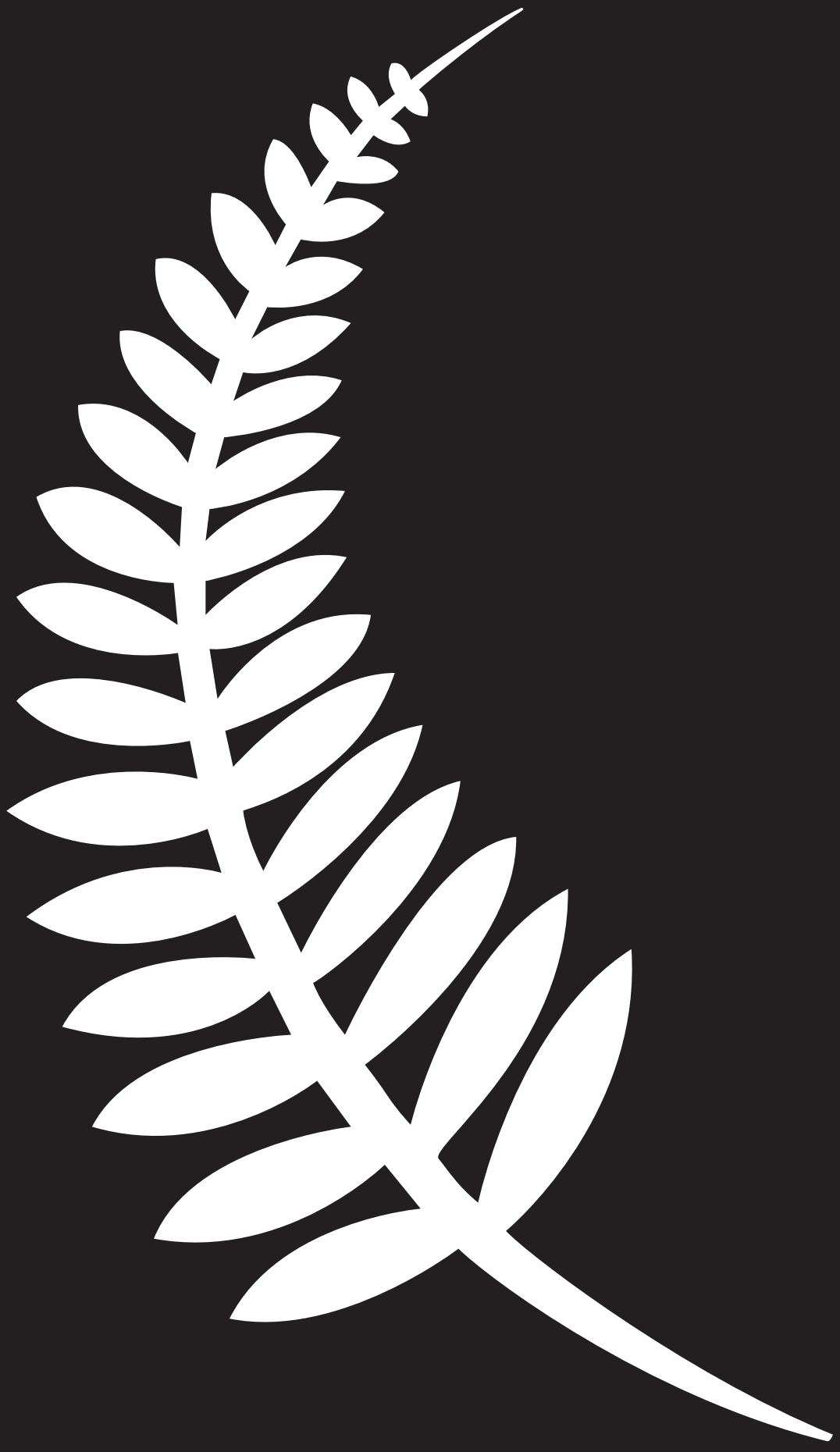

MEDICAL COUNCIL OF NEW ZEALAND

ANNUAL REPORT

2017

Medical Council of New Zealand
Te Kaunihera Rata o Aotearoa

Protecting the public, promoting good medical practice

Te tiaki i te iwi whānui me te whakatairanga pai i te mahi e pā ana ki te taha rongoā

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The Medical Council of New Zealand is pleased to submit this report for the year ended 30 June 2017 to the Minister of Health. The report is presented in accordance with section 134 of the Health Practitioners Competence Assurance Act 2003 and includes a report on activities of the Health Practitioners Disciplinary Tribunal for doctors only.

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FACTS AT A GLANCE

1 July 2016 to 30 June 2017

DOCTORS NEWLY REGISTERED

– TRAINED IN NEW ZEALAND 480

– INTERNATIONAL MEDICAL GRADUATES 1,049

TOTAL PRACTISING DOCTORS AT 30 JUNE 2017 15,744

DOCTORS NEWLY REGISTERED WITH VOCATIONAL SCOPES 619

CANDIDATES WHO SAT NZREX CLINICAL 111

CANDIDATES WHO PASSED NZREX CLINICAL 60

REFERRALS TO A PROFESSIONAL CONDUCT COMMITTEE 21

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CHAIRPERSON'S REPORT

Our strategic goals

GOAL ONE – Optimise mechanisms to ensure doctors are competent and fit to practise.

GOAL TWO – Improve Council's relationship and partnership with the public, the profession and stakeholders to further Council's primary purpose – to protect the health and safety of the public.

GOAL THREE – Promote good regulation of the medical profession by providing standards of clinical competence, cultural competence and ethical conduct and ensuring that the standards reflect the expectations of the public, the profession and stakeholders.

GOAL FOUR – Improve medical regulatory and workforce outcomes in New Zealand by the registration of doctors who are competent and fit to practise and their successful integration into the health service.

GOAL FIVE – Promote good medical education and learning environments throughout the undergraduate/ postgraduate continuum to help ensure all doctors have achieved the necessary standards for their practice.

The past 12 months have been challenging for Council and staff alike, both logistically and operationally.

The Kaikoura earthquake in November 2016 had a significant impact on Council's business operations and led to Council staff moving offices at short notice, following a building engineer's report that indicated significant structural damage to the building Council had occupied.

Despite the difficulties of the past year, Council remains committed to providing the highest standards of medical regulation and being fair and effective in our role of protecting public health and safety. To achieve this, we have continued to progress our strategic priorities through several key initiatives.

Strengthening recertification for vocationally registered doctors

One of Council's key strategic directions is promoting competence, which focuses on ensuring all doctors maintain competence, have up-to-date knowledge and are fit to practise.

Council's 5-year strategic plan, *Towards 2022* states:

> The principles of 'right touch' risk-based regulation will be used to continue Council's focus on changing behaviour through the use of education and non-regulatory levers. We will shift the focus more strongly towards using proactive strategies to improve standards of practice, supporting doctors to provide quality care to patients in an effort to reduce the need for reactive regulatory measures.

Recertification, revalidation and other similarly named systems are in place in a number of international jurisdictions, and the way that this works in each jurisdiction differs. However, the commonality across all is the overarching goal to provide assurance of the competence of doctors, support the maintenance of high standards of practice and strengthen accountability to the public.

Following an initial consultation with the sector, Council set the *Vision and principles for recertification,* published in February 2016.

Feedback from this initial consultation indicated a need for Council to provide further guidance about how medical colleges should develop their recertification programmes to align with the vision and principles. As a result, Council reviewed the requirements for vocational registrants and proposed to set new standards for strengthening recertification programmes in consultation with the sector.

Many of the 149 submissions received in the consultation on strengthening recertification for vocationally registered doctors supported the general direction and core concepts of Council's proposal, but some individual doctors and medical colleges had concerns and sought more information about how it could be implemented. The feedback also suggested a number of submitters could benefit from further engagement with Council about the implementation of the proposed changes. A working group has been established to further develop the next steps in this process

Cultural competence, partnership and health equity

Work continues towards improving the cultural competence of doctors practising in New Zealand and the cultural safety and health equity of patients.

The causes of health inequity and the links with poor health outcomes are well evidenced, but many can be improved or avoided through a coordinated approach from training bodies and health providers and policy makers.

While the causes of health inequity are complex, there are some aspects where the regulator or medical profession has significant control or influence, and therefore we have an ethical responsibility to act.

Council, in partnership with Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association (Te ORA), is driving this work forward and held a successful and very well attended national Cultural Competence, Partnership and Health Equity symposium in June 2017.

Attendees from across the sector considered the challenges and opportunities for improvement, with key discussion centring around:

- strengthening cultural competence, including understanding the role and responsibility in the causes of, and possible solutions to, health inequity
- improving cultural safety for patients
- improving the support and cultural safety for those members of the profession who identify as Māori
- increasing understanding of cultural influences on health.

While in its early stages, work on this initiative will continue throughout the years to come, and Council is committed to continued engagement and partnership with others to make progress.

Prevocational medical education

There has been continued development of the prevocational medical training programme over the past year, with a particular focus on increasing the number of community-based clinical attachments for interns.

An independent review of the implementation of the prevocational medical training programme was undertaken by a group chaired by Dr Kenneth Clark. The review group reported that the changes are contributing to an increased level of interaction between clinical supervisors and interns with better quality feedback, a change in culture and attitudes to prevocational medical training and an overall greater level of transparency for all involved in intern education and training.

It is pleasing to see that medical students in their final year of medical school have access to ePort to allow them to record the attainment of New Zealand Curriculum Framework learning outcomes and the setting and completion of goals in the professional development plan.

Community-based clinical attachments (CBAs) for prevocational medical training

I am pleased to report that progress is being made in developing more community-based clinical attachments to increase the learning opportunities for interns in their first two postgraduate years.

I would like to thank Dr Clark, who also chairs the Workforce Strategy Group, for his time, leadership and expertise in supporting and advocating the concept of CBAs. Similarly, Health Workforce New Zealand and the Resident Doctors' Association have been strong partners in this work.

The progress so far has been excellent, with 149 interns (over 30 percent of interns nationally) expected to complete a CBA over their 2-year internship in 2017. Every District Health Board has interns placed in community attachments for 2017, with 76 in general practice, 54 in other community settings, such as hospice, older persons' health and mental health, and 9 in urgent care.

There are a total of 64 accredited CBAs, potentially allowing up to 256 intern community placements nationally this year. It is pleasing to see there continues to be growth in integrated care and urgent care attachments.

In April 2017, Council held a community-based attachment (CBA) symposium, which was well attended by people from a range of District Health Boards, the community and primary care sector and union members.

The aim of the symposium was to outline where CBAs fit into the prevocational medical training programme and share ideas about the opportunities for CBAs from District Health Board, intern and community care perspectives. Discussions included the different kinds of community placements that could be established, how obstacles had been overcome, individual experiences and suggestions for the future.

The aim now is to build on the success so far and work towards a target of 50 percent of interns completing a CBA by the end of 2018. Council will be encouraging District Health Boards to strive for this target.

Council member changes

The term for Dr Allen Fraser, our longest-serving Council member, expired on 30 April 2017. Dr Fraser is sorely missed on Council for the wisdom, pragmatism and empathy he brought to Council meetings and as Chairperson of Council's Health Committee.

Dr Paul Hutchison was appointed by the Minister of Health on 25 May 2017 for a 3-year term to take the seat vacated by Dr Fraser.

Dr Kate Baddock resigned on 22 May 2017 following her election as Chair of the New Zealand Medical Association. Dr Baddock brought to Council a passion and advocacy for general practice.

Following Dr Baddock's resignation, Council held a recount as required by the Health Practitioners Competence Assurance Act 2003 (Election of Members of Medical Council of New Zealand) Regulations 2009. The recount was for candidates from the 2015 Council election who wished to serve on Council until 30 June 2018 (which is the time remaining for each current elected member to Council).

In February 2017, Ms Laura Mueller, layperson, and I were again re-elected Deputy Chairperson and Chairperson of Council respectively – positions we have both held since February 2014.

The coming 12–18 months will see the terms of a significant number of Council members expire, and this will pose a number of challenges in terms of the loss of institutional knowledge around Council policies and processes.

I would like to thank all existing and former Council members for the contribution they have made to the work of Council during the year and to thank those doctors and laypeople who perform a wide array of tasks to aid the work of Council and our various committees.

Andrew Connolly
Chairperson
Medical Council of New Zealand

AUDIT COMMITTEE REPORT

The Audit Committee is a standing committee of Council.

Terms of reference

The terms of reference for the Audit Committee as approved by Council are to:

- oversee the risk management programme
- review the risk profile (including legal compliance, financial, statutory reporting and fraud risks)
- monitor the internal control systems and assessment
- oversee the annual external audit by the Office of the Auditor-General
- oversee any internal audit
- ensure the integrity of external financial reporting
- ensure appropriate financial management policies and practices are in place
- ensure that Council and management are provided with financial information that is relevant and of high quality
- conduct special investigations as required by Council.

Risk management programme

The Audit Committee this year continued to monitor key risks to Council.

The risk impact assessment Council uses has been useful in managing issues such as business disruption and recertification allowing both Council and staff to anticipate and proactively manage issues.

Business continuity and recovery plan

The Audit Committee has taken an active interest in Council's business continuity and recovery plan.

Council has had a business continuity and recovery plan for a number of years, which has been changed and amended as events demand.

The plan is regarded by the Audit Committee as a dynamic document that details delegations, key staff and stakeholder contacts details and templates for each area of the office in order to recover in the event of a major event.

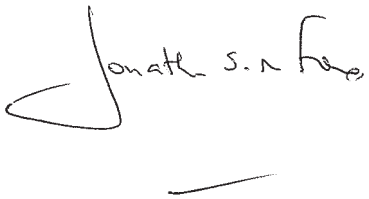
Health and safety

Again, this year the Audit Committee has had a major focus on health and safety and the wellbeing of all Council staff.

The Kaikoura earthquake in November 2016 caused structural damage to Council's office building at 80 The Terrace. Once this was discovered in February 2017, an immediate decision was made to vacate the building.

The Audit Committee has also spent considerable time providing governance oversight to Council's move from 80 The Terrace following the Kaikoura earthquake. The focus has been on providing a safe working environment for all staff and visitors, as well as looking at the accommodation options while remediation work was undertaken.

I would like to acknowledge the work and contributions of the Audit Committee and staff members alike.



Dr Jonathan Fox
Chairperson
Audit Committee
Medical Council of New Zealand

EDUCATION COMMITTEE REPORT

The Education Committee is a standing committee of Council.

Accreditation of prevocational medical training providers

Under the Health Practitioners Competence Assurance Act 2003, the Medical Council of New Zealand (Council) is required to accredit and monitor educational institutions that deliver medical training for doctors and to promote medical education and training in New Zealand. The purpose of accreditation of prevocational training providers is to ensure that minimum standards have been met for the provision of education and training for postgraduate year 1 and 2 interns.

The following training providers have been assessed by a Council Accreditation Team over the past 12 months as part of their requirement to meet Council's accreditation standards for training providers:

- Hutt Valley DHB (site visit conducted in August 2016).
- Wairarapa DHB (site visit conducted in August 2016).
- Capital and Coast DHB (site visit conducted in November 2016).
- Tairawhiti DHB (site visit conducted in April 2017).
- Bay of Plenty DHB (site visit conducted in May 2017).
- Northland DHB (site visit conducted in June 2017).

Review of the committee's terms of reference

The Education Committee considered a discussion paper on its terms of reference and agreed that the appointment processes and composition of the committee should continue to be modelled on the agency model of governance, in line with Council and its other standing committees.

The Education Committee recommended to Council that its composition be amended to include a trainee enrolled and actively participating in a vocational training programme accredited by Council. Council resolved to accept this recommendation, and a trainee was appointed to the Education Committee in April 2017.

Review of the composition of teams who assess prevocational training providers against Council's accreditation standards

The Education Committee resolved to recommend to Council that the composition of accreditation teams who assess prevocational training providers be amended to include a postgraduate year 1–4 resident medical officer. Council resolved to accept the recommendation, and this amendment will come into effect in Council's next accreditation cycle beginning in 2018.

Review of the composition of teams who assess New Zealand-only vocational training providers against Council's accreditation standards

The Education Committee resolved to recommend to Council that the composition of accreditation teams who assess New Zealand-only vocational training providers be amended to include a trainee enrolled and actively participating in a vocational training programme accredited by Council. Council resolved to accept the recommendation, and this amendment came into immediate effect.

Review of accreditation systems within the National Registration and Accreditation Scheme (NRAS) for health professions in Australia

Council responded to the review, highlighting the relationship Council has with the Australian Health Practitioner Regulation Agency (AHPRA), Medical Board of Australia (MBA) and Australian Medical Council (AMC) and how any changes to the NRAS will have implications for the registration and accreditation processes of Council.

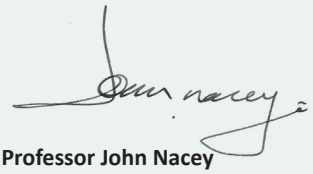
Council also noted that the key purpose of accreditation is to ensure that training providers produce graduates who provide safe and good-quality care to the public and that any changes to the accreditation processes or standards should not compromise the quality of accreditation processes.

Health Workforce New Zealand (HWNZ) consultation paper on funding for postgraduate training

In its submission, Council stated its overarching purpose and explained how its obligations under the Health Practitioners Competence Assurance Act relate to postgraduate medical training.

Council's feedback also emphasised that any change to the funding scheme is likely to have implications for colleges being able to apply for and maintain accreditation as a training provider. In addition, it was noted that the consultation document did not make reference to accreditation processes and standards and how contestable funding cycles and accreditation cycles would be linked.

I would like to thank all members of the Education Committee and staff for their contributions during the year.



Professor John Nacey
Chairperson
Education Committee
Medical Council of New Zealand

MEMBERS OF THE MEDICAL COUNCIL

During the period 1 July 2016 to 30 June 2017

DR KATE BADDOCK

MB ChB 1981 Otago, Dip Obst 1983 Auckland, MRCGP 1986, M 1994 F 1998 RNZCGP

Dr Kate Baddock qualified with an MBChB from Otago in 1981, and after completing a Diploma in Obstetrics and Gynaecology, she travelled overseas for a number of years. While in the United Kingdom, she completed her postgraduate training in general practice and obtained Membership of the Royal College of General Practitioners. After her return to New Zealand in 1988, she joined a rural practice in Warkworth and has been working there full-time for the past 29 years. In 1998, she obtained her Fellowship of the Royal New Zealand College of General Practitioners.

Dr Baddock is part of a teaching practice that has grown steadily over the last decade and now has 13 doctors including registrars and postgraduate doctors as well as medical and nursing students. She has also been involved at a regional level in health organisations and has served on the board of Waitemata Primary Health Organisation for the past decade. Prior to that, she was the chair of one of the first independent practitioner associations in New Zealand for 12 years.

In terms of national roles, Dr Baddock has been the Chair of the General Practitioner Council of the New Zealand Medical Association for the past 7 years and is currently Deputy Chair of the New Zealand Medical Association. She also sits on the Executive Board of General Practice New Zealand, is a member of the General Practice Leaders Forum and also a member of the Ministerial Medicines Classification Committee.

In her spare time, Dr Baddock is a Swimming New Zealand referee. She also enjoys landscaping, reading and travelling.

Dr Baddock is a member of the Audit Committee.

MR ANDREW CONNOLLY

BHB 1984, MB ChB 1987 Auckland, FRACS 1994

Appointed to Council in November 2009, Mr Connolly was elected Deputy Chairperson of Council in February 2012 and Chairperson in February 2014. Mr Connolly was re-elected as Chairperson again in February 2017.

Mr Connolly is a general and colorectal surgeon, employed full-time at Counties Manukau District Health Board.

He has a strong interest in governance, education and clinical leadership and has been the Head of Department of General and Vascular Surgery since 2003. He served on the Ministerial advisory group that was responsible for the In Good Hands document. In 2016, he was part of the Ministry of Health Capability and Capacity Review of the Health Sector.

Mr Connolly has served on various national committees, including the New Zealand Guidelines Group for the screening of patients with an increased risk of colorectal cancer.

He has previously held the role of Presiding Member of the Lotteries Health Research Distribution Committee, he chaired a Ministerial review of the impact of the elective waiting times policy and he was a member of the review panel of the New Zealand Cancer Registry. Mr Connolly currently also serves on the Southern Partnership Group for the redevelopment of Dunedin Hospital.

Outside of medicine, he has a passion for military history, particularly the First World War.

As Council Chairperson, Mr Connolly is an ex officio member of Council's Audit, Education and Health Committees.

DR T LU'ISA FONUA-FAEAMANI

MB ChB 1998 Otago, FRNZCGP 2007

Appointed to Council in July 2015, Dr Lu'isa Fonua-Faeamani is a GP and clinical director for The Fono – Health and Social Services based in West Auckland. The Fono provides affordable healthcare services including medical, dental, pharmacy, health awareness and community support services and delivers a combination of these services across four Auckland locations.

Dr Fonua-Faeamani has worked with Pacific health providers in Central and West Auckland as a GP providing care for this high-needs population.

Dr Fonua-Faeamani graduated from Otago Medical School in 1998. She returned to Tonga for 3 years to work at Vaiola Hospital and was posted to the outer island of 'Eua as the only doctor for 8 months before returning to New Zealand for advanced training.

Dr Fonua-Faeamani is particularly interested in Pacific health and the development of Pacific GPs and the Pacific primary health workforce.

Dr Fonua-Faeamani is a member of Council's Health Committee.

DR JONATHAN FOX

MB BS 1974 Lond, MRCS Eng LRCP Lond 1974, MRCGP 1981, FRNZCGP 1998 (Dist), FRACGP 2010 (Hon) C MinstD

Dr Fox was elected to Council by the profession and appointed to Council in June 2009. He has been re-elected twice since.

Dr Fox is a GP based in Auckland. He is a past President of the Royal New Zealand College of General Practitioners (RNZCGP) and past Chair of the Council of Medical Colleges in New Zealand. He is a board member of ProCare Health Limited – the Auckland GP network. He is also a member of various charitable and research trusts in the Auckland region.

Dr Fox was awarded a Distinguished Fellowship of the Royal New Zealand College of General Practitioners in 2010. He has also been awarded an Honorary Fellowship by the Royal Australian College of General Practitioners.

His previous positions included membership of the board and GP Council of the New Zealand Medical Association and the Competence Advisory Team of the Medical Council, Medical Officer to Kings College Auckland and many RNZCGP Auckland Faculty positions.

Dr Fox qualified from Guys Hospital Medical School, London, in 1974. He then spent 7 years working as a medical officer in the Royal Navy before completing his vocational training in the United Kingdom. After leaving the Navy, he spent 8 years as a GP in Rugby, UK, where he was also medical officer to Rugby School.

He came to New Zealand in 1990 with his GP wife and their children. Over the last 26 years, their practice has grown and is now a seven-doctor practice in Meadowbank, Auckland.

Dr Fox is Chairperson of Council's Audit Committee and Deputy Chairperson of the Education Committee.

MEMBERS OF THE MEDICAL COUNCIL

During the period 1 July 2016 to 30 June 2017

DR ALLEN FRASER

MB ChB 1969 Otago, DPM 1973 Otago, MRCPsych 1976, M 1978 F 1980 RANZCP

Dr Fraser was appointed to Council in August 2008.

Dr Fraser went to medical school in Dunedin in the 1960s and subsequently trained as a psychiatrist in Auckland and at St Thomas' Hospital in London. He was appointed as a consultant psychiatrist in South Auckland in 1977, where he led the development of community-based mental health services, at the same time continuing what has been a career-long commitment to the acute care of the seriously mentally ill.

He has been involved in many local, national and international professional organisations, including the Royal Australian and New Zealand College of Psychiatrists (RANZCP) since 1980. Dr Fraser was chair of RANZCP's New Zealand Committee for 4 and a half years. He has been a union leader (President of the Association of Salaried Medical Specialists for 4 years and is now a life member) and a chief medical officer.

Dr Fraser has ceased private consulting practice and presently works as a locum consultant psychiatrist in adult psychiatry for Waitemata District Health Board and occasionally elsewhere. He remains available for occasional assessments.

Dr Fraser was Chairperson of Council's Health Committee.

DR PAMELA HALE

MB ChB Otago 1982, FRACP 1991

Dr Hale was appointed to Council in July 2015.

She graduated from Otago University in 1982 and completed medical training in Christchurch, Tauranga, Hamilton and Dunedin and in the UK, becoming a Fellow of the Royal Australasian College of Physicians in 1991.

Dr Hale has been a specialist general physician/endocrinologist in Nelson since 1992 developing the diabetes and endocrinology service. She is Head of the Department of Medicine and a Clinical Senior Lecturer for the University of Otago with respect to the Nelson trainee interns. Previously, she was the intern supervisor for many years.

Dr Hale has always been interested in professionalism and has led annual tutorials on this with the junior doctors.

Her interests include acute general medicine and the holistic management of type 1 diabetes and, outside of work, her family.

She is Chairperson of Council's Health Committee.

MS SUSAN HUGHES QC

BA, LLB, GDip Bus Studs, MMgt

Appointed in May 2013 as a Council lay member, Ms Hughes was a partner in the New Plymouth law firm of Govett Quilliam for 18 years, leaving in 2006 to commence practice at the independent Bar. She was appointed Queen's Counsel in 2007 and continues her practice in New Plymouth – a broad-based litigation practice spanning diverse jurisdictions of the Courts.

Ms Hughes has held a number of government appointments over the years. Most recently, she was a Director of the Civil Aviation Authority and the Aviation Security Service from 2004 to 2011.

Ms Hughes has now practised law for more than 30 years, which has honed her interest in matters of process and the effective resolution of disputes.

Ms Hughes is a member of Council's Audit Committee.

DR PAUL HUTCHISON

MB ChB 1970 Otago, MRCOG 1978, FRANZCOG 1983, Dip Com Health

Dr Paul Hutchison graduated from the University of Otago in 1970 and was appointed to Council in May 2017.

He spent time doing postgraduate work at Case Western Reserve University in the United States, National Women's Hospital in Auckland and Addenbrooke's Hospital in Cambridge, England, and was a clinical lecturer for the University of London at St Thomas' Hospital in Central London.

He also undertook medical and general practice work in Papua New Guinea, Western Samoa and the United Arab Emirates.

Dr Hutchison qualified as a specialist in obstetrics and gynaecology and became a consultant at National Women's Hospital and North Shore Hospital during the 1980s and 1990s.

He has held executive positions in the New Zealand Obstetric Society, New Zealand Medical Association and Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Dr Hutchison became Member of Parliament for Port Waikato, then Hunua from 1999 to 2014. He chaired Parliament's Health Select Committee from 2008 to 2014. During that time, he initiated an inquiry into improving child health outcomes and preventing child abuse.

In 2014, Dr Hutchison received the New Zealand Medical Association Chair's Award for making an outstanding contribution to health in New Zealand.

Dr Hutchison currently works in a high-needs South Auckland general practice. He holds a number of directorships and is a trustee of Entrust, the majority shareholder of Vector.

MEMBERS OF THE MEDICAL COUNCIL

During the period 1 July 2016 to 30 June 2017

MS LAURA MUELLER

BA Psych (Calif) 1992, Juris Doctor (Calif) 1996

Appointed to Council in October 2009, Ms Mueller is a lay member of Council and has been Council's Deputy Chairperson since February 2015.

Ms Mueller was appointed as a judicial officer for the Ministry of Justice in 1999 and sits as a referee in the Disputes Tribunal at the Tauranga District Court. Ms Mueller has 20 years of business experience, including management of a large accounting and tax practice and experience as a medical insurance underwriter.

With a keen interest in governance and leadership, Ms Mueller has served on the Disputes Tribunal's National Education Committee for more than years. She has served as Treasurer on the Disputes Tribunal's Referees Association Executive and is a mentor for new referees.

Ms Mueller is a member of Council's Complaints Triage Team and the Audit, Education and Health Committees and is also Council's liaison member on the Health and Disability Commissioner's Consumer Advisory Group.

PROFESSOR JOHN NACEY

MB ChB 1977 Otago, FRACS 1985, MD 1987 (Otago), MBA

Professor Nacey was appointed to Council in March 2010.

Professor Nacey graduated from the University of Otago in 1977. After completing specialist training in urology, which included an appointment as Chief Resident in Surgery at the Flinders University Medical Centre, Adelaide, Australia, he returned to New Zealand to take up a joint hospital/university position in Wellington. In 1998, he was appointed Dean and Head of Campus at the University of Otago's Wellington School of Medicine, a position he held for 10 years.

With an interest in prostate disease, Professor Nacey has published extensively on this subject. He acts as referee for several major international journals and chaired the recent Government Prostate Cancer Taskforce. As past examiner for the Royal Australasian College of Surgeons, he has maintained his interest in teaching undergraduate medical students and postgraduate surgical trainees.

Professor Nacey currently holds the position of Professor of Urology at the Wellington School of Medicine.

He has widespread community involvement including the position of President of the Wellington Medical Research Foundation and Chairman of the Board of Management. He remains a strong advocate for promoting men's health.

Professor Nacey is Chairperson of Council's Education Committee.

KIM NGĀRIMU

BBS

Ms Ngārimu is a director of Tāua Limited, a consulting company specialising in the provision of public policy and management advice, and is a member of a number of government-appointed statutory boards.

She held the position of Deputy Secretary Policy with Te Puni Kōkiri from March 2007 until December 2013. Ms Ngārimu has also held positions as Acting Chief Executive of the Ministry of Women's Affairs and Acting Director for the Waitangi Tribunal.

Following the completion of her university studies, Ms Ngārimu worked for Te Rūnanga o Ngāti Porou, gaining a solid grounding in Māori community dynamics and aspirations. Following this, she first joined Te Puni Kōkiri in 1992, and she worked in various senior management, policy management and regional roles until 1999. She left Te Puni Kōkiri in 1999 to take up a sector manager role at the Office of the Controller and Auditor-General.

In the 7 years before rejoining Te Puni Kōkiri, Ms Ngārimu continued to build her experience in policy, strategic management, business and governance through co-directorship of her management and public policy consulting company.

Ms Ngārimu's tribal affiliation is Te Aitanga ā Mate, Ngāti Porou.

MS JOY QUIGLEY JP

QSO (2008)

Ms Quigley was appointed to Council as a lay member in 2011.

Ms Quigley served as a National Member of Parliament from 1990 to 1999, chairing the Māori Affairs, Foreign Affairs and Defence, and Social Services Select Committees during that time. After retiring from Parliament, she became the Executive Director of Independent Schools of New Zealand until 2008 and is currently a director, with her husband, of a consultancy business based in Ohope.

Ms Quigley graduated from the School of Physical Education, University of Otago in 1967 and subsequently from Christchurch Teachers College. She has been involved with a wide range of local, regional and national voluntary organisations during her adult life. In 2008, she became a Member of the Queen's Service Order recognising her public and community service.

During 2009 and 2010, Ms Quigley was a member of the government-appointed panel considering New Zealanders' access to high-cost, highly specialised drugs.

Ms Quigley is a member of Council's Audit and Education Committees and an alternative layperson member on Council's Health Committee.

MEMBERS OF THE MEDICAL COUNCIL

During the period 1 July 2016 to 30 June 2017

DR CURTIS WALKER

MB ChB 2007 Auckland, FRACP 2015

Dr Walker was elected to Council in 2015.

Ko Whakatōhea rāua ko Ngāti Porou ngā iwi.

Formerly a veterinarian, Dr Walker retrained in human medicine and qualified from Auckland in 2007. He started work as a house officer at Waikato Hospital and commenced internal medicine training there before moving to Palmerston North and Wellington to complete his Fellowships in Nephrology and General Medicine (Fellow of the Royal Australasian College of Physicians) in 2015 and 2016 respectively.

During his time as a resident doctor, he was President of the New Zealand Resident Doctors Association (NZRDA) for 5 years. Dr Curtis also serves on the board of the Māori Medical Practitioners Association (Te ORA). These roles reflect the strong commitment that Dr Walker has to improving health outcomes for Māori and to supporting doctors during the long and challenging years spent in specialist training.

Dr Walker works as a renal and general physician at MidCentral DHB and loves living in Palmerston North with his wife and two young children.

Dr Walker is a member of Council's Education Committee.

CHIEF EXECUTIVE'S REPORT

COUNCIL STATEMENTS

Council has reviewed and updated the following statements:

- *Providing care to yourself and those close to you*
- *Advertising*
- *Doctors and performance enhancing medicines in sport*
- *Good prescribing practice*
- *Telehealth.*

These statements have been revised after extensive consultation with stakeholders and after consideration of international evidence and regulatory trends. The position taken by Council in each area is broadly in line with the views expressed by the overwhelming majority of submitters.

Primary-source verification

In August 2016, Council made it a requirement that applicants for registration who hold overseas qualifications must have their qualifications primary-source verified.

This means the institution that awarded the overseas medical qualification (for example a medical school or college) has to confirm to Council that they did award the submitted qualification to the doctor who is applying for registration.

Council agreed to require the primary-source verification (PSV) of:

- final medical degrees/diplomas (or alternative degree documents)
- postgraduate medical qualifications (if applicable)
- certificates of medical registration to practise medicine (if applicable).

Council also agreed to have the ECFMG (Educational Commission for Foreign Medical Graduates) provide this service, using their EPIC (Electronic Portfolio of International Credentials) service.

Primary-source verification will be required of the following:

- All doctors relying on international medical qualifications in their registration applications. This includes doctors with primary medical degrees from Australian medical schools and with postgraduate qualifications from Australia-only vocational training providers.
- First-time applicants only, unless a doctor who is already registered in New Zealand applies for a new scope of practice that relies on a qualification that Council has not previously assessed (for example, a international postgraduate qualification).
- Applicants for registration in a provisional general, general, provisional vocational, vocational or special purpose scope of practice. The only exception to this is for those doctors applying for a Special Purpose: Emergency or a Special Purpose: Pandemic/Disaster scope of practice.

New policies are currently being drafted, as are the electronic resources to incorporate primary-source verification into our registration processes. It is anticipated primary-source verification will be implemented in the second half of 2017.

Use of social media

To date, social media has not been used to communicate with the profession because of concerns around resourcing and the staff time needed for monitoring and responding.

In mid-April 2017, an electronic survey was randomly sent to 1,500 doctors inviting them to provide feedback to Council. A total of 260 doctors responded, with 255 completing the survey.

These respondents were also asked whether they wanted Council to continue using email to send information and updates to them in addition to the use of social media. An overwhelming 91 percent indicated that they preferred Council to continue communicating with them by email.

Lastly, these respondents were asked whether they would like to receive a text message alert when there is an important piece of news or update from Council. Of those who responded, 40 percent answered yes and 60 percent said no.

IBM Kenexa Employee Engagement survey

Council was a finalist in the small to medium (organisation) category of the IBM Kenexa Employee Engagement survey. This was the first time Council had been shortlisted. Although we did not win in this category, having been shortlisted was an encouragement in itself that staff are engaged and that Council is an employer of choice.

Consumer Advisory Group (CAG)

The purpose of the Consumer Advisory Group is to gather feedback from a consumer's perspective on Council's strategic and policy development.

Topics discussed during the year by the Consumer Advisory Group included:

- raising concerns about a doctor through the Medical Council's website
- Council statements, for example Advertising, Doctors and performance enhancing medicines in sport and Complementary and alternative medicine.
- *Choosing Wisely,* which aims to help create a culture where patients and health professionals can have valuable, informed conversations about managing a patient's care effectively
- the Vision for the University of Auckland Medical Programme 2030.

Council office relocation

I would like to acknowledge and thank all staff for their resilience following the Kaikoura earthquake in November 2016. The weeks that followed the earthquake were challenging and testing for everyone. That Council's core functions under the Act could be fulfilled after the third move in 3 years is a testimony of every staff member's commitment to the business and the investment of time and resources into the business continuity and recovery plan.

The moves have been both costly and disruptive to Council's day-to-day business but have been necessary as Council will not compromise the safety of Council staff.

Thanks

I would also like to thank Mr Andrew Connolly and all Council members for their support and understanding following what has been a stressful year for many staff. Their support and concern for the wellbeing and safety of all Council employees has to a large extent been key in achieving Council's goals and strategic directions.

Again, to everyone, my thanks.

Philip Pigou
Chief Executive

REGISTRATION OF DOCTORS AND PRACTISING CERTIFICATES

Principal activities: maintaining the medical register, considering applications for registration, issuing practising certificates and certificates of professional status (good standing) and developing registration policy.

All doctors who practise medicine in New Zealand must be registered by Council and hold a practising certificate. Registration ensures that a doctor is fit to practise medicine and that the doctor has met the required standards of competence to practise safely. Registered doctors must comply with Council's recertification requirements each year to maintain their registration (including continuing professional development).

Confirmation of eligibility for doctors seeking registration in general and special purpose scopes of practice is provided within 20 working days of receiving a completed application. Eligibility for registration within a vocational scope of practice is provided after consultation with the relevant vocational education and advisory body and takes, on average, 4–6 months.

TABLE 1:

Scopes of practice – summary of registration status

At 30 June 2017

Provisional general	3,598
General	8,562
Provisional vocational	265
Vocational	11,549
Special purpose	218
Total on register	**24,192**
Total practising	15,744
Suspended	13

Note: Doctors holding more than one scope of practice concurrently have been counted once for this table.

TABLE 2:

Registrations issued

1 July 2016 to 30 June 2017

	Number
Provisional general/vocational issued	
New Zealand graduates (interns)	474
Australian graduates (interns)	6
Passed NZREX	15
Graduate of competent authority accredited medical school	490
Worked in comparable health system	185
New Zealand and international medical graduates reregistration (following erasure)	-
Transitional	-
Non-approved postgraduate qualification – vocational assessment	98
Non-approved postgraduate qualification – vocational eligible	88

Special scope issued	
Visiting expert	15
Research	-
Postgraduate training or experience	45
Locum tenens in specialist post	112
Emergency or other unpredictable short-term situation	-
Teleradiology	-

General scope after completion of supervised period	
New Zealand/Australian graduates (interns)	413
Passed NZREX Clinical	30
Graduate of competent authority accredited medical school	360
Worked in comparable health system	100
Transitional	-

Vocational scope after completion of supervised period	
Non-approved postgraduate qualification – vocational assessment	37
Non-approved postgraduate qualification – vocational eligible	61
Approved vocational education and advisory bodies (VEAB) training programme	3

General scope issued	
New Zealand graduates	1
Overseas graduates	66
Restorations	25

	Number
Vocational scope issued	
Approved postgraduate qualification	467
Suspensions	
Suspended or interim suspension	6
Revocation of suspension	2

Conditions	
Imposed	333
Revoked	292

Cancellations under the Health Practitioners Competence Assurance Act	
Death – section 143	32
Discipline order – section 101 (1)(a)	2
False, misleading or not entitled – section 146	1
Revision of register – section 144 (5)	217
At own request – section 142	178

TABLE 3:

Doctors registered in vocational scopes

1 July 2016 to 30 June 2017

Vocational scope	Vocational registration at 30/6/2016[1]	Added 2016/2017	Removed 2016/2017	Net change	Vocational scope at 30/6/2017[1,2]
Anaesthesia	931	49	6	43	974
Cardiothoracic surgery	37	3	–	3	40
Clinical genetics	16	–	–	–	16
Dermatology	74	3	1	2	76
Diagnostic and interventional radiology	583	47	3	44	627
Emergency medicine	318	38	1	37	355
Family planning and reproductive health	32	3	1	2	34
General practice	4,143	187	88	99	4,242
General surgery	364	16	3	13	377
Intensive care medicine	101	8	–	8	109
Internal medicine	1,266	67	10	57	1,323
Medical administration	37	1	–	1	38
Musculoskeletal medicine	22	3	–	3	25
Neurosurgery	27	2	–	2	29
Obstetrics and gynaecology	372	18	2	16	388
Occupational medicine	67	1	–	1	68
Ophthalmology	165	10	–	10	175
Oral and maxillofacial surgery	23	1	–	1	24
Orthopaedic surgery	325	15	2	13	338
Otolaryngology head and neck surgery	133	3	3	–	133
Paediatric surgery	23	3	–	3	26
Paediatrics	442	20	1	19	461
Pain medicine	25	3	–	3	28
Palliative medicine	70	8	1	7	77
Pathology	351	18	1	17	368
Plastic and reconstructive surgery	79	3	–	3	82
Psychiatry	763	34	19	15	778
Public health medicine	213	2	–	2	215
Radiation oncology	77	4	–	4	81
Rehabilitation medicine	27	2	–	2	29
Rural hospital medicine	114	5	–	5	119
Sexual health medicine	21	3	–	3	24
Sports medicine	28	3	–	3	31
Urgent care	187	29	–	29	216
Urology	79	6	–	6	85
Vascular surgery	40	1	–	1	41
Total	**11,575**	**619**	**142**	**477**	**12,052**

Notes:

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

[2] Includes 482 doctors with registration in two vocational scopes and nine doctors with registration in three vocational scopes.

TABLE 4:

Registrations issued, by country of primary qualification

1 July 2016 to 30 June 2017

	Provisional general	Provisional vocational	Special purpose	Total
England	304	41	20	365
United States of America	66	32	80	178
Scotland	103	19	7	129
Ireland	53	1	5	59
India	12	16	13	41
Canada	11	4	14	29
Netherlands	19	7	2	28
Germany	14	8	1	23
Wales	18	3	–	21
South Africa	3	14	1	18
Northern Ireland	12	2	1	15
Sweden	6	6	–	12
Australia	6	–	5	11
Denmark	9	1	–	10
Belgium	6	2	–	8
Fiji	–	–	6	6
Other[3]	54	28	14	96
New Zealand	474	3	3	480
Total	**1,170**	**187**	**172**	**1,529**

[3] Other represents 40 countries that had fewer than six registrations in the reporting period.

TABLE 5:

Vocational scopes granted to doctors, by vocational scope of practice

1 July 2016 to 30 June 2017

Vocational scope	New Zealand	Overseas	Total
Anaesthesia	26	23	49
Cardiothoracic surgery	1	2	3
Clinical genetics	2	1	3
Dermatology	16	31	47
Diagnostic and interventional radiology	15	23	38
Emergency medicine	3	–	3
General practice	111	76	187
General surgery	9	7	16
Intensive care medicine	4	4	8
Internal medicine	34	33	67
Medical administration	1	–	1
Obstetrics and gynaecology	3	–	3
Anaesthesia	–	2	2
Cardiothoracic surgery	8	10	18
Occupational medicine	1	–	1
Ophthalmology	5	5	10
Oral and maxillofacial surgery	1	–	1
Orthopaedic surgery	13	2	15
Otolaryngology head and neck surgery	1	2	3
Paediatric surgery	–	3	3
Paediatrics	11	9	20
Pain medicine	3	–	3
Palliative medicine	2	6	8
Pathology	8	10	18
Plastic and reconstructive surgery	2	1	3
Psychiatry	5	29	34
Public health medicine	2	–	2
Radiation oncology	1	3	4
Rehabilitation medicine	1	1	2
Rural hospital medicine	3	2	5
Sexual health medicine	–	3	3
Sport and exercise medicine	3	–	3
Urgent care	11	18	29
Urology	2	4	6
Vascular surgery	–	1	1
Total	**308**	**311**	**619**

TABLE 6:

Outcomes of applications for vocational registration assessments

1 July 2016 to 30 June 2017

Branch	Incomplete applications	Pending	Withdrawn/ lapsed	Vocational eligible	Vocational assessment	NZREX	Total
Anaesthesia	8	6	8	10	9	2	43
Cardiothoracic surgery	–	–	–	–	1	–	1
Dermatology	1	–	2	1	4	–	8
Diagnostic and interventional radiology	8	9	5	11	5	–	38
Emergency medicine	9	2	3	9	10	–	33
General practice	6	–	3	–	18	1	28
General surgery	7	4	–	1	5	1	18
Intensive care medicine	2	1	–	–	3	–	6
Internal medicine	11	5	12	17	21	2	68
Medical administration	1	–	–	–	–	–	1
Neurosurgery	–	–	–	–	1	–	1
Obstetrics and gynaecology	6	1	3	3	5	–	18
Occupational medicine	–	–	–	–	2	–	2
Ophthalmology	1	2	5	2	–	–	10
Oral and maxillofacial surgery	1	–	–	–	1	–	2
Orthopaedic surgery	7	1	1	1	6	–	16
Otolaryngology head and neck surgery	3	4	2	2	2	1	14
Paediatric surgery	–	2	–	4	–	–	6
Paediatrics	4	2	4	2	2	1	15
Pain medicine	1	–	–	–	–	–	1
Palliative medicine	1	3	1	3	–	–	8
Pathology	4	2	1	8	5	–	20
Plastic and reconstructive surgery	4	2	–	–	1	–	7
Psychiatry	10	9	11	29	11	4	74
Public health medicine	1	1	–	–	1	–	3
Rehabilitation medicine	–	–	–	–	1	–	1
Sexual health medicine	2	–	–	–	–	–	2
Sports and exercise medicine	1	–	1	1	1	–	4
Urology	1	2	–	–	–	–	3
Total	**100**	**58**	**62**	**104**	**115**	**12**	**451**
Percentages based on total number of outcomes (%)				45.0	49.8	5.2	

TABLE 7:

Doctors on the New Zealand medical register, by country of primary qualification

As at 30 June 2017

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificates
England	1,138	1,467	28	1,456	23	**4,112**	2,025
United States of America	526	129	64	325	110	**1,154**	386
Scotland	279	405	15	405	4	**1,108**	582
South Africa	62	171	16	767	3	**1,019**	715
Australia	11	484		409	–	**904**	484
India	70	219	24	428	20	**761**	491
Ireland	180	282	2	79	6	**549**	236
Germany	85	82	18	146	–	**331**	187
Wales	110	127	3	68	1	**309**	109
Sri Lanka	9	72	1	166	1	**249**	130
Canada	123	26	7	71	15	**242**	75
Netherlands	102	43	15	51	1	**212**	99
Iraq	4	55	1	106	–	**166**	109
Pakistan	16	66	1	44	1	**128**	74
Northern Ireland	31	44	3	30	1	**109**	55
China	3	42	1	59	–	**105**	77
Bangladesh	3	28	2	68	–	**101**	46
Sweden	54	14	12	16	–	**96**	16
Egypt	11	20	2	50	1	**84**	43
Fiji	–	16	–	45	11	**72**	67
Russia	9	29	2	22	1	**63**	50
Philippines	4	22	2	29	1	**58**	41
Poland	15	19	3	19	–	**56**	30
Denmark	29	12	3	7	1	**52**	17
Belgium	21	15	4	11	–	**51**	16
Singapore	12	15	–	23	–	**50**	28
Zimbabwe	1	3	2	38	–	**44**	35
Nigeria	8	16	1	14	1	**40**	15
Italy	12	5	6	15	–	**38**	20
Romania	5	13	1	16	–	**35**	17
Serbia	–	9	1	24	–	**34**	21
Spain	8	6	–	14	1	**29**	23
Czech Republic	7	11	2	8	–	**28**	16
Austria	10	11	2	4	–	**27**	11
Switzerland	11	7	1	8	–	27	11
France	7	9	1	8	–	**25**	16
Hungary	6	6	–	13	–	**25**	16

Spain	7	5	2	11	-	**25**	20
France	7	8	1	7	-	**23**	15
Ukraine	3	12	1	6	-	**22**	18
Malaysia	-	9	-	8	1	**18**	14
Mexico	5	1	1	6	4	**17**	10
Bulgaria	-	7	-	9	-	**16**	12
Croatia	1	4	-	10	-	**15**	10
Iran	3	6	1	4	1	**15**	8
Israel	3	3	1	5	2	**14**	9
Syria	3	5	2	3	-	**13**	10
Zambia	1	6	-	6	-	**13**	8
Finland	3	7	1	1	-	**12**	7
Netherlands Antilles	8	3	-	1	-	**12**	6
Norway	4	-	-	8	-	**12**	9
Papua New Guinea	2	-	-	9	1	**12**	8
Sudan	3	6	-	3	-	**12**	10
Brazil	2	3	2	4	-	**11**	6
Colombia	1	5	-	4	1	**11**	6
Dominica	5	2	-	1	2	**10**	3
Other[4]	40	68	11	76	8	**203**	122
New Zealand	**524**	**4,392**	**–**	**6,298**	**1**	**11,215**	**9,055**
Total	**3,598**	**8,562**	**265**	**11,549**	**218**	**24,192**	**15,744**

[4] Other represents 61 countries with fewer than 10 registered doctors.

PROFESSIONAL STANDARDS

Principal activities: receiving referrals of concerns, administering the complaints triage committee, undertaking performance assessments, establishing individual education programmes and recertification programmes, maintaining assessment tools, developing policy on performance assessment, setting up professional conduct committees and monitoring doctors who are subject to conditions arising from competence and conduct concerns and disciplinary action.

TABLE 8:

Referral sources to full Council meeting for performance processes

1 July 2016 to 30 June 2017

ACC	5
Employer (DHB)	1
Employer (private hospital or general practice)	4
Health and Disability Commissioner (HDC)	21
Medical practitioner colleague	8
Ministry of Health	1
Professional conduct committee	1
Other	1

TABLE 9:

Referral sources to full Council meeting for conduct processes

1 July 2016 to 30 June 2017

Employer (DHB)	5
Employer (private hospital or general practice)	3
Member of public or patient	3
HDC	4
Internally referred within Council	4
Medical practitioner colleague	6
Health practitioner colleague	1
Ministry of Health	3
Media	1
Other	4

PERFORMANCE

Council seeks to implement mechanisms to ensure doctors are competent to practise. When receiving referrals that relate to a doctor's competence to practise, Council does not investigate specific incidents (that is the HDC's role) but considers whether the circumstances raise questions about deficiencies in the doctor's competence.

Table 10 shows the number of cases considered by Council during the year that related to a doctor's competence to practise and Council's decisions as to how those cases should be addressed. The table shows the number of Council's processes during the year rather than the number of individual doctors. Many doctors will have been the subject of more than one decision or process because the numbers reflect processes during the year. The numbers include processes that commenced before the year commencing 1 July 2016 and processes that continued after 30 June 2017 and illustrates the volume of Council's work during the year in this area.

TABLE 10:

Competence-related Council processes

1 July 2016 to 30 June 2017

No further action or educational letter on first consideration	14
Await HDC after first consideration	2
Defer – request further information after first consideration	3
Recertification programme ordered on first consideration	1
Referral to performance assessment committee (PAC)[5]	21
Doctor meets required standard of competence following PAC	16
Doctor does not meet required standard of competence following PAC	14
Recertification programme ordered after PAC (section 41)	7
Educational programme ordered after PAC (section 38)	13
Conditions ordered after PAC (section 38)	3
Educational programme completed satisfactorily	5
Did not complete recertification programme satisfactorily	1
Did not complete educational programme satisfactorily	1
Recertification programme ordered after educational programme	1

[5] Council's processes can extend over 12 months, so the number of referrals to PACs may not necessarily correlate with outcomes within the same year.

CONDUCT

Where Council receives information that raises one or more questions about the appropriateness of the conduct or the safety of the practice of a doctor, it may refer any or all of those questions to a professional conduct committee (PCC).

Table 11 shows the number of cases considered by Council during the year that related to a doctor's conduct and Council's decisions as to how those cases should be addressed. The table shows the number of Council's processes during the year rather than the number of individual doctors. Many of these doctors will have been the subject of more than one decision or process because the numbers reflect processes during the year. The numbers include processes that started before the year commencing 1 July 2016 and processes that continued after 30 June 2017 and illustrates the volume of Council's work in this area.

Council is prevented by statute from referring a doctor to a professional conduct committee while the HDC is conducting an investigation in relation to a consumer complaint. Council may, however, make an order for interim suspension or impose conditions on the doctor's practice if it considers that the doctor poses a risk of harm to the public.

When a doctor is convicted of any offence punishable by imprisonment for a term of 3 months or longer or of an offence under certain specified Acts, the doctor is automatically referred to a professional conduct committee. It is not a Council decision. Table 12 shows the PCCs that were commenced as a result of a conviction.

TABLE 11:

Conduct-related Council processes

1 July 2016 to 30 June 2017

No further action or educational letter on first consideration	10
Recertification programme ordered on first consideration	–
Referral to professional conduct committee (PCC)[6]	21
Refer new information to existing PCC	–
Interim conditions ordered (section 69)	2
Interim suspension ordered (section 69)	2
PCC determined charge be brought in the Health Practitioners Disciplinary Tribunal	9
PCC recommended no further action and Council endorses	6
PCC recommended counselling or mentoring and Council endorses	7
PCC recommended review of fitness to practise and Council endorses	1
PCC recommended review of competence to practise and Council endorses	–

[6] Council's processes can extend over 12 months, so the number of referrals to PCCs may not necessarily correlate with outcomes within the same year.

TABLE 12:

PCC as a result of a conviction

1 July 2016 to 30 June 2017

PCC as a result of a conviction	8

DOCTORS' HEALTH

Principal activities: considering the cases of doctors with possible health conditions, establishing treatment and monitoring programmes for doctors whose health conditions affect their fitness to practise and promoting doctors' health.

Council aims to protect patients by appropriately managing doctors who may not be fit to practise because of a mental or physical condition.

Doctors, like the general population, can suffer from various afflictions, including drug and alcohol dependence, psychiatric problems and a wide range of physical disorders, any of which can affect their performance.

TABLE 13:

Notifications of inability to perform required functions due to mental or physical (health) condition

1 July 2016 to 30 June 2017

Source	HPCAA				
		Existing	New	Closed	Still active
Health service	section 45 (1) a	–	–	3	–
Health practitioner	section 45 (1) b	–	45[7]	7	39
Employer	section 45 (1) c	–	6	2	4
Medical Officer of Health	section 45 (1) d	–	–	–	–
Any person	section 45 (3)	–	9	1	8
Person involved with education	section 45 (5)	–	1	–	–
Total		**–**	**61**	**10**	**51[8]**

[7] 33 of the 45 were self referred.

[8] 5 of the 51 are in abeyance

TABLE 14:

Outcomes of health notifications

1 July 2016 to 30 June 2017

Outcomes	HPCAA	Number[9]
No further action	–	10
Order medical examination	section 49 (1)	87[10]
Interim suspension	section 48 (1)(a)	15[11]
Conditions	section 48 (1) (b)	–
Restrictions imposed	section 50 (3) or (4)	See note[12]

[9] There may be more than one outcome.

[10] 21 assessments agreed voluntarily (5 of which are pending), and 66 reports from treating clinicians, occupational physicians and so forth.

[11] Achieved through voluntary agreement.

[12] Requisite monitoring for 46 doctors still active achieved through informal agreement without use of statutory provisions of the Health Practitioners Competence Assurance Act 2003.

EXAMINATIONS

Principal activities: ensuring that international medical graduates who wish to be registered in New Zealand are safe to practise medicine.

New Zealand registration examination – NZREX Clinical

The New Zealand's health consumers expect that all doctors will meet practice standards defined by Council.

International medical graduates are required to sit and pass NZREX Clinical, our registration examination, if they are not eligible for registration under any other registration pathway. This examination is set at the level of a recent New Zealand medical graduate.

NZREX Clinical is a 16-station objective-structured clinical examination that tests various competencies including history, clinical examination, investigating, management, clinical reasoning, communication and professionalism.

The prerequisites for applying to sit NZREX Clinical are:

- a medical degree listed in the World Directory of Medical Schools
- meeting Council's English language policy
- within the last 5 years having passed the United States Medical Licensing Examination (USMLE) Steps 1 and 2 (Clinical Knowledge), the Australian Medical Council multi-choice (MCQ) examination or the United Kingdom's Professional and Linguistic Assessments Board (PLAB) Part 1.

TABLE 15:

Candidates sitting and passing NZREX Clinical

1 July 2016 to 30 June 2017

		Attempts						Passes				
COUNTRY	**Number sitting**	**1**	**2**	**3**	**4**	**5**	**Number passed**	**1**	**2**	**3**	**4**	**5**
Argentina	**1**	1	–	–	–	–	**1**	1	–	–	–	–
Bangladesh	**4**	2	2	–	–	–	**1**	–	1	–	–	–
Brazil	**2**	–	1	1	–	–	**1**	–	–	1	–	–
Cayman Islands	**1**	1	–	–	–	–	**–**	–	–	–	–	–
China	**8**	4	4	–	–	–	**5**	1	4	–	–	–
Egypt	**1**	1	–	–	–	–	**–**	–	–	–	–	–
Ethiopia	**1**	1	–	–	–	–	**1**	1	–	–	–	–
Fiji	**4**	4	–	–	–	–	**2**	2	–	–	–	–
Germany	**1**	1	–	–	–	–	**1**	1	–	–	–	–
Grenada	**1**	1	–	–	–	–	**1**	1	–	–	–	–
Hungary	**1**	1	–	–	–	–	**1**	1	–	–	–	–
India	**20**	13	3	3	1	–	**11**	8	1	1	1	–
Indonesia	**1**	1	–	–	–	–	**1**	1	–	–	–	–
Iran	**2**	–	2	–	–	–	**1**	–	1	–	–	–
Iraq	**5**	1	3	1	–	–	**3**	–	3	–	–	–
Italy	**1**	1	–	–	–	–	**1**	1	–	–	–	–

continued...

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TABLE 15:

Candidates sitting and passing NZREX Clinical

1 July 2016 to 30 June 2017

		Attempts						Passes				
COUNTRY	**Number sitting**	**1**	**2**	**3**	**4**	**5**	**Number passed**	**1**	**2**	**3**	**4**	**5**
Jamaica	**1**	1	–	–	–	–	**1**	1	–	–	–	–
Japan	**2**	1	1	–	–	–	**1**	–	1	–	–	–
Jordan	**1**	1	–	–	–	–	**1**	1	–	–	–	–
Korea (ROK)	**1**	1	–	–	–	–	**1**	1	–	–	–	–
Kosovo	**2**	–	–	–	1	1	–	–	–	–	–	–
Kyrgyzstan	1	1	–	–	–	–	–	–	–	–	–	–
Malaysia	3	3	–	–	–	–	3	3	–	–	–	–
Mauritius	3	2	1	–	–	–	1	–	1	–	–	–
Netherlands	2	2	–	–	–	–	2	2	–	–	–	–
Nigeria	2	1	–	1	–	–	1	–	–	1	–	–
Pakistan	15	12	2	–	1	–	9	7	1	–	1	–
Peru	1	1	–	–	–	–	1	1	–	–	–	–
Philippines	3	2	–	1	–	–	1	1	–	–	–	–
Russia	4	3	1	–	–	–	–	–	–	–	–	–
Samoa	1	1	–	–	–	–	1	1	–	–	–	–
Saudi Arabia	2	1	1	–	–	–	–	–	–	–	–	–
Sint Maarten	1	–	1	–	–	–	–	–	–	–	–	–
South Africa	1	1	–	–	–	–	1	1	–	–	–	–
Sri Lanka	3	3	–	–	–	–	1	1	–	–	–	–
St Kitts and Nevis	1	1	–	–	–	–	–	–	–	–	–	–
St Lucia	1	1	–	–	–	–	1	–	–	–	–	–
Ukraine	2	1	1	–	–	–	1	–	1	–	–	–
United Arab Emirates	1	–	1	–	–	–	1	–	1	–	–	–
United States	1	1	–	–	–	–	1	1	–	–	–	–
Zimbabwe	2	2	–	–	–	–	–	–	–	–	–	–
Total	**111**	**75**	**24**	**7**	**3**	**1**	**60**	**39**	**15**	**3**	**2**	**–**

HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL (HPDT)

Principal activities: disciplinary proceedings brought against doctors are heard and determined by the Health Practitioners Disciplinary Tribunal (Health Practitioners Competence Assurance Act 2003).

Medical charges before the Health Practitioners Disciplinary Tribunal

During the year, the HPDT received 16 charges relating to nine doctors –15 charges were received from a professional conduct committee and one from the director of proceedings.

The HPDT sat during the year to hear 15 charges relating to 12 doctors over 39 days. Nine of the 15 charges were received in 2015/2016. One charge was received in 2016/2017. Nine charges received during 2016/2017 are yet to be heard.

TABLE 16:

Medical charges before the Health Practitioners Disciplinary Tribunal

1 July 2016 to 30 June 2017

Nature of charges	
Professional misconduct 2015/2016	9
Professional misconduct 2016/2017	13
Conviction 2016/2017	3
Total	**25**

Source	
Prosecution of charges brought by professional conduct committee 2015/2016	9
Prosecution of charges brought by professional conduct committee 2016/2017	6
Charges brought by professional conduct committee yet to be heard	9
Charges brought by director of proceedings yet to be heard	1
Total	**25**

Outcome of hearings	
Guilty – professional misconduct 2015/2016	8
Guilty – conviction 2015/2016	2
Not guilty – professional misconduct 2015/2016	1
Guilty – professional misconduct 2016/2017	3
Not guilty – professional misconduct 2016/2017	1
Yet to be heard 2016/2017	10
Total	**25**

Further information about these statistics can be found on the Tribunal's website www.hpdt.org.nz.

CORPORATE GOVERNANCE

Role of Council: members of Council set the strategic direction of the organisation, monitor the CEO's performance and ensure Council meets the requirements of the Health Practitioners Competence Assurance Act 2003.

Council is accountable for its performance to Parliament, the Minister of Health, the medical profession and the public.

Council membership

Council aims to have members who represent:

- a range of age, gender and ethnic groups
- a broad mix of the medical profession, New Zealand society as a whole and people with a wide general knowledge and breadth of vision and who also have one of the following:
  - Broad health sector knowledge.
  - Experience in one of the main vocational scopes of practice.
  - Experience in health service delivery in a variety of provincial and tertiary settings.
  - Experience in medical education and assessment.

Council committee structure

Council operates three standing committees – Audit, Education and Health. Members of these committees are listed on page 39. Council receives committee meeting minutes at its formal meetings and, in approving those minutes, confirms the decisions made. Delegation limits are established.

Linking with stakeholders

We have continued to be actively involved with registration bodies overseas. We share ideas for future developments and maintain contact with organisations including:

- Medical Board of Australia and Australian Medical Council
- International Association of Medical Regulatory Authorities
- Federation of State Medical Boards and the Educational Commission for Foreign Medical Graduates (United States of America)
- Medical Council of Canada
- General Medical Council (United Kingdom)
- Irish Medical Council.

As in previous years, Council has had regular meetings with key stakeholders to discuss matters of mutual interest. Those stakeholders include:

- Accident Compensation Corporation
- medical colleges and associations
- chief medical officers of DHBs
- Council of Medical Colleges
- Health and Disability Commissioner
- Medical Protection Society
- Minister of Health
- Ministry of Health
- Te Ohu Rata O Aotearoa
- Association of Salaried Medical Specialists
- Resident Doctors' Association
- New Zealand Medical Association
- members of the profession, other regulatory authorities, medical students and community groups.

COUNCIL COMMITTEES

Council standing committees at 30 June 2017

Chairperson

Mr Andrew Connolly

Deputy Chairperson

Ms Laura Mueller

Audit Committee

Mr Andrew Connolly (ex officio)[13]

Dr Jonathan Fox (Chairperson)

Ms Laura Mueller

Ms Susan Hughes QC

Ms Joy Quigley

Mr Roy Tiffin

Health Committee

Mr Andrew Connolly (ex-officio)[1]

Dr Lu'isa Fonua-Faeamani

Dr Pamela Hale (Chairperson)

Ms Laura Mueller (Deputy Chairperson)

Ms Joy Quigley (alternative layperson)

Education Committee – Council members

Mr Andrew Connolly (ex officio)	Dr Jonathan Fox (Deputy Chairperson)
Ms Laura Mueller	Professor John Nacey (Chairperson)
Ms Joy Quigley	Dr Curtis Walker

Education Committee – non-Council members

Dr Katelyn Costello	Active consumer of education
Dr Andrew Curtis	Active consumer of education
Professor Peter Ellis	Medical Council of New Zealand representative of MedSAC
Dr Liza Lack	Nominee of appropriate college or branch advisory body – Royal New Zealand College of General Practitioners
Dr Bryony Nicholls	Active consumer of education
Dr Sarah Nicolson	Nominee of appropriate college or branch advisory body – Australian and New Zealand College of Anaesthetists
Dr Greig Russell	Nominee of appropriate college or branch advisory body – Royal New Zealand College of Urgent Care Physicians
Dr John Thwaites	Nominee of appropriate college or branch advisory body – Australasian College of Physicians
Dr Ian Wallace	Prevocational educational supervisor

[13] The Chairperson is an ex officio member of all committees. External members of committees are recognised by Council as being desirable on some committees although a minimum of two Council members and at least one layperson must sit on each committee.

COUNCIL OFFICE

OFFICE OF THE COUNCIL AT 30 JUNE 2017

Chief Executive	Philip Pigou
Registrar	David Dunbar
Deputy Registrar	Aleyna Hall
Executive Assistant	Dot Harvey
Human Resources Manager	Bernadine Lynch
Project Manager	Sidonie
Senior Legal Adviser	Vacant
Legal Adviser	Jessica Schreiber
Junior Legal Advisor	Elliot Foxall

ADVISER GROUP

Medical Adviser	Dr Steven Lillis (part-time)
Medical Adviser	Dr Kevin Morris (part-time)
Senior Policy Adviser	Kanny Ooi
Communications Manager	George Symmes (part-time)

CORPORATE SERVICES

Chief Financial Officer	Peter Searle
ICT Team Leader	Bill Taylor
Business Process Analyst	Carolyn Berry (part-time)
Senior ICT Systems Analyst	Andrew Cullen
Business Analyst	Diane Latham
ICT Systems Analyst	Alecia Thompson (part-time)
ICT Systems Analyst	Ray van der Veen
Accountant	Jim Peebles (part-time)
Assistant Accountant	Atish Pathak
Finance Officer	Marika Puleitu (part-time)
Senior Office Administrator	Dianne Newport
Office Administrator	Jennifer Porter (part-time)

HEALTH

Health Manager	Lynne Urquhart
Health Case Manager	Meredith Baron
Health Case Manager	Hollie Bennett
Health Case Manager	Jo Hawken
Health Case Manager	Jasmine Walker
Health Case Manager	Garth Wyatt
Health Administrator	Vacant

HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL (HPDT) FOR MEDICAL PRACTITIONERS

HPDT Manager	Gay Fraser
Legal Officer	Kim Davis
Executive Officer	Debra Gainey
Personal Assistant to HPDT Manager	Deborah Harrison

CORE SERVICES

General Manager of Core Services	**Valencia van Dyk**
Registration Team Manager – General	**Kylie Johnston**
Registration Team Manager – General (Acting)	**Anastasia Appleyard**
Registration Coordinator – General	Trudy Clarke
Registration Coordinator – General	Alastair Gibbons
Registration Coordinator – General	Prakash Joseph
Registration Coordinator – General	Patrick McKane
Registration Coordinator – General	Devan Menon
Registration Coordinator – General	Vacant
Registration Coordinator – General	Vacant
Registration Team Manager – Practising Certificate	**Helen Vercoelen**
Practising Certificate Coordinator	Bronwyn Courtney
Practising Certificate Coordinator	Brady Miller
Practising Certificate Audit Coordinator	Sharon Mason
Registration Team Manager – Vocational	**Laura Lumley**
Registration Coordinator – Vocational	Sandra Clark
Registration Coordinator – Vocational	Francesca Dalli-Niven
Registration Coordinator – Vocational	Imojini Kotelawala
Registration Coordinator – Vocational	Geethanjali Raghunath
Registration Coordinator – Vocational	Sandra Tam
Registration Coordinator – Vocational	Vacant
Professional Standards Team Manager	**Charlotte Provan**
Professional Standards Coordinator	Anna Yardley
Professional Standards Coordinator	Maria Bernal
Professional Standards Coordinator	Nadia Hampton
Professional Standards Coordinator	Danielle Lee
Professional Standards Coordinator	Nikita Takai
Education Coordinator	Eleanor Quirke
Professional Standards Coordinator	Ancari van Niekerk

APPENDICES – FINANCE

Financial statements 2017

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staplesrodway
CHARTERED ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT TO THE READERS OF MEDICAL COUNCIL OF NEW ZEALAND'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

The Auditor-General is the auditor of the Medical Council of New Zealand (the Medical Council). The Auditor-General has appointed me, Robert Elms, using the staff and resources of Staples Rodway Audit Limited, to carry out the audit of the financial statements of the Medical Council on his behalf.

Opinion

We have audited the financial statements of the Medical Council on pages 1 to 18, statement of financial position as at 30 June 2017, the statement of comprehensive income, the statement of movements in equity 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.

In our opinion the financial statements of the Medical Council on pages 1 to 18, present fairly, in all material respects:

- its financial position as at 30 June 2017; 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.

Our audit was completed on 20 September 2017. 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 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 for the financial statements

The Council is responsible for preparing financial statements that are fairly presented and that comply with generally accepted accounting practice in New Zealand.

The Council is responsible for such internal control as it determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Council is responsible on behalf of the Medical Council for assessing the Medical Council's ability to continue as a going concern. The Council is 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's responsibilities arise from the Health Practitioners Competence Assurance Act 2003.

Responsibilities of the auditor for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements, 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.

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

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, 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 Medical 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 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 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, including the disclosures, and whether the financial statements 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 section 15 of the Public Audit Act 2001 and section 134(1) of the Health Practitioners Competence Assurance Act 2003.

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.

Robert Elms
Staples Rodway Audit Limited
On behalf of the Auditor-General
Wellington, New Zealand

MEDICAL COUNCIL OF NEW ZEALAND
Statement of financial position
as at 30 June 2017

	Notes	2017	2016
Current assets			
Petty cash		600	600
Bank accounts		29,609	730
Receivables	6	518,156	420,613
Interest accrued		35,424	36,086
Investments	7	5,442,000	5,621,550
Total current assets		$6,025,789	$6,079,579
Term assets			
Property, plant and equipment	8	819,738	845,374
Intangibles	9	4,089,326	3,586,001
Total term assets		$4,909,064	$4,431,375
Current liabilities			
GST		27,666	100,538
Sundry creditors		938,955	753,049
Employee entitlements		430,039	507,627
Lease rent free liability		34,927	34,927
Payments received in advance		343,237	395,788
Total current liabilities		$1,774,824	$1,791,929
Term liabilities			
Employee entitlements		41,681	34,346
Lease rent free liability		175,438	209,562
Total term liabilities		$217,119	$243,908
TOTAL NET ASSETS		**$8,942,910**	**$8,475,117**
CAPITAL ACCOUNT			
General Fund		7,103,430	6,193,497
Complaints Investigation and Prosecution Fund		1,376,000	1,855,330
Examination Fund		463,480	426,290
Total capital account		**$8,942,910**	**$8,475,117**

Authorised for issue for and on behalf of the Council.

Andrew Connolly
Chairperson
Dated: 13/09/2017

Philip Pigou
Chief Executive
Dated: 13/9/17

These financial statements should be read in conjunction with the attached accounting policies and notes to the accounts.

STAPLES RODWAY WELLINGTON For Identification Purposes Only

MEDICAL COUNCIL OF NEW ZEALAND
Statement of comprehensive income
for the year ended 30 June 2017

	Notes	2017	2016
Income			
Exchange Income			
Fees received		1,914,514	1,595,756
Vocational registration income		663,935	400,074
Interest received		170,854	163,070
Recovery of staff costs		89,008	86,944
Other income		1,718	797
		2,840,029	2,246,641
Non Exchange Income			
APC Fees		10,765,842	10,213,226
Recovered legal costs		217,526	272,467
Fines received		5,000	14,000
		10,988,368	10,499,693
		$13,828,397	$12,746,334
Expenditure			
Advice and consultancy		123,730	113,971
Archives		65,506	77,765
Audit fees		30,820	28,777
Council and standing committee meeting costs		637,717	600,166
Credit card fees and commissions		8,365	6,664
Debt collection costs and debt impairment expense		140,833	58,372
Depreciation and amortisation	10	1,061,050	1,003,499
Employee benefits		6,074,115	5,840,948
Health Practitioners Disciplinary Tribunal fees		239,640	232,060
Information brochures and notices		24,070	15,221
Intern supervisors payments		688,226	461,070
Legal prosecutor		612,116	224,187
Medsys service level agreement		51,957	25,678
Office relocation		152,586	0
Professional Conduct Committee - Member fees		269,428	197,555
Professional Conduct Committees - Other fees		18,701	0
Rent		434,062	519,419
Repairs and maintenance office equipment		78,995	131,952
Reports and health assessments		152,225	143,696
Vocational registration expenses		442,614	350,011
Other administrative costs		2,053,848	1,607,719
		$13,360,604	$11,638,730
Net surplus / (deficit) for year		$467,793	$1,107,604
Other comprehensive income		0	0
Total comprehensive income		$467,793	$1,107,604

These financial statements should be read in conjunction with the attached accounting policies and notes to the accounts.

MEDICAL COUNCIL OF NEW ZEALAND
Statement of movements in equity
for the year ended 30 June 2017

	Notes	2017	2016
A) ACCUMULATED FUNDS AND RESERVES			
Balance brought forward		8,475,117	7,367,513
Total comprehensive income		467,793	1,107,604
Closing balance		$8,942,910	$8,475,117
B) ANALYSIS OF INDIVIDUAL FUNDS			
1) General Fund			
Balance brought forward		6,193,497	5,179,902
Total comprehensive income	2	909,933	1,013,595
Closing balance		$7,103,430	$6,193,497
2) Complaints Investigation and Prosecution Fund			
Balance brought forward		1,855,330	1,721,352
Total comprehensive income	3	-479,330	133,978
Closing balance		$1,376,000	$1,855,330
3) New Zealand Registration Examination Fund			
Balance brought forward		426,290	466,259
Total comprehensive income	4	37,190	(39,969)
Closing balance		$463,480	$426,290

These financial statements should be read in conjunction with the attached accounting policies and notes to the accounts.

MEDICAL COUNCIL OF NEW ZEALAND
Statement of cash flows
for the year ended 30 June 2017

	Notes	2017	2016
Cash flows from operating activities			
Cash was provided from:			
Receipts pertaining to statutory functions		13,559,874	12,454,323
Cash was distributed to:			
Council fees, disbursements and office expenses		(12,342,786)	(10,567,735)
Net cash flows from operating activities		1,217,088	1,886,588
Cash flows from investing activities			
Cash was provided from:			
Interest received		170,980	168,279
Short-term investments		2,179,550	318,450
		2,350,530	486,729
Cash was applied to:			
Purchase of assets		(1,538,739)	(637,444)
Short-term investments		(2,000,000)	(1,750,000)
		(3,538,739)	(2,387,444)
Net cash flows from investing activities		(1,188,209)	(1,900,715)
Net increase / (decrease) in cash and cash equivalents		$28,879	-14,127
Opening cash brought forward		1,330	15,457
Ending cash carried forward		$30,209	$1,330
Represented by:			
Petty cash		600	600
ASB bank account		29,609	730
		$30,209	$1,330

These financial statements should be read in conjunction with the attached accounting policies and notes to the accounts.

1. Statement of accounting policies

Basis of preparation

The Medical Council of New Zealand ('Council') is a statutory body constituted under the Health Practitioners Competence Assurance Act 2003.The Council is a public benefit entity (PBE).

The Council has elected to apply New Zealand Tier 2 Public Sector Public Benefit Entity accounting Standards (PBE Accounting Standards). The Council is eligible to report in accordance with Tier 2 PBE Standards as the Council does not:

- Have public accountability in respect of issuing debt or equity instruments
- Hold assets in a fiduciary capacity for a broad group of outsiders
- Have expenses over $30 million per annum.

The financial statements have therefore been prepared in accordance with Tier 2 PBE Standards under which certain disclosure concessions are available. The Council has chosen to continue to disclose the following information for which a disclosure concession is available:

- Reconciliation of Plant, Property and Equipment movements for the prior year (Note 8)
- Reconciliation of Intangible Assets for the prior year (Note 9)
- The nature and extent of exposures to credit risk, liquidity risk and market risk (Note 14)
- Capital management note (Note 16).

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest dollar. They are prepared on the historical cost basis.

Statement of compliance

These financial statements are a general purpose financial report as defined in the External Reporting Board's Framework, and are prepared in accordance with Public Sector Public Benefit Entity Accounting Standards and Generally Accepted Accounting Practice in New Zealand (NZGAAP).

Measurement base

The accounting principles recognised as appropriate for the measurement and reporting of financial performance and financial position on a historical cost basis are followed by the Council.

Specific accounting policies

The following specific accounting policies which materially affect the measurement and reporting of financial performance and financial position have been applied:

(a) **Revenue** – Practising certificate (PC) revenue is 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.

New Zealand registration examination revenue is recognised at the time the exam is held.

Vocational registration income is recognised at the time of invoicing. However a value equivalent to three month's invoicing (the average time taken to process applications) is assessed and held in payments made in advance

(b) **Depreciation** – Property, plant and equipment have been depreciated on a straight line basis at the following rates:

Furniture and fittings 10%pa
Office alterations..... 10%pa
Office equipment 20%pa
Computer hardware..... 33%pa

(c) **Property, plant and equipment** – is shown at cost less accumulated depreciation (Note 8).

(d) **Goods and services tax** – These financial statements have been prepared on a GST exclusive basis except for receivables and sundry creditors which include GST.

(e) **Fines and costs recovered** – Fines and recovery of legal costs have been accounted for on an accrual basis from the date of judgement.

(f) **Income tax** – The Council is not subject to income tax (Note 5).

(g) **Receivables** – Receivables are valued at the amount expected to be realised (Note 6).

(h) **Interest received** – Interest owing at balance date has been accrued.

(i) **Payments received in advance** – The outstanding balance at 30 June 2017 represents payments in advance or deposits made by debtors for services to be provided but not yet completed by the Council at balance date.

(j) **Salaries, holiday pay accrual, long service leave**– An accrual is made for any salaries relating to the current financial period paid after balance date. Holiday pay owing at balance date is valued at the applicable salary rate applying at the date of valuation. Long service leave is valued at the salary rate applicable at valuation date and discounted on an actuarial basis recognising the probability that the employee will reach entitlement as well as discounting for expected inflation and expected salary increases

(k) **Leases** – The value of the leases are recognised in the statement of commitments at the current negotiated value of a number of current leases. The Council has a long term lease on premises at 80 The Terrace, Wellington. Refer to Note 13 for full details of lease commitments at balance date

(l) **Intangible assets** – Intangible assets comprise software development costs, intellectual property costs and software licences. The external costs for the development of registration software is capitalised and disclosed as an intangible asset in the statement of financial position. Intangible assets under construction are not amortised until they are available for use.

Intangible assets have a finite useful life and are amortised on a straight line basis at 10% on Medsys internal software development and 33% per annum on software licences, electronic data management and disaster recovery software systems.

(m) **Provisions** – A provision is made for the amount of accounts receivable that are expected not to be received. This provision is created by reviewing all outstanding amounts at the end of the year and assessing the likelihood of payment. Where a payment plan is in place, amounts scheduled to be recovered after 5 years are provided in full and other balances are provided for after assessment of the likelihood of collection.

(n) **Statement of cash flows**

'Cash' refers to amounts held in banks, net of bank overdraft. It also includes short term deposits held as part of day-to-day cash management but excludes short term cash investments held for the intention of investing.

'Operating activities' are amounts received for the supply of services by the Council, and payments made to employees and suppliers necessary to support those services. Operating activities also include any transactions or events that are not investing or financing activities.

'Investing activities' are the acquisition, holding and disposal of property, plant and equipment and investments.

'Investments' include securities not falling within the definition of cash.

'Financing activities' are the receipt and repayment of the principal on borrowings.

Significant changes in accounting policies

There have been no significant changes in accounting policies.

Critical accounting estimates and assumptions

The preparation of financial statements in conformity with PBE IPSAS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next year are:

Estimating the useful lives and residual values of intangible assets
At each balance date, Council reviews the useful lives and residual values of intangible assets. Assessing the appropriateness of useful life estimates requires Council to consider the expected period of use of the asset by Council.

An incorrect estimate of the useful life affects the depreciable amount of an asset, therefore affecting the amortisation expense recognised in the surplus or deficit and the asset's carrying amount. Council minimises the risk of this estimation uncertainty by an asset replacement program.

Council has not made any changes to past assumptions concerning useful lives.

Estimating the doubtful debt provision
At each balance date each debtor is reviewed and an assessment is made on the likelihood of collection of the amount owed. Where this assessment indicates that impairment exists, a further assessment is made of the amount of that impairment and a provision is created. Any receivable that is uncollectible is written off against the provision. An impairment will be assessed to exist where there has been no payment received,

no payment schedule has been entered into, an existing payment programme is breached or information is received that would indicate the likelihood of collection is diminished.

Impairment
Asset carrying values are reviewed at the end of each year to determine whether there is any indication that the assets have suffered an impairment loss or increase in fair value. If any such indication exists, the fair value of the asset is estimated in order to determine the extent of the impairment loss or gain.

Administration charge
This is a charge on the Complaints Investigation and Prosecution Fund and the Examination Fund to meet overhead costs incurred by the General Fund. The charge is based on the proportion of staff engaged in the activity. This is an internal charge and is not represented on the statement of comprehensive income.

2.

General Fund

Statement of comprehensive income

for the year ended 30 June 2017

	Notes	2017	2016
REVENUE			
Exchange Income			
Fees received	1	1,493,863	1,288,467
Vocational registration income		663,935	400,074
Interest received	1	145,267	139,164
Administration fee - Complaints Investigation and Proscecution Fund	1	790,000	790,000
Administration fee - Examination Fund		160,000	160,000
Workforce survey and other income		46,000	46,000
		3,299,065	2,823,705
Non Exchange Income			
APC Fees		8,789,066	8,337,612
		8,789,066	8,337,612
		$12,088,131	$11,161,317
ADMINISTRATION AND OPERATING EXPENSES			
Communications		94,737	82,276
Legal expenses and other consultancies		123,730	113,971
Office relocation		152,586	0
Rent		434,062	519,419
Staff costs including recruitment and training		5,687,238	5,441,424
Other administration and operating expenses		1,888,596	1,680,701
Total administration and operating expenses		$8,380,949	$7,837,791
COUNCIL AND COMMITTEE EXPENSES			
Council			
- Fees and expenses		572,125	586,990
- Conference and liaison costs		88,344	63,789
- Strategic directions		91,981	48,509
Audit committee			
- Fees and expenses		13,986	13,281
Health committee			
- Fees and expenses		48,864	38,216
- Independent assessment reports, Doctors' Health Advisory Service, other costs		152,225	143,697
Education committee			
- Fees and expenses		79,775	49,430
- Intern supervisor contracts		644,134	428,418
- Hospital visits and other costs		178,346	171,696
Professional standards			
- Performance assessments and other costs		328,438	312,253
Registration			
- Workshops and other costs		599,031	453,652
Total Council and committee expenses		**$2,797,249**	**$2,309,931**
TOTAL EXPENDITURE		$11,178,198	$10,147,722
Net surplus/(deficit) for year and total comprehensive income		**$909,933**	**$1,013,595**

3.

Complaints Investigation and Prosecution Fund
Statement of comprehensive income
for the year ended 30 June 2017

	Notes	2017	2016
Revenue			
Exchange Income			
Recovery of staff costs		89,008	86,944
Interest received		19,105	18,046
		108,113	104,990
Non Exchange Income			
APC Fees		1,976,776	1,875,614
Recovered costs		217,526	272,467
Fines received		5,000	14,000
		2,199,302	2,162,081
Total revenue		$2,307,415	$2,267,071
ADMINISTRATION AND OPERATING EXPENSES			
Administration fee	1	790,000	790,000
Debt impairment expense relating to unpaid penalties and costs		140,833	47,685
General administration and operating expenses		373,213	384,586
Total administration and operating expenses		$1,304,046	$1,222,271
COUNCIL AND TRIBUNAL EXPENSES			
Professional conduct committee costs			
- Members fees		269,428	197,555
- Legal prosecutor costs		612,116	224,187
- Other expenses		181,705	156,290
Total professional conduct committee costs		1,063,249	578,032
Health Practitioners Disciplinary Tribunal			
- Administration fee		179,810	100,731
- Fees and other hearing expenses		239,640	232,059
Total Health Practitioners Disciplinary Tribunal costs		419,450	332,790
Total Council and Tribunal expenses		$1,482,699	$910,822
TOTAL EXPENDITURE		$2,786,745	$2,133,093
Net surplus/(deficit) for year and total comprehensive income		($479,330)	**$133,978**

4.

New Zealand Registration Examination Fund
Statement of comprehensive income
for the year ended 30 June 2017

	Notes	2017	2016
Revenue			
Exchange Income			
NZ Rex candidate fees		372,838	260,690
Interest received		6,481	5,860
Other income		3,530	1,395
		$382,849	$267,945
ADMINISTRATION AND OPERATING EXPENSES			
Administration fee	1	160,000	160,000
Centre costs		72,312	55,105
Examiners' fees and expenses		64,336	49,196
Honorarium, staff costs and other administrative expenses		49,011	43,613
Total administration and operating expenses		$345,659	$307,914
Net surplus/(deficit) for year and total comprehensive income		**$37,190**	($39,969)

5. Taxation

The Medical Council is registered as a charity with the Charities Commission and accordingly its transactions for a charitable purpose are exempted from income tax.

6. Receivables

	2017	2016
Debtors	1,243,296	869,984
Provision for impairment	(782,434)	(641,600)
	460,862	228,384
Payments in advance	57,294	192,229
Total debtors and other receivables	**$518,156**	**$420,613**

Fair Value

The carrying value of debtors and other receivables approximates their fair value.

Impairment

The age profile of receivables at year end is detailed below:

	2017			2016		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	140,460	0	140,460	64,319	0	64,319
Past due 1-30 days	79,122	0	79,122	29,550	0	29,550
Past due 31-60 days	17,871	0	17,871	6,770	0	6,770
Past due 61-90days	28,299	(1,415)	26,884	19,553	(978)	18,575
Past due >90 days	977,544	(781,019)	196,525	749,792	(640,622)	109,170
Total	**$1,243,296**	**($782,434)**	**$460,862**	**$869,984**	**($641,600)**	**$228,384**

The provision for impairment has been based on a review of all debtor balances.

7 Investments

	2017	2016
Current Investments		
ASB - Call Account -1.2%	192,000	1,121,550
ANZ - Matures 18 Oct 2017 -3.00%	250,000	250,000
ASB - Matures 8 Nov 2017 - 3.60%	250,000	250,000
ASB - Matures 9 Aug 2017 - 3.20%	250,000	250,000
ASB - Matures 10 July 2017 - 2.75%	250,000	250,000
ASB - Matures 16 July 2017 - 3.15%	500,000	500,000
BNZ - Matures 24 Sept 2017 - 3.60%	250,000	250,000
BNZ - Matures 10 Dec 2017 - 3.65%	250,000	250,000
Westpac - Matures 10 Oct 2017 - 3.51%	250,000	250,000
Westpac - Matures 3 July 2017 - 3.50%	250,000	250,000
Westpac - Matures 15 Sept 2017 - 3.05%	250,000	250,000
Westpac - Matures 17 Oct 2017 - 3.05%	250,000	250,000
Westpac - Matures 20 Oct 2017 - 3.52%	250,000	250,000
New Investments		
ASB - Matures 26 July 2017 - 3.60%	500,000	0
ASB - Matures 26 July 2017 - 3.15%	1,000,000	0
ASB - Matures 8 Sept 2017 - 3.10%	250,000	0
ASB - Matures 28 Sept 2017 - 3.10%	250,000	0
Closed Investments		
ASB - Matured 24 Sept 2016 - 3.30%	0	500,000
BNZ - Matured 23 July 2016 - 3.30%	0	500,000
Westpac - Matured 29 Sept 2016 - 3.25%	0	250,000
	$5,442,000	**$ $5,621,550**
Current	5,442,000	5,621,550
Term	0	0
	$5,442,000	**$5,621,550**

8. Property, plant and equipment

	Computer Hardware	Furniture and Fittings	Office Alterations	Office Equipment	Artwork	TOTAL
Cost						
Balance at 1 July 2015	556,223	384,164	747,882	235,154	7,138	1,930,561
Additions	89,485	13,827	12,726	7,134	0	123,172
Disposals		0	$0		0	
Balance at 30 June 2016	645,708	397,991	760,608	242,288	7,138	2,053,733
Balance at 1 July 2016	645,708	397,991	760,608	242,288	7,138	2,053,733
Additions	138,209	11,729	22,496	875	0	173,309
Disposals						0
Balance at 30 June 2017	783,917	409,720	783,104	243,163	7,138	2,227,042
Accumulated depreciation and impairment losses						
Balance at 1 July 2015	405,654	298,193	73,160	225,347	0	1,002,354
Depreciation expense	108,674	15,555	75,751	6,025	0	206,005
Impairment losses	0	0		0	0	0
Disposals		0			0	0
Balance at 30 June 2016	514,328	313,748	148,911	231,372	0	1,208,359
Balance at 1 July 2016	514,328	313,748	148,911	231,372	0	1,208,359
Depreciation expense	102,263	15,967	77,021	3,694	0	198,945
Impairment losses					0	0
Disposals					0	0
Balance at 30 June 2017	616,591	329,715	225,932	235,066	0	1,407,304
Carrying amounts						
At 30 June and 1 July 2016	131,380	84,243	611,697	10,916	7,138	845,374
At 30 June 2017	167,326	80,005	557,172	8,097	7,138	819,738

9. Intangibles

	Intangibles
Cost	
Balance at 1 July 2015	6,616,097
Additions	510,032
Disposals	0
Balance at 30 June 2016	7,126,129
Balance at 1 July 2016	7,126,129
Additions	1,365,430
Disposals	0
Balance at 30 June 2017	8,491,559
Accumulated amortisation and impairment losses	
Balance at 1 July 2015	2,742,634
Amortisation expense	797,494
Impairment losses	0
Disposals	0
Balance at 30 June 2016	3,540,128
Balance at 1 July 2016	3,540,128
Amortisation expense	862,105
Impairment losses	0
Disposals	0
Balance at 30 June 2017	4,402,233
Carrying amounts	
At 30 June and 1 July 2016	3,586,001
At 30 June 2017	4,089,326

Included in Intangible assets is the cost of acquiring Intellectual Property rights in relation to the registration software. These costs are incidental to the construction of the registration software and have not been separately identified so it is not possible to measure their separate carrying value.

10. Depreciation

	2017	2016
Depreciation on Plant, Property and Equipment	198,945	206,005
Depreciation on Intangible Assets	862,105	797,494
Total Depreciation	**$1,061,050**	**$1,003,499**

11. Related party transactions

Key management personnel compensation

	2017	2016
Salaries and other short-term employee benefits	1,534,242	1,472,993
Other long-term benefits	28,179	23,267
Total key management personnel compensation	**$1,562,421**	**$1,496,260**

Key management personnel include the Chief Executive and the other 9 members (2016: 8) of Council's management team.

Council member's fees and expenses

	2017	2016
Council members - fees	605,276	566,521
Council members - other expenses	184,175	183,295
Total Council members fees and expenses	**$789,451**	**$749,816**

There were no other related party transactions.

12. Statement of contingent liabilities

There are no known contingent liabilities (2016: Nil).

13. Statement of commitments

Lease commitments under non-cancellable operating leases.

	2017	2016
Less than one year	920,245	542,242
Between 1 and 5 years	2,821,239	2,711,210
Greater than 5 years	15,177	563,381
	$3,756,661	**$3,816,833**

The Council has a long term lease on premises at 80 The Terrace, Wellington. The Council has vacated these premises as a result of earthquake damage sustained in the November 2016 earthquake. At balance date, the Council occupies leased office space at Plimmer Towers, Wellington. The question of re occupation of 80 The Terrace is currently under dispute but the Council's obligations under this lease are included in the statement of commitments. The Council has signed leases in respect of Levels 13, 20 and 28 Plimmer Towers, Wellington and these values are also included in the statement of commitments

14. Financial instruments

Credit Risk

Financial instruments which potentially subject the Council to credit risk consist principally of bank balances and accounts receivable. The Council places investments with recognised banking institutions within an approved reserves and investment policy to limit exposure to concentrations of credit risk.

The Council's maximum credit risk exposure for each class of financial instrument is represented by the total carrying amount of bank accounts, receivables and investments.

Liquidity Risk

This is the risk that Council will encounter difficulty raising liquid funds to meet commitments as they fall due. Council manages liquidity risk by monitoring forecast and actual cash flow requirements and investment maturities.

Market Risk

The Council is exposed to interest rate risk as interest rate movements will affect the returns generated from investments and related cash flows. At year end the interest rates on term deposits ranged from 2.75% to 3.65% (2016: 3.00% to 4.55%).

The estimated fair values of the financial instruments are as follows:

	2017	2016
Receivables	$553,580	$456,699
Bank balances	$29,609	$730
Investments	$5,442,000	$5,621,550
Sundry creditors	($1,282,192)	($1,148,837)

For financial instruments held at balance date, the Council has no exposure to market risk that give rise to an impact on surplus or deficit.

15. Council members' fees and allowances

Council members receive a daily fee for attending meetings and an hourly rate for any preparatory work for any Council or Committee meeting.

In addition a communications allowance has been approved to cover incidental costs of an internet connection, telephones calls and postage/courier charges.

	2017	2016
Attendance allowance:		
Daily	$960.00	$916.00
Hourly	$120.00	$114.50
Communication allowance:		
Quarterly	$161.37	$150.00
Total fees and allowances paid to members of Council	**$605,276**	**$566,521**

	2017	2016
Attendance allowance:		
Daily	$960.00	$916.00
Hourly	$120.00	$114.50
Communication allowance:		
Quarterly	$161.37	$150.00
Total fees and allowances paid to members of Council	**$605,276**	**$566,521**

16. Capital management

The Council's capital is its equity, which comprises retained surpluses. Equity is represented by net assets.

Council's equity is largely managed as a by-product of managing revenues, expenses, assets, liabilities, investments and general financial dealings.
The objective of managing Council's equity is to ensure that the Council effectively achieves its objectives and purpose whilst remaining a going concern.

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