continued)

Disciplinary reserve

Disciplinary reserves are used to separate all funding and expenditure related to disciplinary matters known or anticipated in any one year.

Examination reserve

Examination reserves are used to separate all funding and expenditure related to the New Zealand Registration Examination (NZREX Clinical).

5. Significant accounting judgements, estimates and assumptions

The preparation of the Council's financial statements requires management to make judgements, estimates and assumptions that affect the reported amounts of revenues, expenses, assets and liabilities, and the accompanying disclosures, and the disclosure of contingent liabilities. Uncertainty about these assumptions and estimates could result in outcomes that require a material adjustment to the carrying amount of assets and liabilities affected in future periods.

Judgements

In the process of applying the Council's accounting policies, management have not made any significant judgements that would have a material impact on the financial statements.

Estimates and assumptions

The key assumptions concerning the future and other key sources of estimates uncertainty at the reporting date, that have a significant risk of causing a material adjustment to the carrying amounts of the assets and liabilities within the next financial year, are described below.

The Council based its assumptions and estimates on parameters available when the financial statements were prepared. Existing circumstances and assumptions about future developments, however, may change due to market changes or circumstances arising beyond the control of the Council. Such changes are reflected in the assumptions when they occur.

Accrued expenses

Accrued expenses represents outstanding expenses, invoices and obligations for services provided to the Council prior to the end of the financial year. The amounts are recorded at the best estimate of the expenditure required to settle the obligation. This may involve estimating the value of work completed at balance date.

Useful lives and residual values

The useful lives and residual values of assets are assessed using the following indicators to determine potential future use:

- condition of the asset
- nature of the asset, its susceptibility and adaptability to changes in technology and processes
- nature of the processes in which the asset is deployed
- availability of funding to replace the asset
- changes in the market in relation to the asset

The estimated useful lives of the asset classes held by the Council are listed in Notes 4.7 and 4.8. The Council has not made any changes to past assumptions concerning useful lives.

Recoverability of receivables

The recoverability of receivables is a significant estimate. For information on how these are assessed refer to 4.4 above.

Long service leave

The measurement of long service lease was based on a number of assumptions. An assessment of 87 eligible employees employed at 30 June 2023 was undertaken as to which employees would reach the long service criteria. 7 employees had entitlements and this is reflected as the current portion. The non-current portion reflects the assessment of the probability of employees earning long service leave in the future. Due to the number of employees affected and relatively low length of service, discount rates and salary inflation factors were not incorporated into the calculation.

Notes to the financial statements

For the year ended 30 June 2023

6. Expenses

	Administration	Council and profession	Disciplinary	Examination	Total
2023	**(000's)**	**(000's)**	**(000's)**	**(000's)**	**(000's)**
Administration	309	-	-	-	309
Amortisation	1,071	-	-	-	1,071
Communication	51	-	-	-	51
Council	-	553	-	-	553
Depreciation	336	-	-	-	336
Disciplinary and legal	-	232	1,412	-	1,644
Education committee	11	64	10	-	85
Education general	-	981	-	-	981
Health committee	-	56	-	-	56
Health general	-	214	-	-	214
HPDT disciplinary	-	-	899	-	899
Insurance	75	-	-	-	75
IT & systems	1,051	-	-	-	1,051
NZRex clinical	-	-	-	88	88
Premises	1,301	-	-	-	1,301
Professional standards	-	391	-	-	391
Registration	-	1,131	-	-	1,131
Staff general	435	-	8	-	443
Staff remuneration	7,784	-	949	56	8,789
Strategy	-	135	-	-	135
Total expenses	**12,424**	**3,757**	**3,278**	**144**	**19,603**
2022					
Administration	307	-	-	-	307
Amortisation	1,000	-	-	-	1,000
Communication	43	-	-	-	43
Council	-	447	-	-	447
Depreciation	316	-	-	-	316
Disciplinary and legal	-	493	772	-	1,265
Education committee	12	39	-	-	51
Education general	-	969	-	-	969
Health committee	-	49	-	-	49
Health general	-	217	-	-	217
HPDT disciplinary	-	-	452	-	452
Insurance	65	-	-	-	65
IT & systems	927	-	-	-	927
NZRex clinical	-	-	-	38	38
Premises	1,224	-	-	-	1,224
Professional standards	-	275	-	-	275
Registration	-	1,054	-	-	1,054
Staff general	344	-	12	-	356
Staff remuneration	6,742	-	883	63	7,688
Strategy	-	96	-	-	96
Total expenses	**10,980**	**3,639**	**2,119**	**101**	**16,839**

Notes to the financial statements

For the year ended 30 June 2023

7. Auditor's remuneration

Baker Tilly Staples Rodway Audit Limited provide audit services to the Council on behalf of the Auditor-General. The total amount recognised for audit fees is $34k (2022: $32k). No non-audit services have been provided by the auditor.

8. Receivables

	2023 (000's)	2022 (000's)
Interest receivable - exchange	191	41
Receivables from exchange transactions	136	239
Provision for doubtful debts - exchange	(15)	(28)
Receivables from exchange transactions	**312**	**252**
Receivables from non-exchange transactions	98	88
Provision for doubtful debts - non-exchange	(55)	(52)
Receivables from non-exchange transactions	**43**	**36**
Total receivables	**355**	**288**

9. Intangible assets

	Cost	Accumulated amortisation	Net book value
2023	**(000's)**	**(000's)**	**(000's)**
Medsys	8,110	(7,151)	**959**
MyMCNZ	4,472	(2,445)	**2,027**
Document management system	464	(437)	**27**
Website	278	(273)	**5**
Purchased software	30	(24)	**6**
Total	**13,354**	**(10,330)**	**3,024**
2022			
Medsys	8,110	(6,765)	**1,345**
MyMCNZ	3,896	(1,836)	**2,060**
Document management system	465	(418)	**47**
Website	278	(217)	**61**
Purchased software	30	(23)	**7**
Total	**12,779**	**(9,259)**	**3,520**

Reconciliation of the carrying amount at the beginning and end of the period:

	Opening balance	Additions	Disposals	Amortisation	Closing balance
2023	**(000's)**	**(000's)**	**(000's)**	**(000's)**	**(000's)**
Medsys	1,345	-	-	(386)	959
MyMCNZ	2,061	575	-	(609)	2,027
Document management system	46	-	-	(19)	27
Website	61	-	-	(56)	5
Purchased software	7	-	-	(1)	6
Total	**3,520**	**575**	**-**	**(1,071)**	**3,024**

Notes to the financial statements

For the year ended 30 June 2023

10. Work in progress

	2023 (000's)	2022 (000's)
Developed Software	-	40
Total work in progress	**-**	**40**

11. Property, plant and equipment

	Computer hardware	Equipment, furniture and fittings	Office alterations	Total
2023	**(000's)**	**(000's)**	**(000's)**	**(000's)**
Cost	1,366	975	2,509	4,850
Less: Accumulated depreciation and impairment	(1,198)	(783)	(1,497)	(3,478)
Net book value	**168**	**192**	**1,012**	**1,372**
2022				
Cost	1,270	926	2,509	4,705
Less: Accumulated depreciation and impairment	(1,087)	(731)	(1,324)	(3,142)
Net book value	**183**	**195**	**1,185**	**1,563**

Reconciliation of the carrying amount at the beginning and end of the period:

	Computer hardware	Equipment, furniture and fittings	Office alterations	Total
2023	**(000's)**	**(000's)**	**(000's)**	**(000's)**
Opening balance	183	195	1,185	1,563
Additions	96	49	-	145
Disposals	-	-	-	-
Depreciation	(111)	(52)	(173)	(336)
Impairment	-	-	-	-
Closing balance	**168**	**192**	**1,012**	**1,372**

12. Payables

	2023 (000's)	2022 (000's)
Creditors	30	173
Accrued expenses	1,245	925
GST payable	75	133
	1,350	**1,231**

Notes to the financial statements

For the year ended 30 June 2023

13. Employee entitlements

	2023 (000's)	2022 (000's)
Current portion		
Accrued salaries and wages	107	58
Annual leave	434	426
Long service leave	25	27
Total current portion	**566**	**511**
Non-current portion		
Long service leave	65	58
Total non-current portion	**65**	**58**
Total employee entitlements	**631**	**569**

14. Categories of financial assets and liabilities

The carrying amounts of financial instruments presented in the Statement of Financial Position relate to the following categories of assets and liabilities:

	2023 (000's)	2022 (000's)
Financial assets		
Cash and cash equivalents	1,441	1,707
Short term investments	9,000	7,000
Prepayments	829	194
Receivables from exchange transactions	312	252
Receivables from non-exchange transactions	43	36
Total financial assets	**11,625**	**9,189**
Financial liabilities		
Payables	1,275	1,098
Employee entitlements	566	511
Total financial liabilities	**1,841**	**1,609**

15. Related party transactions

Remuneration paid to the Council members

The Council has related party transactions with respect to fees paid to Council members and with respect to Council members who pay practising certificate fees and disciplinary levies to the Council as medical practitioners.

Council members receive a daily fixed rate of $1,000 per day or $125 per hour. The Chair receives an honorarium to recognise a 0.5 FTE commitment. The honorarium of $170k p.a. is shared equally with Te Whatu Ora to recognise the significant leave required from their employment for Council business. These rates were effective from 1 December 2022.

The rates were last reviewed in July 2020 when the Council member daily fixed rate was reduced to $860 per day or $107.50 per hour (from $988.80 per day or $123.60 per hour). The honorarium was also reduced to $130k p.a. (from $160k p.a.).

The July 2020 review reflected the unprecedented and challenging times, with uncertainty from COVID-19 and an ongoing focus on financial sustainability.

15. Related party transactions (continued)

The total fees earned by Council members attending Council, committee, accreditation, working party meetings and participating in other forums are disclosed below:

Fees paid to Council members

	2023 (000's)	2022 (000's)
R Aston	-	23
K Clark	44	43
S Child	32	29
T Fonua-Faeamani	33	32
K Fox	-	24
A Goodman	37	41
P Hale	44	44
C Hornabrook	38	32
S Hughes	-	7
D Ivory	20	-
R Love	36	26
G McLachlan	13	29
K Ngarimu *(Deputy Chair to Feb 2023)*	39	35
C Walker *(Chair)*	77	65
C Walker *(Te Whatu Ora)*	77	65
S Watt *(Deputy Chair from Feb 2023)*	21	-
Total fees paid to Council members	**511**	**495**

Key management personnel

The key management personnel, as defined by PBE IPSAS 20 Related Party Disclosures, are the members of the governing body comprising Council members, the Chief Executive Officer, Deputy Chief Executive, Registrar, Deputy Registrar, Chief Financial Officer, Manager - Strategy and Policy, Health Manager and Kaitiaki Mana Māori.

The remuneration paid to Council members is set out above. The aggregate remuneration of key management personnel and the number of individuals, determined on a full-time equivalent basis, receiving remuneration are detailed below.

	2023 (000's)	2022 (000's)
Total key management personnel remuneration	**1,702**	**1,427**
Number of persons	8	8
Full time equivalents basis (FTE)	7.70	6.62

16. Capital and other commitments

During the reporting period, the Council has renewed a contract with an IT vendor to support and develop our information systems. The Council is committed to incur $881k (2022: $838k) during the financial year ending 30 June 2024.

The Council has no other capital commitments at the reporting date (2022: None).

Non cancellable operating lease commitments

As at the reporting date, the Council has entered into the following non-cancellable operating leases:

	2023 (000's)	2022 (000's)
Not later than 1 year	1,305	1,207
Later than 1 year no later than 5 years	4,964	4,806
Later than 5 years	-	993
Total minimum lease payments	**6,269**	**7,006**

The non cancellable operating lease relates to the lease of Level 24 and 25, AON Centre, 1 Willis Street, Wellington, and Fuji Xerox printing equipment. The building lease expires in April 2028, with one right of renewal and an escalation clause allowing for annual rent increases of 2.25% and market rent reviews in 2025 and 2028 (if the lease is renewed).

17. Contingent assets and liabilities

There are no contingent assets or liabilities at the reporting date (2022: None).

18. Events after the reporting period

There are no significant events after the reporting period to be disclosed.

Baker Tilly Staples Rodway Audit Limited
Level 6, 95 Customhouse Quay, Wellington 6011
PO Box 1208, Wellington 6140
New Zealand

T: +64 4 472 7919
F: +64 4 473 4720
E: wellington@bakertillysr.nz
W: www.bakertillysr.nz

INDEPENDENT AUDITOR'S REPORT TO THE READERS OF THE MEDICAL COUNCIL OF NEW ZEALAND'S FINANCIAL STATEMENTS AND SERVICE PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2023

The Auditor-General is the auditor of the Medical Council of New Zealand ('the Medical Council'). The Auditor-General has appointed me, Chrissie Murray, using the staff and resources of Baker Tilly Staples Rodway Audit Limited, to carry out the audit of the financial statements and the service performance information of the Medical Council on his behalf.

Opinion

We have audited the financial statements and the service performance information of the Medical Council. The financial statements comprise the statement of financial position as at 30 June 2023, the statement of comprehensive revenue and expenses, the statement of changes in net assets and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information. The service performance information is contained in the statement of service performance.

In our opinion,

- the financial statements of the Medical Council,
    - present fairly, in all material respects:
        - its financial position as at 30 June 2023; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Standards – Reduced Disclosure Regime; and
- the statement of service performance,
    - presents fairly, in all material respects, the Medical Council's performance for the year ended 30 June 2023 in accordance with the service performance criteria of the Council; and
    - complies with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Standards Reduced Disclosure Regime.

Our audit was completed on 12 December 2023. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Council and our responsibilities relating to the financial statements and the statement of service performance, and we explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the Auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of the Council members for the financial statements and service performance information
The Council members are responsible for preparing financial statements and the statement of service performance that are fairly presented and that comply with generally accepted accounting practice in New Zealand.

The Council members are responsible for such internal control as they determine is necessary to enable the preparation of financial statements and the statement of service performance that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and statement of service performance, the Council members are responsible for assessing the Medical Council's ability to continue as a going concern. The Council members are also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Medical Council or to cease operations, or there is no realistic alternative but to do so.

The Council members' responsibilities arise from the Health Practitioners Competence Assurance Act 2003.

Responsibilities of the auditor for the audit of the financial statements and service performance information
Our objectives are to obtain reasonable assurance about whether the financial statements and the statement of service performance, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements and the statement of service performance.

We did not evaluate the security and controls over the electronic publication of the financial statements and the statement of service performance.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the statement of service performance, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Council's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Council

- We evaluate the appropriateness of the reported performance information within the Council's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Council and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Medical Council's ability

to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the statement of service performance or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Medical Council to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the statement of service performance, including the disclosures, and whether the financial statements and the statement of service performance represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Council regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibility arises from the Public Audit Act 2001.

Independence
We are independent of the Medical Council in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1(Revised): *Code of Ethics for Assurance Practitioners* issued by the New Zealand Auditing and Assurance Standards Board.

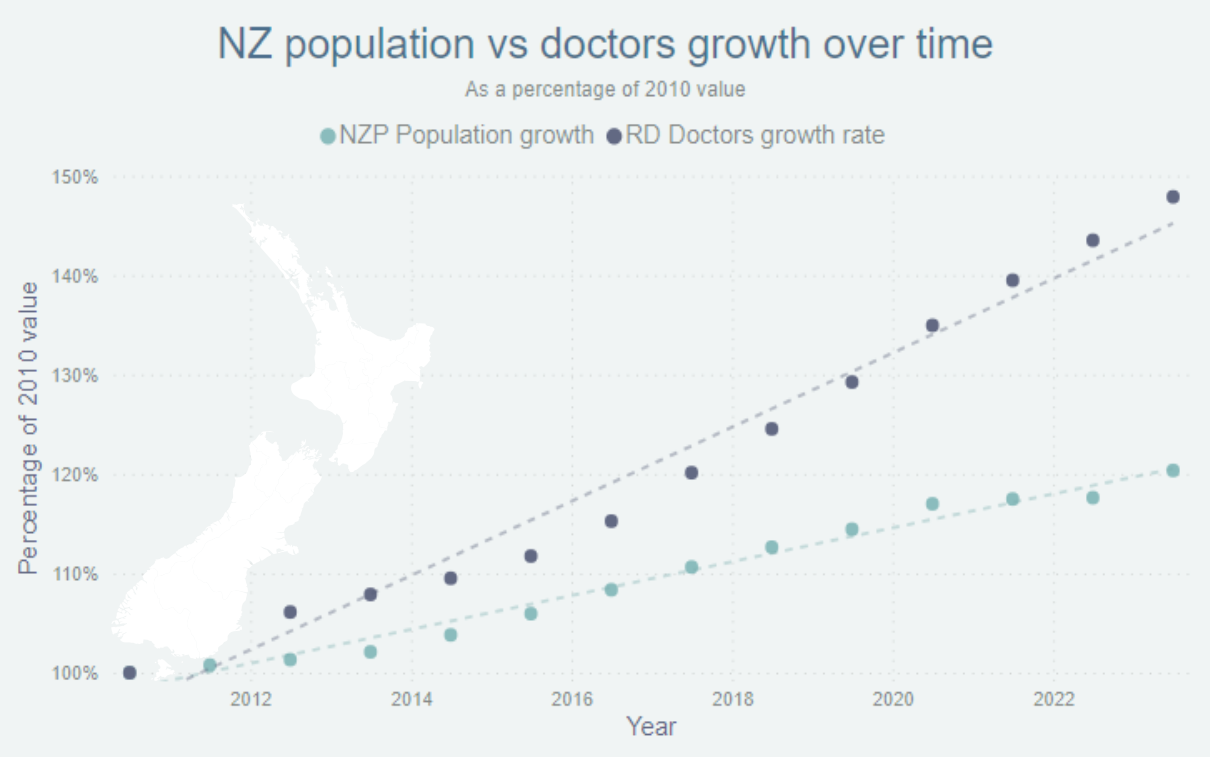
Other than the audit, we have no relationship with, or interests in, the Medical Council.

Chrissie Murray
Baker Tilly Staples Rodway Audit Limited

On behalf of the Auditor-General
Wellington, New Zealand


MUSIC

He Raraunga Kaimahi
Workforce Data

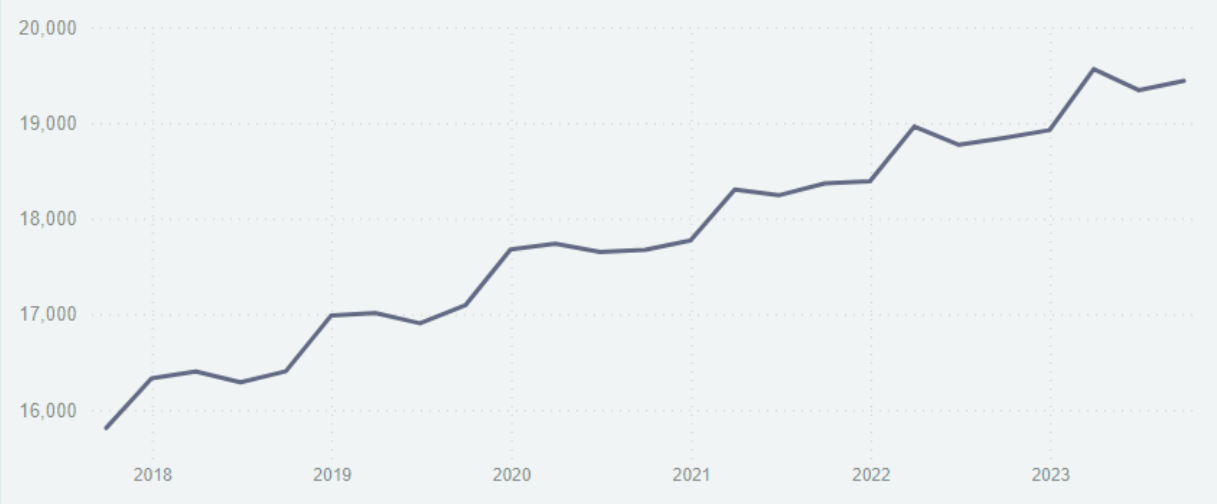


The number of registered doctors is increasing faster than the number of people in the population.

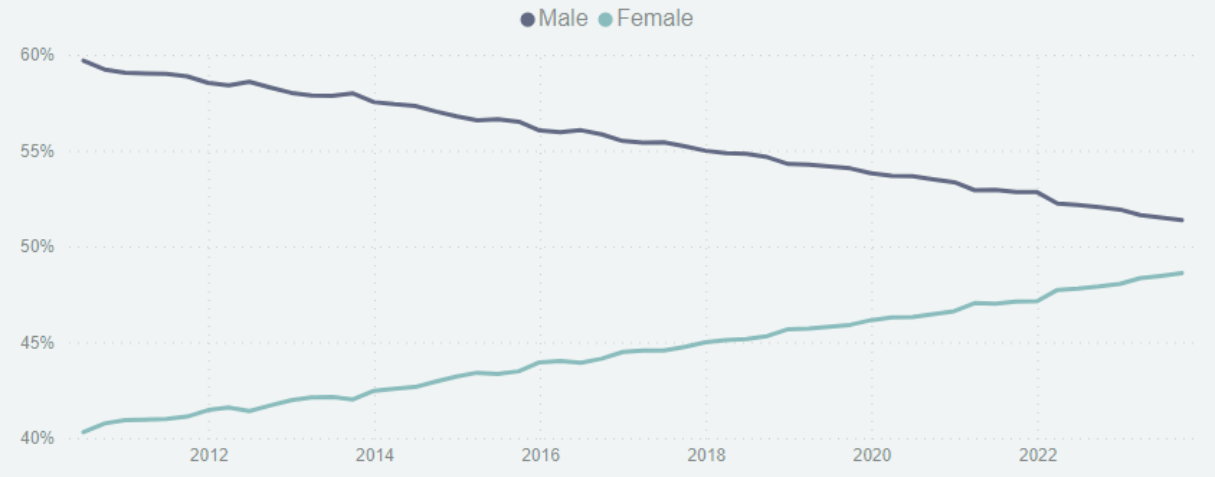
19,443 **Registered doctors**

Total female	Total male	Total gender diverse
9,450	9,987	< 10

Registered doctors - trends over time



Doctors on the medical register with a current practising certificate



Doctors on the medical register

Data dashboard

See more workforce data

The Medical Council's user-friendly data dashboard is designed to assist health sector stakeholders and researchers, the media, and the public with valuable information. Users can explore key data and trends over time about registered doctors.

https://www.mcnz.org.nz/about-us/our-data

He Raraunga Kaimahi
Workforce Data

Table 1: Scopes of practice – summary of registration status (1 July to 30 June of the year)					
	2019	2020	2021	2022	2023
Provisional general – NZ graduates	547	558	582	667	648
Provisional general – IMGs	494	443	445	526	621
General	5,680	6,081	6,205	6,310	6,449
Provisional vocational	133	129	191	199	199
Vocational	9,948	10,332	10,713	11,000	11,323
Special purpose	104	108	110	70	104
Total on register					
Total practising	16,906	17,651	18,246	18,772	19,344
Suspended	11				

Note: Doctors holding more than one scope of practice concurrently have been counted once for this table. To achieve this, doctors are allocated to the first scope they hold in this order of priority:

1. Suspended
2. Vocational
3. General
4. Provisional vocational
5. Provisional general
6. Special purpose

Table 2: Registration activities (1 July to 30 June of the year)					
	2019	2020	2021	2022	2023
Provisional general/vocational registrations					
New Zealand graduates (interns)	507	521	527	566	547
Australian graduates (interns)	4	1	2	3	1
Passed NZREX Clinical (interns)	26	30	18	38	61
Australian general registrants	2	8	4	8	3
Graduate of competent authority accredited medical school	527	493	325	402	500
Worked in comparable health system	186	150	160	182	177
New Zealand and international medical graduates re-registration (following cancellation)	-	-	-	-	-
Non-approved postgraduate qualification – vocational assessment	81	77	118	125	130
Non-approved postgraduate qualification – vocational eligible	74	95	108	92	57
Special purpose scope registrations					
Visiting expert	21	10	-	2	11
Research	3	1	5	2	1
Postgraduate training or experience	43	45	19	15	34
Locum tenens in specialist post	111	109	92	63	100
Emergency or other unpredictable short-term situation	-	5	-	-	-
Pandemic	-	8	15	23	-
Teleradiology	-	-	2	5	14
General scope registrations, after completion of supervised period					
Australian General Registrant	-	1	2	2	5
New Zealand/Australian graduates (interns)	483	506	502	478	566
Passed NZREX Clinical	33	33	20	26	29
Graduate of competent authority accredited medical school	442	398	250	244	311
Worked in comparable health system	94	75	82	62	85

	2019	2020	2021	2022	2023
Vocational scope registrations, after completion of supervised period					
Non-approved postgraduate qualification – vocational assessment	50	40	45	66	67
Non-approved postgraduate qualification – vocational eligible	74	86	74	92	77
General scope registrations					
New Zealand graduates	5	3	2	6	6
Overseas graduates	85	85	72	83	81
Restorations	22	12	19	8	3
Vocational scope registrations					
Approved postgraduate qualification (VOC1)	421	481	491	465	567
Approved postgraduate qualification (VOC2)	-	-	2	1	1
Suspensions of registration					
Suspension or interim suspension	2	7	4	7	7
Revocation of suspension	1	3	2	7	4
Numbers of doctors who had conditions imposed on scope of practice[1]					
Imposed	82	91	114	124	122
Revoked	59	52	100	79	4
Cancellations under the HPCAA					
Death–section 143	43	36	43	43	41
Discipline order–section 101 (1)(a)	2	3	1	3	2
False, misleading or not entitled–section 146	-	1	-	-	-
Revision of register–section 144(5)	147	256	527	2	-
At own request–section 142	188	120	80	148	132

Table 3: Doctors registered in vocational scopes of practice (1 July 2022 to 30 June 2023)					
Vocational scope					
Anaesthesia	1,201	63	4	59	1,260
Cardiothoracic surgery	53	2	-	2	55
Clinical genetics	22	-	-	-	22
Dermatology	93	7	1	6	99
Diagnostic & interventional radiology	972	63	5	58	1,029
Emergency medicine	533	40	-	40	573
Family planning & reproductive health	43	-	1	-1	42
General practice	4,873	196	41	155	5,028
General surgery	444	26	4	22	466
Intensive care medicine	140	8	1	7	147
Internal medicine	1,714	129	9	120	1,834
Medical administration	48	2	-	2	50
Musculoskeletal medicine	30	2	1	1	31
Neurosurgery	33	-	-	-	33
Obstetrics & gynaecology	491	22	4	18	509
Occupational medicine	78	1	-	1	79
Ophthalmology	211	13	1	12	223
Oral & maxillofacial surgery	38	6	-	6	44
Orthopaedic surgery	400	9	-	9	409
Otolaryngology head & neck surgery	159	8	1	7	166
Paediatric surgery	33	3	1	2	35
Paediatrics	566	44	2	42	608

[1] Includes doctors who may currently be inactive (have no practising certificate).

[2] Includes 634 doctors with registration in two vocational scopes and 17 doctors with registration in three vocational scopes.

Vocational scope					
Pain medicine	40	-	-	-	40
Palliative medicine	104	4	-	4	108
Pathology	457	22	3	19	476
Plastic & reconstructive surgery	99	8	1	7	106
Psychiatry	962	43	5	38	1,000
Public health medicine	236	9	1	8	244
Radiation oncology	102	2	-	2	104
Rehabilitation medicine	34	2	-	2	36
Rural hospital medicine	152	8	1	7	159
Sexual health medicine	27	-	-	-	27
Sport and exercise medicine	41	6	-	6	47
Urgent care	326	15	1	14	340
Urology	97	4	1	3	100
Vascular surgery	48	2	-	2	50
Total	14,900	769	89	680	15,579

[1] Includes doctors who may currently be inactive (have no practising certificate).

[2] Includes 634 doctors with registration in two vocational scopes and 17 doctors with registration in three vocational scopes.

Table 4: Doctors registered in vocational scopes of practice (1 July to 30 June of the year)					
Vocational scope	2019	2020	2021	2022	2023
Anaesthesia	1,057	1,110	1,154	1201	1260
Cardiothoracic surgery	45	48	51	53	55
Clinical genetics	20	20	20	22	22
Dermatology	85	87	91	93	99
Diagnostic & Interventional Radiology	694	772	853	972	1029
Emergency Medicine	419	453	503	533	573
Family Planning & Reproductive Health	38	40	43	43	42
General Practice	4482	4,621	4742	4873	5028
General Surgery	408	417	426	444	466
Intensive Care Medicine	120	128	134	140	147
Internal Medicine	1,466	1,549	1,632	1714	1834
Medical Administration	44	46	47	48	50
Musculoskeletal Medicine	25	27	26	30	31
Neurosurgery	31	31	30	33	33
Obstetrics & Gynaecology	426	447	467	491	509
Occupational Medicine	75	76	77	78	79
Ophthalmology	195	205	203	211	223
Oral & Maxillofacial Surgery	30	33	34	38	44
Orthopaedic Surgery	365	375	385	400	409
Otolaryngology Head & Neck Surgery	146	148	151	159	166
Paediatric Surgery	31	31	33	33	35
Paediatrics	497	521	543	566	608
Pain Medicine	32	35	39	40	40

Vocational scope	2019	2020	2021	2022	2023
Palliative Medicine	95	97	101	104	108
Pathology	412	425	433	457	476
Plastic & Reconstructive Surgery	90	90	93	99	106
Psychiatry	867	910	917	962	1000
Public Health Medicine	223	230	231	236	244
Radiation Oncology	88	93	96	102	104
Rehabilitation Medicine	32	32	33	34	36
Rural Hospital Medicine	128	135	141	152	159
Sexual Health Medicine	25	25	26	27	27
Sport and Exercise Medicine	33	36	39	41	47
Urgent Care	256	277	301	326	340
Urology	87	89	94	97	100
Vascular Surgery	45	46	46	48	50
Total	13,112	13,705	14,235	14,900	15,579

Table 5: Registration granted, by country of primary qualification (1 July 2022 to 30 June 2023)				
	Provisional general	Provisional vocational	Special purpose	Total
New Zealand	548	-	-	548
England	336	20	10	366
United States of America	46	61	67	174
Scotland	88	4	2	94
Ireland	48	3	2	53
South Africa	3	27	16	46
India	18	8	9	35
Netherlands	23	5	-	28
Wales	22	1	2	25
Pakistan	17	3	2	22
Germany	9	9	2	20
Canada	8	3	8	19
Sweden	9	4	1	14
Belgium	11	2	-	13
Israel	5	5	1	11
Singapore	9	2	-	11
Fiji	4	-	6	10
Sri Lanka	5	-	5	10
Other	80	30	27	137
Total	1289	187	160	1636

[1] Other represents 44 countries that had fewer than ten registrations in the reporting period.

Table 6: Registration granted, by country of primary qualification (1 July to 30 June of the year)					
	New registrations by year				
	2019	2020	2021	2022	2023
New Zealand	512	530	537	583	548
England	375	359	258	294	366
United States of America	161	145	171	137	174
Scotland	119	87	61	94	94
Ireland	95	79	48	46	53
South Africa	31	51	65	47	46
India	36	36	45	35	35
Netherlands	29	30	19	31	28
Wales	17	22	15	32	25
Pakistan	7	18	9	7	22
Germany	19	12	7	17	20
Canada	30	26	20	24	19
Sweden	6	1	6	3	14
Belgium	7	9	11	12	13
Singapore	6	5	5	4	11
Israel	4	4	9	6	11
Sri Lanka	2	7	6	6	10
Fiji	8	7	5	6	10
Other	123	121	92	141	137
Total	1,587	1,549	1,389	1,525	1,636

Table 7: Vocational registration granted, by vocational scope of practice (1 July 2022 to 30 June 2023)			
Vocational scope	New Zealand	Overseas	Total
Anaesthesia	26	37	63
Cardiothoracic Surgery	-	2	2
Dermatology	3	4	7
Diagnostic & Interventional Radiology	9	54	63
Emergency Medicine	7	33	40
General Practice	123	73	196
General Surgery	13	13	26
Intensive Care Medicine	3	5	8
Internal Medicine	73	56	129
Medical Administration	1	1	2
Musculoskeletal Medicine	2	-	2
Obstetrics & Gynaecology	12	10	22
Occupational Medicine	-	1	1
Ophthalmology	5	8	13
Oral & Maxillofacial Surgery	1	5	6
Orthopaedic Surgery	3	6	9
Otolaryngology Head & Neck Surgery	4	4	8
Paediatric Surgery	3	-	3
Paediatrics	26	18	44
Palliative Medicine	1	3	4
Pathology	11	11	22
Plastic & Reconstructive Surgery	4	4	8
Psychiatry	14	29	43

Vocational scope	New Zealand	Overseas	Total
Public Health Medicine	6	3	9
Radiation Oncology	1	1	2
Rehabilitation Medicine	-	2	2
Rural Hospital Medicine	6	2	8
Sport and Exercise Medicine	4	2	6
Urgent Care	8	7	15
Urology	3	1	4
Vascular Surgery	2	-	2
Total	374	395	769

Table 8: Outcomes of applications for vocational registration assessments (1 July 2022 to 30 June 2023)							
Branch	Incomplete applications	Pending	Withdrawn /lapsed	Supervision path	Assessment	NZREX*	Other
Anaesthesia	13	3	11	9	10	1	6
Cardiothoracic Surgery	4	-	1	-	2	-	-
Clinical Genetics	-	-	-	-	1	-	-
Dermatology	2	-	2	-	2	-	-
Diagnostic & Interventional Radiology	25	1	9	8	4	-	8
Emergency Medicine	13	-	5	12	3	-	5
General Practice	9	-	9	2	6	-	10
General Surgery	11	-	4	3	4	1	2
Intensive Care Medicine	3	-	1	-	-	2	1
Internal Medicine	33	-	24	6	21	2	2
Medical Administration	1	-	-	-	-	-	-
Neurosurgery	5	-	2	-	-	-	1
Obstetrics & Gynaecology	13	-	3	-	10	1	1
Occupational Medicine	-	-	1	-	-	-	-
Ophthalmology	9	1	6	1	1	1	1
Oral & Maxillofacial Surgery	1	-	-	-	-	-	-
Orthopaedic Surgery	12	-	4	-	1	2	-
Otolaryngology Head & Neck Surgery	6	-	-	1	2	-	2
Paediatric	1	-	-	-	-	-	-
Paediatrics	6	-	7	1	7	2	-

Branch	Incomplete applications	Pending	Withdrawn /lapsed	Supervision path	Assessment	NZREX*	Other
Pain Medicine	3	-	-	-	-	-	1
Palliative Medicine	-	-	-	1	1	-	-
Pathology	19	1	3	1	1	-	-
Plastic & Reconstructive Surgery	5	-	1	-	-	2	-
Psychiatry	20	1	9	3	14	-	7
Public Health Medicine	2	-	3	-	1	-	-
Radiation Oncology	2	-	1	-	-	-	1
Rural Hospital Medicine	-	-	1	-	-	-	-
Sexual Health Medicine	-	-	-	-	1	-	-
Sport and Exercise Medicine	1	-	-	-	-	1	-
Urology	4	-	-	-	-	1	-
Vascular Surgery	3	1	-	-	-	-	-
Total	226	8	107	48	92	16	49
Percentages based on total number of outcomes (%)				30.8	59.0	10.3	

* Doctors who are assessed as not meeting the required standard for registration within a vocational scope must apply for registration via the NZREX pathway.

Table 9: Practising doctors on the NZ medical register, by country of primary qualification (1 July 2022 to 30 June 2023)						
Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total
New Zealand	4163	648	-	6332	-	11143
England	718	233	16	1458	8	2433
Australia	346	1	1	459	1	808
South Africa	70	5	31	658	18	782
Scotland	177	62	1	385		625
India	115	21	9	389	10	544
USA	73	41	59	280	30	483
Ireland	189	28	3	101	1	322
Germany	43	13	10	138	1	205
Netherlands	35	30	6	74	-	145
Wales	63	15	-	64	2	144
Sri Lanka	23	6	1	88	4	122
Pakistan	45	20	2	46	1	114
Iraq	21	4	-	82	-	107
Canada	9	9	3	58	7	86
China	32	6	1	46	1	86
Fiji	9	7	-	49	8	73
Northern Ireland	20	8	-	32	-	60
Russia	29	5	1	22	-	57
Philippines	21	6	1	28	-	56
Egypt	11	1	1	37	1	51
Bangladesh	9	4	-	31	-	44
Singapore	14	9	2	17	-	42
Poland	7	2	2	28	1	40

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total
Belgium	11	9	3	16	-	39
Israel	10	6	4	18	1	39
Spain	10	7	-	17	-	34
Zimbabwe	1	-	1	30	-	32
France	10	8	3	9	-	30
Romania	7	1	3	16	-	27
Malaysia	13	-	-	12	2	27
Hungary	6	2	4	14	-	26
Italy	4	3	1	17	-	25
Sweden	3	7	4	8	1	23
Czech Republic	7	3	-	12	1	23
Serbia	2	2	-	18	-	22
Brazil	3	2	5	10	-	20
Nigeria	8	2	1	8	-	19
Ukraine	6	4	-	9	-	19
Iran	8	3	-	6	-	17
Myanmar	7	1	-	9	-	17
Austria	7	-	-	8	-	15
Switzerland	2	3	1	7	1	14
Hong Kong	1	-	5	8	-	14
Bulgaria	3	-	1	9	-	13
Argentina	3	2	1	7	-	13
Sudan	4	-	-	8	-	12
Libya	4		1	7		12
Other[1]	67	20	11	138	4	240
Total	6,449	1,269	199	11,323	104	19,344

[1] Other represents 71 countries with fewer than 12 registered doctors.

Table 10: Doctors on the New Zealand medical register, by country of primary qualification (1 July to 30 June of the year - Doctors with a current practising certificate)					
	June 2019	June 2020	June 2021	June 2022	June 2023
New Zealand	9,732	10,182	10,568	10,865	11,143
England	2,189	2,289	2,289	2,324	2,433
Australia	574	650	707	800	808
South Africa	738	746	767	776	782
Scotland	617	620	623	631	625
India	509	519	536	533	544
United States of America	385	410	461	470	483
Ireland	288	320	316	308	322
Germany	191	193	187	189	205
Netherlands	114	121	129	132	145
Wales	115	121	131	141	144
Sri Lanka	115	117	120	120	122
Pakistan	78	89	92	97	114
Iraq	109	105	106	107	107
Canada	85	79	84	79	86
China	75	78	78	83	86
Fiji	64	65	63	64	73
Northern Ireland	54	57	59	61	60
Russia	53	54	53	55	57
Philippines	44	45	46	53	56
Egypt	43	49	49	53	51
Bangladesh	44	44	43	44	44
Singapore	30	31	33	35	42
Poland	**38**	**36**	**37**	**39**	**40**
Belgium	**28**	**29**	**34**	**36**	**39**

	June 2019	June 2020	June 2021	June 2022	June 2023
Israel	16	17	25	29	39
Spain	28	30	30	33	34
Zimbabwe	37	34	33	34	32
France	20	19	20	23	30
Romania	19	23	25	26	27
Malaysia	22	23	25	26	27
Hungary	20	20	22	21	26
Italy	23	24	23	27	25
Sweden	20	14	19	18	23
Czech Republic	19	18	22	24	23
Serbia	23	20	18	19	22
Brazil	10	12	15	16	20
Nigeria	13	14	16	17	19
Ukraine	16	17	17	17	19
Iran	11	10	11	15	17
Myanmar	16	14	15	17	17
Austria	13	14	13	16	15
Switzerland	13	11	10	9	14
Hong Kong	3	8	9	12	14
Bulgaria	14	15	14	12	13
Argentina	9	10	11	13	13
Sudan	16	14	14	14	12
Libya	7	8	11	12	12
Other[1]	206	214	217	227	240
Total	16,906	17,652	18,246	18,772	19,344

[1] Other represents countries with less than 15 registered doctors in 2022/2023.

Table 11: Candidates sitting and passing NZREX Clinical (1 July 2022 to 30 June 2023)										
		Attempt					Attempt			
Country	# sitting	1	2	3	4	# passed	1	2	3	4
Argentina	1	1	-	-	-	1	1	-	-	-
Bangladesh	4	2	1	1	-	2	1	1	-	-
Belarus	1	-	1	-	-	1	-	1	-	-
China	10	7	3	-	-	7	5	2	-	-
Ethiopia	2	1	-	1	-	-	-	-	-	-
Fiji	4	4	-	-	-	4	4	-	-	-
India	11	9	2	-	-	5	4	1	-	-
Iran	3	3	-	-	-	3	3	-	-	-
Iraq	2	-	-	1	1	2	-	-	1	1
Kyrgyzstan	2	-	1	1	-	-	-	-	-	-
Mexico	1	1	-	-	-	1	1	-	-	-
Pakistan	5	1	4	-	-	4	-	4	-	-
Philippines	2	2	-	-	-	2	2	-	-	-
South Africa	2	2	-	-	-	2	2	-	-	-
Sri Lanka	4	4	-	-	-	2	2	-	-	-
Ukraine	1	1	-	-	-	-	-	-	-	-
United Arab Emirates	1	-	1	-	-	1	-	1	-	-
Total	56	38	13	4	1	37	25	10	1	1

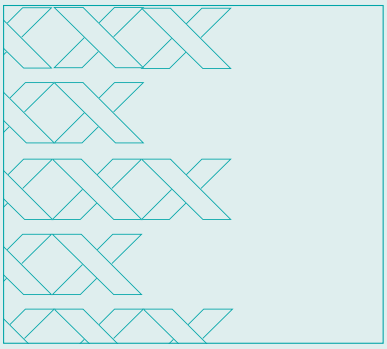
Table 12 : Referral sources for performance and mixed-related notifications	
(1 July 2022 to 30 June 2023)	
ACC	9
Colleague[1]	13
College	0
Employer (DHB/GP)	3
Employer	6
HDC	81
Internally referred within the Medical Council (Health)	3
Notifier[2]	36
Other health agency	0
Other health professional	1
Total	152

[1] Includes colleagues and peers

[2] Includes notifiers who were members of the public

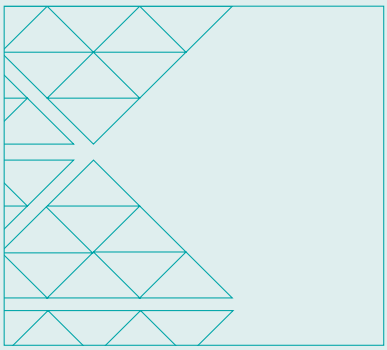
Table 13 : Performance and mixed-related Medical Council processes [1]	
(1 July 2022 to 30 June 2023)	
No further action after first consideration	25
Educational letter after first consideration	32
No further action or educational letter	57
Awaiting outcome from HDC after first consideration	35
Preliminary Competence Inquiry (PCI) requested	12
Total	104

He Kupu Whakamārama
Words of Explanation



Purapura Whetū / Stars in the Night Sky

The stars in the sky are based on Purapura Whetū, a tukutuku pattern that represents the stars and the great numbers of people of a nation. We have used this to represent the people of Aotearoa New Zealand, and also the people within Te Kaunihera Rata o Aotearoa. Five of the stars represent our organisation's values; Whakapono, Whakamārama, Kotahitanga, Manaakitanga, and Kaitiakitanga.

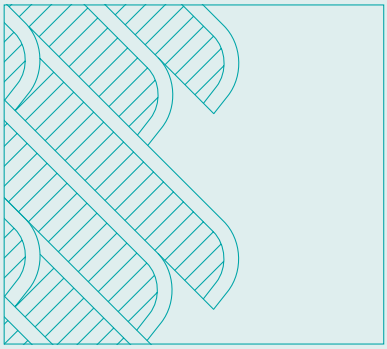


Niho Taniwha / Teeth of the Taniwha

The sawtooth tāniko and tukutuku pattern of Niho Taniwha is used to depict the hills around Whanganui-a-Tara, and represents whānau and hapū, chiefly lineage, the communities in which we live, and the organisations we rely on. Niho Taniwha also speaks to community empowerment and self-determination.

Tangaroa / God of the Seas

Beneath the hills lies Tangaroa, the source and foundation of all life, both bountiful and dangerous. This motif depicts the waters that the people of Aotearoa New Zealand must navigate; here it represents our own health and our health system - wai ora, the waters of life.



Kiri Taniwha / Skin of the Taniwha

This motif depicts the skin of the taniwha, and represents the qualities of Te Āraihaumaru – strength, guardianship, protection, and safe navigation.

Te Āraihaumaru / The Guardian Protector

The taniwha represents Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand as the kaitiaki, the guardian and protector of the people. The taniwha swims beside the reflection of Purapura Whetū in the sea of Tangaroa, guiding the people safely through. The stars themselves are also used in navigation, so both the people and the taniwha work alongside each other.

The name we have given the taniwha, Te Āraihaumaru, translates as The Defender of Safety.


Te Kaunihera Rata
o Aotearoa
Medical Council
of New Zealand