Te Kaunihera Rata o Aotearoa
Medical Council of New Zealand

Annual Report
Pūrongo-ā-Tau

2025–2026



Annual Report

Pūrongo-ā-Tau

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand is pleased to submit this report, for the year ended 30 June 2026, to the Minister of Health.

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

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Our year at a glance

He tirohanga whānui o te tau

Highlights year ended 30 June 2026

This snapshot illustrates a year of careful balance; supporting the entry of qualified international medical graduates while ensuring every doctor meets the high standards of competence and professionalism expected in Aotearoa New Zealand.

50%+



Women make up just over 50 percent of practising doctors, becoming the majority for the first time.

21,097



There were 21,097 doctors practising in New Zealand at 30 June 2026, an increase of 15.6 percent over the past five years.

44%



International medical graduates made up 44 percent of the medical workforce.

56%



Graduates of Aotearoa New Zealand medical schools made up 56 percent of the medical workforce.

1,969



During the year, 1,969 doctors were approved for registration.

1,407



During the year, 1,407 international medical graduates gained registration, accounting for 71.5 percent of all new registrations.

80%



Of all respondents to Torohia, the medical training survey, 80 percent rated the quality of clinical supervision as excellent or good.

99%



During the year, 99 percent of provisional general, general and special purpose registration applications were processed within 20 working days, compared with 92 percent of all registration applications received.

12,278



There were 12,278 doctors registered in a vocational scope of practice, an increase of 304 in the specialist workforce over the year.

9



Fast-track specialist registration was expanded to cover nine specialties: anaesthesia, dermatology, emergency medicine, general practice, internal medicine, anatomical pathology, psychiatry, obstetrics and gynaecology, and general paediatrics.

From the Chair

Mai i te Tumuaki



Dr Kenneth Clark
Tumuaki | Chairperson

Tēnā koutou katoa

It is a privilege to write my first Annual Report foreword as Chair of Council.

Throughout 2025/26, Council remained focused on its core purpose: protecting the health and safety of the public. Alongside its day-to-day regulatory work, Council completed a statutory performance review, approved a new strategic plan, continued its response to the Royal Commission of Inquiry into Abuse in State Care, and strengthened the systems and capability that support its work.

Protecting the health and safety of the public

The Health Practitioners Competence Assurance Amendment Bill, introduced in May 2026, has significant implications for Council's regulatory responsibilities. Changes under the Legislation Amendment Act 2026 will also affect how Council structures and publishes its standards for doctors.

Council will contribute its practical regulatory experience as these changes are developed and implemented. Our focus will be on ensuring the resulting arrangements are clear, workable and support both access to care and strong safeguards for the public.

Council will continue to make its regulatory decisions independently, based on evidence and in line with its statutory responsibilities.

Strengthening governance and accountability

I welcome the 2026 statutory performance review's finding that Council was competent in performing its statutory functions. The review provides independent assurance while identifying opportunities to make our regulatory practice even stronger.

Council also approved *Te Mahere Rautaki | Strategic Plan 2026–2031*. The Plan sets our direction for the next five years through four strategic priorities: effective regulation, trust, workforce and equity. We will track progress through clear performance measures, sound financial oversight and transparent reporting.

Building trust through partnership and transparency

During the year, Council worked with the Ministry of Health, Health New Zealand, other responsible authorities and sector and consumer stakeholders. This engagement strengthened our understanding of shared challenges and informed our regulatory decision-making.

We also have a responsibility to explain our role, decisions and performance clearly. Publishing data, providing accessible information and consulting openly support our accountability and help support public confidence in medical regulation.

Acknowledging the past, strengthening the future

Council continued its response to the Royal Commission of Inquiry into Abuse in State Care and considered the findings of the independent review it commissioned. Council continued to offer and provide individual apologies to survivors, in accordance with their wishes.

Council remains committed to implementing the review's findings, listening to survivors and consumers, and ensuring the lessons from this work continue to strengthen public protection and trust.

Resilience and organisational capability

Reliable systems are essential to protecting the health and safety of the public. Carrying out our core regulatory functions related to registration, competence, conduct, health and education effectively depends on secure, resilient and well-managed systems.

Council will continue to oversee financial sustainability, cybersecurity, information risk, business continuity and the next stages of business transformation. Our investment decisions must be well governed, proportionate to risk and support the continuity of our regulatory functions through change and disruption.

Governance transition and service

At the end of the reporting year, Council elected me as Chair and Ming-chun Wu as Deputy Chair. Council also welcomed three new members. Although the appointments of these three members were confirmed retrospectively and took effect during the reporting period, the gazettal notice did not occur until after the end of the financial year, therefore they were unable to commence their roles immediately. I look forward to the knowledge, experience and perspectives they bring as we continue our work to protect the health and safety of the public.

I acknowledge Dr Rachelle Love and Simon Watt for their leadership of Council, and Dr David Ivory and Dr Charles Hornabrook for their valued service. Rachelle led Council's response to the Royal Commission of Inquiry into Abuse in State Care, engaging directly with survivors of Lake Alice and helping to guide Council through a significant and challenging period of reflection, accountability and change. I also acknowledge Simon Watt for his significant contribution to Council, including his leadership of the Audit and Risk Committee.

As membership changes, Council's responsibilities do not. Careful decisions continue to be made with public safety as the central consideration.

I thank Council members, the Chief Executive and staff, our advisory groups and sector stakeholders for their commitment and expertise. I look forward to working with them as we continue to strengthen confidence in medical regulation and protect the health and safety of the public.

Ngā mihi,



Dr Kenneth Clark
Tumuaki | Chairperson

From the CEO

Mai i te Manukura



Joan Simeon
Manukura | Chief Executive Officer

Tēnā koutou katoa

Over the past year we have continued to strengthen the way we protect the health and safety of the public while also supporting a sustainable medical workforce. Our decisions continue to be guided by the principles of right-touch regulation, with our responses proportionate to the risk posed and public safety uppermost in our minds.

Improvements to our core statutory functions have enabled registration applications to be approved more quickly and doctors to start work sooner. We have also strengthened workforce reporting, improved notification processes and published new guidance to support safe patient care.

Establishing regulation for physician associates

We have established the framework for regulating physician associates, including setting scopes of practice, qualifications and supervision requirements. This work has involved engagement across the health sector, and we are grateful to the stakeholders whose input has helped shape the new regulatory system.

Registration of physician associates is expected to commence on 1 October 2026. Our focus is on ensuring the public can have confidence that doctors and physician associates meet the standards required to practise safely

Supporting the workforce

Over the past twelve months, 1,969 new doctors have been registered. Of these, 1,407, or 71.5 percent, gained their primary medical qualification overseas. The number of practising doctors has increased by 15.6 percent over the past five years, with 21,097 doctors holding practising certificates at 30 June 2026.

We processed 92 percent of all registration applications within 20 working days. We also expanded specialist and other registration pathways, amended English language requirements for international medical graduates, and introduced a new peer-support and supervision framework that includes expectations for induction and orientation.

Our workforce and training reports continue to provide data to inform those involved in workforce planning, medical training and employment. The 2025 Workforce Survey identified concerns about the retention of newly registered international medical graduates. We have started collecting information from doctors who request a Certificate of Professional Status and indicate that they are leaving Aotearoa New Zealand about why they are leaving. This will help us better understand issues relating to retention.

Torohia, the medical training survey for New Zealand, provided insight into over 1200 doctors' experiences of training, supervision and teaching. We shared the findings with Health New Zealand, the Ministry of Health and medical colleges to drive improvement in medical training. We also progressed work to strengthen medical training and accreditation.

Strengthening regulatory practice

We reviewed and strengthened our processes and communications for people who raise concerns about doctors. This included working with the Health and Disability Commissioner to develop a more coordinated pathway when sexual boundary concerns are raised and making information and support easier to find online.

We continued to take a proportionate and compassionate approach when a doctor's health may affect their fitness to practise. This means responding to any risk to patients while supporting doctors with well-managed health conditions to continue practising safely.

We published guidance on the use of artificial intelligence in patient care, making clear that doctors remain accountable for the care they provide. Our review of the core ethical standards for doctors is also being informed by feedback from doctors and members of the public. The feedback highlighted the importance of patients being listened to, treated with respect and involved in decisions about their care.

Whakawaha, our consumer advisory group, contributed to our strategy, professional standards for physician associates and public information. Its advice helped strengthen our focus on plain language, professional role clarity, disability awareness and access to information.

Business transformation

Following a review of our technology, we continued planning for a staged business transformation to modernise core systems, strengthen cybersecurity and business continuity, and support the organisation's long-term sustainability. This work will continue over the coming year.

Preparing for the future

Council's Strategic Plan 2026–2031 will guide our work over the coming years. It maintains our focus on effective, trusted and responsive regulation and adds a new strategic direction emphasising our contribution to a sustainable, high-quality workforce.

I would like to thank Council members, our staff, Council agents, advisory groups and stakeholders for their commitment and expertise. We will continue listening to patients, doctors, physician associates and the communities we serve, and applying what we learn to strengthen regulation and maintain public confidence.

Ngā mihi nui,



Joan Simeon
Manukura | Chief Executive Officer

About us

Mō mātou

The Medical Council's primary purpose is to protect the public health and safety of Aotearoa New Zealand by ensuring doctors are competent and fit to practise. Whether it's assessing a doctor's performance or promoting good medical practice that reflects the expectations of Aotearoa New Zealand communities. All our decisions are based on the principles of right-touch regulation. This is an internationally tried and tested decision-making model for regulators.

Our functions

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

Right-touch regulation

Proportionate

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

Consistent

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

Targeted

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

Transparent

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

Accountable

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

Agile

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

Council members



Dr Kenneth (Ken) Clark
MB ChB 1981 Otago,
FRANZCOG 1989, FRACMA 2012
Tumuaki | Chairperson –
Term started 4 June 2026.



Dr Rachelle Love
MB ChB 2002 Auckland, FRACS 2017
Tumuaki | Chair –
Term ended 27 May 2026



Professor Marie Bismark
MBChB MPH MPsych MD
FRANZCP FAFPHM (RACP)



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



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



Dr Charles Hornabrook
MBChB Otago 1985, FRANZCP 1999



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



Dr Hinamaha Lutui
MB ChB 2010 Auckland,
FRNZCGP 2017



Dr Alexandra Muthu
MBChB Auckland 2000,
FAFOEM (RACP) 2013, CMInstD



Professor Ron Paterson
LLB (Hons) 1979 Auckland, BCL
1981 Oxford, FRACP (Hon) 2014



Mr Simon Watt
LL.B (Hons), B.A. (VUW),
LL.M (London)



Miss Ming-chun Wu
CMInstD, MBA (1st Hons), BSc,
BBus, BEd, BA



Ms Joan Simeon
Our Manukura | Chief Executive



Ms Christine Anderson
LL.B, B.A. (VUW)
Our Pouroki | Registrar

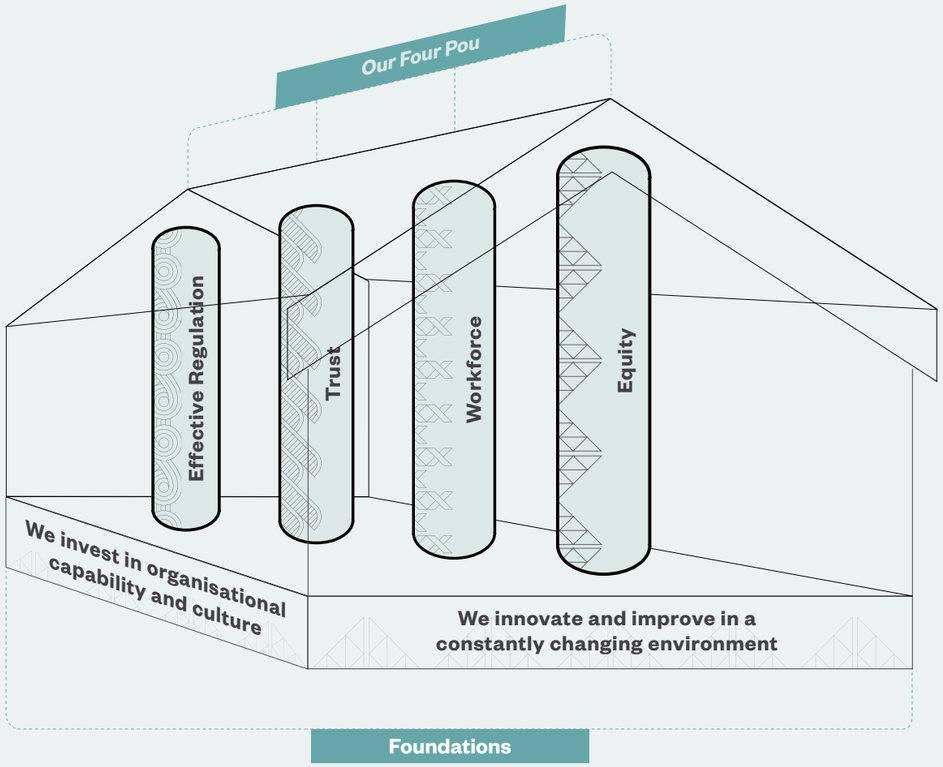
Strategic Plan

Vision
Te moemoeā

A medical profession and a physician associate profession all New Zealanders can trust.

Our purpose
Tō mātou kaupapa

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



Our new four pou and foundations for Te Mahere Rautaki Strategic Plan – 2026–2031

Our values
Ā mātou uara

Whakapono
We act with integrity

Whakamārama
We lead by listening

Kotahitanga
We are a team

Manaakitanga
We support each other

Kaitiakitanga
We protect the public

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

Workforce and registration

Pūnaha kaimahi me te whakaurunga

The practising medical workforce reached several important milestones during the year

1,969 doctors were approved registration over the year:

- 1,407 (71.5 percent) were international medical graduates (IMGs), who gained their primary medical qualification overseas.
- 562 (28.5 percent) were graduates of Aotearoa New Zealand.

21,097 doctors held practising certificates at 30 June 2026, an increase of 568 doctors over the previous year. Women made up just over 50 percent of practising doctors, becoming the majority for the first time. Since 2021, the workforce has grown by 15.6 percent.

Council supported expanding the medical workforce over the year by improving the timeliness of registration, expanding the fast-track specialist registration pathway in high-demand specialties, and maintaining safeguards to protect patients.

Workforce trends and composition

The total number of doctors practising increased by 2.8 percent over the year. Of all doctors practising:

- 11,868 (56.3 percent) were graduates of Aotearoa New Zealand
- 9,229 (43.7 percent) were IMGS.

Steady growth, changing workforce demographics, and continued reliance on both locally and internationally qualified doctors are expected to remain important trends in the years ahead.

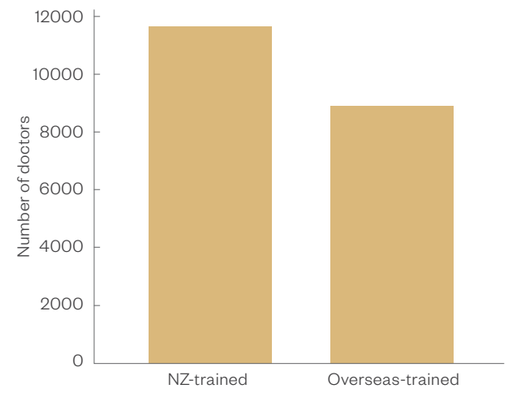
21,097

doctors held practising certificates at 30 June 2026.

Over 50%

Women became the majority of practising doctors for the first time.

Figure 1: Practising doctors by place of primary medical qualification, as at 30 June 2026



Faster registration pathways

Council continued to improve the speed and accessibility of registration without compromising requirements for competence and fitness to practise.

We processed 99 percent of complete provisional general, general and special purpose applications and 97 percent of specialist fast-track applications within 20 working days.

A major focus over the year was reducing the expected timeframe for processing provisional vocational registration (VOC3) applications. The resulting reduction in timeframe from six months to three months provided applicants and employers greater certainty and supported suitably qualified specialists to start work in Aotearoa New Zealand sooner.

Fast-track specialist registration – We expanded the pathway from seven high-demand areas (anaesthesia, dermatology, emergency medicine, general practice, internal medicine, pathology (anatomical), psychiatry) to nine, by adding obstetrics and gynaecology and general paediatrics.

International pathways – We introduced an efficient pathway to registration for doctors who have passed the Australian Medical Council Clinical Examination.

Support and coordination – We updated English language requirements to allow greater flexibility and also applied new principles that strengthened expectations for induction, orientation, supervision and peer support.

99%

of complete provisional general, general, and special purpose applications processed within 20 working days.

Three nationwide workshops, supplemented with smaller training sessions and meetings with Health New Zealand, Immigration New Zealand and medical recruiters improved coordination across registration, recruitment and visa processes.

New registrants by country of qualification

The countries where the most IMGs who gained registration came from were:

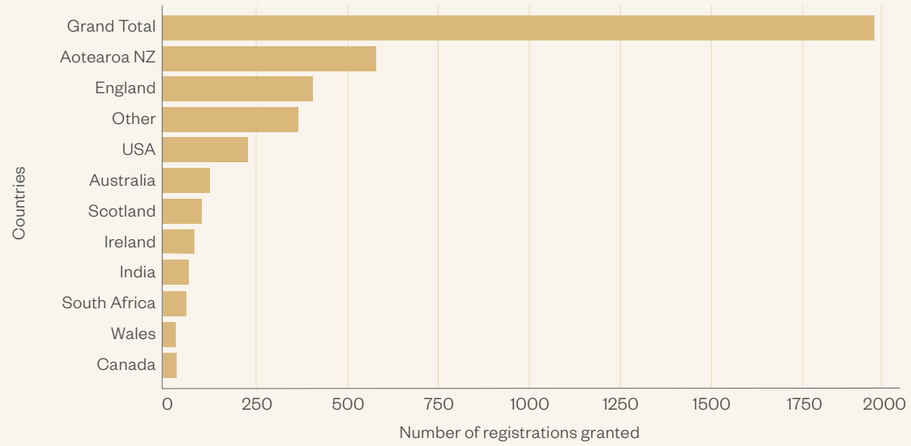
- England (366)
- United States (220)
- Australia (119).

Doctors from a range of other countries also gained registration. Together with the steady pipeline of New Zealand-qualified doctors, these IMGs continued to support workforce growth.

71.5%

of new registrants qualified overseas.

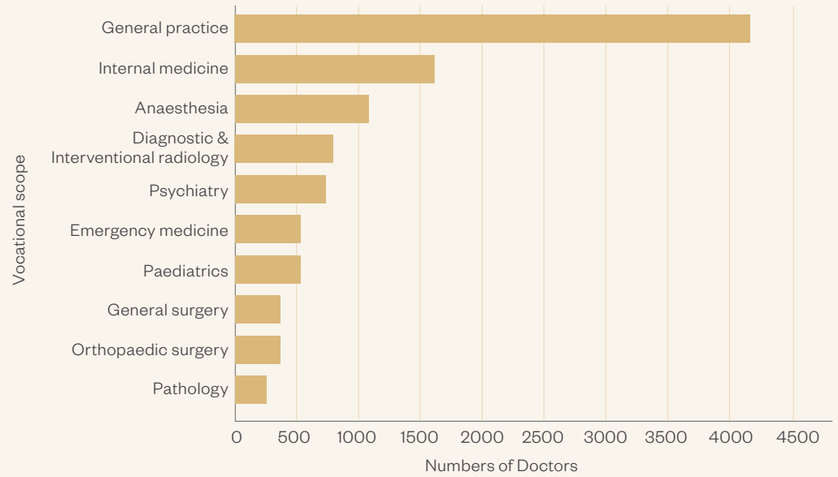
Figure 2: Registrations granted by country of qualification for the year ended June 2026



Vocational distribution

Doctors were registered across more than 30 vocational scopes. General practice remained the largest, with 4,144 doctors, followed by internal medicine with 1,565 and anaesthesia with 1,073. Together, these three scopes grew by 153 doctors during the year. Diagnostic and interventional radiology and psychiatry remained the fourth – and fifth – largest scopes. Emergency medicine and paediatrics each had more than 500 doctors, while orthopaedic suregery was also among the 10 largest scopes.

Figure 3: Top 10 vocational scopes by doctors registered for the year ended June 2026



NZREX Clinical examination

NZREX Clinical remains an important registration pathway for the small number of doctors who are not eligible through another route. In the year ended 30 June 2026, 105 candidates sat the examination – the highest number in the five-year period – and 69 passed, a pass rate of 65.7 percent.

At the reporting date, 27 successful candidates had subsequently gained registration. This number is expected to increase because candidates may apply for registration after the year in which they sit the examination. By maintaining 150 examination places, Council continued to support an important pathway into New Zealand's medical workforce.

In the year ended 30 June 2026, 105 candidates sat NZREX Clinical.

Table 1: NZREX Clinical examination results

	2022	2023	2024	2025	2026
Candidates sat	28	53	59	103	105
Candidates passed	21	37	35	77	69
Pass rate (%)	75.0	69.8	59.3	74.8	65.7
Gaining registration*	19	36	32	45	27
Registration rate (%)	90.5	97.3	91.4	58.4	39.1
Avg days to register	269	183	186	145	156

** "Gaining registration" refers to doctors registered at any point after the examination, rather than specifically within the relevant reporting year. The 2026 registration outcome is provisional as at 30 June 2026.*

Looking ahead

New Zealand's medical workforce continues to grow, but pressures around retention and the distribution of doctors across regions and specialties are expected to continue. To strengthen the evidence available to workforce planners, doctors requesting a Certificate of Professional Status are now asked whether they are leaving Aotearoa New Zealand and why. This information will help the Ministry of Health, Health New Zealand and the wider health sector better understand workforce movement and inform future retention initiatives.

Council's role is to maintain trusted standards, minimise unnecessary regulatory delay and provide robust evidence to support workforce planning.

We will continue working with the Ministry of Health, Health New Zealand, medical colleges and other partners to improve registration pathways, strengthen induction and supervision, and share timely workforce information.

Education

Te mātauranga

Education Committee



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

I am pleased to report that, despite sustained clinical demands and ongoing workload pressures, the quality of medical education and training across Aotearoa New Zealand remains high.

The Education Committee accredits and monitors medical education providers, including medical schools, prevocational training providers, and vocational training and recertification providers, to support high-quality education across the medical training continuum and help ensure doctors are equipped to provide safe, effective care.

A major focus this year was the approval of a strengthened prevocational medical training accreditation framework, following extensive consultation and engagement. The framework reflects the new Health New Zealand | Te Whatu Ora structures. We have commenced implementation and will continue this over the coming year. We appreciate the input and support of Health New Zealand | Te Whatu Ora colleagues.

Accreditation assessments and monitoring

Over the past year we carried out accreditation visits across the Central | Te Ikaroa district training providers – Whanganui, Hawke's Bay, Wairarapa, Capital, Coast and Hutt Valley, and MidCentral – to assess them against our prevocational accreditation standards. We also carried out an accreditation of South Canterbury.

We assessed two Aotearoa New Zealand medical colleges against the vocational training and recertification standards: the New Zealand College of Musculoskeletal Medicine and the Royal New Zealand College of Urgent Care.

In addition, the University of Auckland's Faculty of Medical and Health Sciences medical programme was assessed and accredited, in partnership with the Australian Medical Council (AMC).

The new University of Waikato Graduate School of Medicine submitted its application for accreditation as a primary medical training provider, and this assessment has commenced.

Ongoing monitoring was carried out through prevocational training providers and medical colleges reporting to us on their progress with addressing required actions from earlier accreditation assessments.

Despite clinical demands and ongoing workload challenges, I am pleased to report that the quality of medical training across the training continuum remains high.

Medical training and recertification projects

Council has partnered with the AMC on two key projects: reviewing standards for assessing and accrediting vocational specialist medical programmes delivered by binational colleges; and developing model accreditation standards and procedures for Australasian colleges accrediting vocational training sites.

Council has also approved updated standards and policy for recognising new vocational scopes of practice in Aotearoa New Zealand.

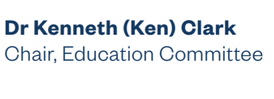
Finally, Council hosted three prevocational educational supervisor (PES) annual meetings in late 2025, in Auckland, Wellington and via Zoom. The meetings provide professional development, role support, collaboration and cross-region partnership opportunities. Topics included addressing professionalism and health concerns with interns, the supervisor/intern mid-attachment meeting, and Torohia – medical training survey results.

Together, this work reflects an education system that is maintaining high standards while responding to structural change, workforce pressures and evolving medical training needs.

Future focus

Over the coming year, we will carry out prevocational accreditation assessments of Te Manawa Taki – Bay of Plenty, Lakes, Tairāwhiti, Taranaki and Waikato – under the revised framework. We will also continue to progress the accreditation of the University of Waikato Graduate School of Medicine.

We value the ongoing contributions of all those committed to medical education in Aotearoa New Zealand. With their continued collaboration, the Committee is confident it can continue supporting a high-quality, responsive and sustainable medical education system.



Dr Kenneth (Ken) Clark
Chair, Education Committee

Health

Te hauora

Health Committee



Professor Ron Paterson
LLB (Hons) 1979 Auckland, BCL 1981 Oxford, FRACP (Hon) 2014

With over 21,000 doctors in New Zealand with a current practising certificate, it is hardly surprising that, like the patients they serve, doctors experience physical and mental health issues. Each year, Council receives notifications about doctors where there are concerns they may be 'unable to perform the functions required for the practice of [their] profession because of some mental or physical condition'.

The Health Committee is a subcommittee delegated by Council to assess and manage notifications and disclosures about doctors' health. In the past year, the Committee has had up to four medical members (a psychiatrist, an occupational medicine specialist, a GP and urgent care practitioner, and a general physician) and two lay members. We meet every month, advised and supported by Council's Health team.

Public protection is the Committee's guiding principle, underpinned by a compassionate and rehabilitative approach. In considering individual cases, we consider extensive reports from the doctor, their treatment providers and independent assessors. We are always conscious of the sensitivity of the health issues disclosed to us and of the need to act fairly and proportionately. We continually look for ways to support a doctor to continue or return to safe practice.

Concerns about doctors' mental health are the most common reason for notifications to Council. Cases involving substance use disorders are especially complex, with the extent of the doctor's insight and compliance with voluntary monitoring (via breath, urine, hair, and blood tests) important considerations. In the vast majority of cases, the doctor is willing to sign a voluntary undertaking to meet requirements set by the Health Committee, designed to safeguard their practice and protect patients. Compliance is carefully monitored.

During the past year, Council received 53 new notifications about doctors' health, including 31 self-notifications. The rest were mainly from treatment providers, health practitioners and employers, fulfilling their statutory duty to make a notification if they have reason to believe the doctor's health may be impacting their fitness to practise.

Council also received 289 self-disclosures from doctors applying for registration or a practising certificate. Most required only minimal intervention as their health conditions were not affecting their fitness to practise, or they were receiving ongoing care from appropriate treatment providers, and taking sick leave as needed. Encouragingly, the number of disclosures from new graduates and registrants shows that doctors are willing to seek support early in their careers, when it can have the greatest impact. This openness and awareness helps ensure safe practice and contributes to healthier working lives.

My thanks to the Health Committee members – in particular psychiatrist Dr Charles Hornabrook, who served on the Committee for the past eight years – and the Health team for their dedication and professionalism.



Professor Ron Paterson
Chair, Health Committee

Health notifications and disclosures

In 2025/26, Council recorded 342[1] health notifications[2] and disclosure[3] across its health processes. This comprised 53 health notifications and 289 health disclosures, with the disclosures made through registration and practising certificate application processes. The combined total increased from 310 in 2024/25 to 342 in 2025/26. It was higher than in four of the previous five years, but below the 399 recorded in 2023/24. The increase was driven by health disclosures, while health notifications decreased.

Most disclosures related to conditions that were well managed or were not affecting the doctor's fitness to practise. Nearly three-quarters (73 percent) required no further action.

342	53	289	73%
Recorded health notifications and disclosures	Health notifications received	Health disclosures received	Of health disclosures required no further action

Supporting doctors while protecting patients

Health notifications

Health notifications decreased from 59 in 2024/25 to 53 in 2025/26 and remained consistent with the level received over the previous five years.

More than half of the notifications, 31, were made by doctors about their own health. A further 11 arose when a doctor's health was identified as a factor in performance or conduct concerns already before Council. Six notifications were made by employers, four by treating doctors and one came from another source.

Mental health conditions and physical health conditions remained the most commonly identified, appearing in 23 and 19 notifications respectively. Some notifications were recorded in more than one category, resulting in 63 category entries across 53 individual notifications.

1 The combined figure is a count of recorded notifications and disclosures, rather than a count of individual doctors.

2 Health notification: Under section 45 of the Health Practitioners Competence Assurance Act 2003, specified people and organisations must promptly give the Registrar written notice if they have reason to believe a doctor is unable to perform the functions required for medical practice because of a mental or physical condition. When doctors notify Council about their own health, this is called self-notification.

3 Health disclosure: Doctors applying for registration or a practising certificate must disclose health conditions that have the potential to affect their ability to practise safely.

Figure 4: Sources of health notifications 2025/26

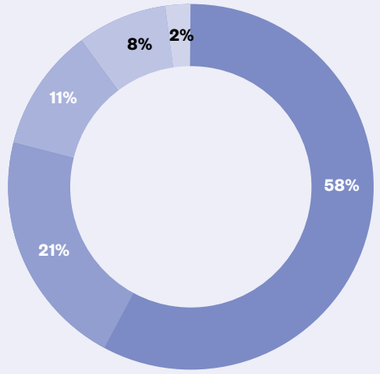
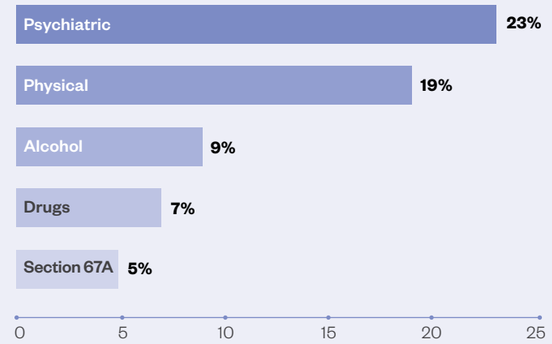


Figure 5: Health conditions identified in notifications 2025/26



Conditions recorded: Some notifications involved more than one health condition

Table 2: Health notifications by condition type, 2020/21–2025/26

Year	Mental Health Conditions	Drugs	Alcohol	Physical	s67A	Notifications
2025/26	**23**	**7**	**9**	**19**	**5**	**53**
2024/25	20	5	9	22	4	59
2023/24	33	4	5	24	1	66
2022/23	25	3	5	12	2	50
2021/22	22	2	2	10	3	39
2020/21	40	4	4	14	6	68

Note: Section 67A refers to convictions notified the Council, most commonly drink-driving convictions. The 2025/26 total is 53 individual notifications. Some notifications involved more than one health condition, so the condition columns sum to 63.

Early disclosure supports safe practice

Doctors applying for registration or a practising certificate must disclose health conditions that have the potential to affect their ability to practise safely. In 2025/26, Council received 289 health disclosures from 22,051 applications, an overall disclosure rate of 1.31 percent.

The number of disclosures increased from 251 in 2024/25 to 289 in 2025/26, but remained below the 333 received in 2023/24. The increase from the previous year was mainly in practising certificate renewals, where disclosures rose from 143 to 175. Disclosures through registration applications increased from 75 to 83, while disclosures from new graduates decreased slightly from 33 to 31.

Most disclosures related to conditions that were well managed or were not affecting the doctor's fitness to practise. Nearly three-quarters (73 percent) required no further action. In other cases, doctors were receiving appropriate treatment, taking sick leave where needed, or had other supports or safeguards in place. This enabled Council to focus further action where it was needed to protect patient safety.

5.7%	0.9%	4.3%
Disclosure rate for new graduates	Disclosure rate for practising certificate renewals	Disclosure rate for registration applications

Table 3: Health disclosures and applications by application type, 2020/21–2025/26

Year	New graduates (PGY1)		Practising certificate renewals		Registration applications	
	Disclosures	Applications	Disclosures	Applications	Disclosures	Applications
2025/26	**31**	**545**	**175**	**19,574**	**83**	**1,932**
2024/25	33	556	143	19,051	75	1,834
2023/24	35	540	196	18,695	102	1,662
2022/23	36	569	143	18,653	57	1,547
2021/22	52	597	118	18,098	45	1,360
2020/21	56	543	121	17,564	44	1,420

Disclosure patterns by application type

New graduates	Practising certificate renewals	Registration applications
31 disclosures from 545 applications (5.7 percent). Most related to mental health. Six were received from New Zealand's two medical school deans, while the remainder were disclosed by applicants. The disclosure rate for new graduates has generally decreased over the longer term, from 10.3 percent in 2020/21 to 5.7 percent in 2025/26.	**175 disclosures from 19,574 applications (0.9 percent).** Although the number increased from the previous year, the disclosure rate remained low and below the level recorded in 2023/24.	**83 disclosures from 1,932 applications (4.3 percent).** Where appropriate, Council may obtain further medical information or put temporary safeguards in place while a doctor transitions safely into practice in New Zealand.

A proportionate and compassionate response

Having a health condition does not automatically prevent a doctor from practising. Council considers the condition's current impact, the doctor's insight and treatment, their working environment, and any safeguards already in place.

Where a condition is well managed, no further regulatory action may be needed. Where a risk remains, Council can seek further information and put appropriate monitoring or safeguards in place.

This proportionate approach protects patients while supporting doctors with appropriately managed conditions to continue contributing to the workforce.

Competence and conduct processes

Ngā tukanga aheinga me te whanonga

Concerns raised about the conduct and competence of doctors

Notifications received

Table 4: Notifications received by source for the reporting period ending 30 June

Source of Notification	2021 –2022	2022 –2023	2023 –2024	2024 –2025	2025 –2026
Members of the public	60	59	44	102	113
Health and Disability Commissioner (HDC)	83	94	91	97	62
Registered health professionals	40	59	64	37	45
Employers	10	14	15	9	20
Self-disclosure	4	11	7	14	19
Internal Council processes	4	10	7	15	17
Accident Compensation Corporation (ACC)	9	9	20	13	8
Police	2	1	2	7	5
Coroner and Courts	–	–	2	4	3
Other agencies*	32	17	18	13	13
Total	**244**	**274**	**270**	**311**	**305**

**Other organisations include government agencies, professional bodies, health service providers and community organisations (for example, Medsafe, Medicines Control, Department of Corrections, Oranga Tamariki and Southern Cross).*

Notification patterns varied across sources over time. The most notable change was the increase in notifications from members of the public, from 60 in 2021/22 to 113 in 2025/26 (an increase of 88.3 percent). While we cannot be certain about the reasons for this increase in notifications from the public, over recent years Council has improved the accessibility of information about notifications processes and has increased public awareness of its role.

Notification concerns by type

Table 5: Notification by concern type for the reporting period ending 30 June

Type	2021 –2022	2022 –2023	2023 –2024	2024 –2025	2025 –2026
Conduct	91	111	123	132	152
Competence	40	110	101	159	138
*Mixed	113	53	46	20	15
Total	**244**	**274**	**270**	**311**	**305**

**Mixed concerns involve notifications that raise both competence and conduct issues.*

Notification concerns are categorised according to the primary issues identified at the time a notification is received:

- Conduct notifications relate to concerns about a doctor's professional behaviour (eg criminal offending, convictions, breaches of professional or sexual boundaries, inappropriate behaviour and self-prescribing).
- Competence notifications relate to concerns about a doctor's performance (eg clinical knowledge and skills, diagnosis, prescribing, communication and clinical decision-making).

Figure 6: Action taken following notification



- No further action or educational letter
- Referred to or awaiting HDC
- Refer matter to a Professional Conduct Committee (PCC) for investigation
- Performance assessment (competence review)

More than half of notifications (55 percent) were closed with either no further action or an educational letter to the doctor, while 17 percent progressed to a formal Council process – referral to a PCC for investigation (10 percent) or a performance assessment (7 percent). These outcomes reflect Council's proportionate approach to managing notifications, with the response determined by the nature of the concerns raised and the level of risk identified.

The remaining 28 percent represents notifications referred to the HDC, or where Council was awaiting the outcome of HDC consideration. This is an interim stage rather than a final Council outcome. Under section 64 of the HPCAA, Council must refer notifications to the HDC where a doctor's practice or conduct may have affected a patient. Council may consider competence concerns alongside the HDC process or await the HDC's findings before determining whether further action is required.

Formal Council processes

Table 6: Formal processes initiated for the reporting period ending 30 June

Outcome	2021 –2022	2022 –2023	2023 –2024	2024 –2025	2025 –2026
Refer to a Professional Conduct Committee for investigation	33	41	31	18	25
Refer for a competence review by way of a performance assessment	19	17	24	21	14

Referrals to a PCC were highest over the three years from the 2021/22 year and 2023/24 year, and this reflects the impact of COVID-19-related notifications received during that period. Referral numbers subsequently declined and appear to be returning to pre-COVID-19 levels.

Referrals for performance assessments showed some year-to-year variation but remained within a similar range over the five-year period. The lower number of performance assessments in 2025/26 may, in part, reflect an increased use of Preliminary Competence Inquiries to gather additional information before determining whether a performance assessment is required.

Performance assessment outcomes

The HPCAA requires Council to determine whether a doctor has met the required standard of competence following completion of a competence review / performance assessment of a doctor's practice. Where Council determines that the doctor is competent, it may take no further action or send an educational letter. Where Council determines that the doctor is not competent, it must make one or more orders in accordance with section 38 of the HPCAA.

Table 7: Council decisions following performance assessments for the reporting period ending 30 June

	2021 –2022	2022 –2023	2023 –2024	2024 –2025	2025 –2026	Grand Total
Educational programme	8	8	7	8	8	**39**
No further action or an educational letter	3	3	6	12	8	**32**
Conditions on scope of practice			2	2	2	**6**
Counselled			1		2	**3**
Sit an examination or assessment				1		**1**
Risk of harm notification issued (s35)					2	**2**

Where a doctor has been found to not be practising at the required standard, requiring the doctor to complete an educational (competence) programme is the most common outcome following performance assessment, accounting for 76 percent of all performance assessment outcomes. Educational programmes are intended to support the doctor to focus on areas identified for improvement and address the competence concerns that were identified in the assessment.

Other outcomes, including counselling, conditions imposed on the doctor's scope of practice, or further examination or assessment, were used less frequently.

This reflects Council's proportionate approach to regulation, with the action taken informed by the nature and extent of the concerns identified. It also reflects Council's focus on education and remediation, supporting doctors to address concerns and improve their practice where appropriate.

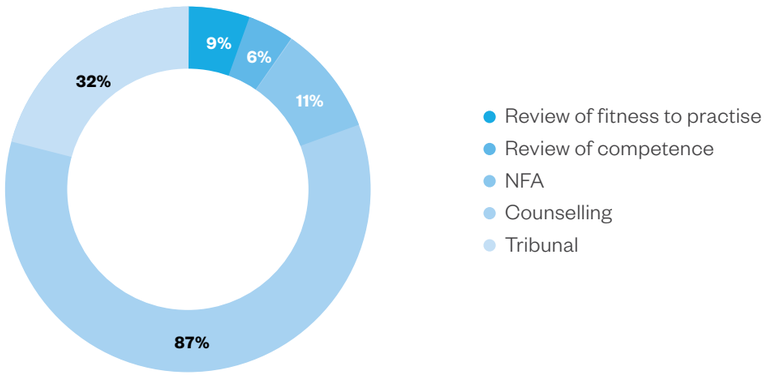
Professional conduct committee outcomes

Under the HPCAA, Council may refer notifications to a professional conduct committee (PCC) to investigate.

Table 8: PCC Investigation Outcomes for the reporting period ending 30 June

Outcome Type	2021 –2022	2022 –2023	2023 –2024	2024 –2025	2025 –2026
Review of fitness to practise	2	3	1	3	0
Review of competence	0	4	0	1	1
No further action	1	3	2	4	1
Counselling	13	27	20	13	14
Tribunal	8	5	11	6	2

Figure 7: PCC Investigation Outcomes 2022–2026



PCCs most commonly decided that a doctor should be counselled, with 87percent of PCCs recommending this outcome. This can include undergoing an educative programme or being sent an educative letter. Around a third of PCCs determined to charge the doctor before the Health Practitioners Disciplinary Tribunal. Note that a single PCC investigation may result in more than one outcome type.

The Health Practitioners Disciplinary Tribunal

Te Rōpū Whakatika Kaimahi Hauora

Table 9: HPDT Hearings for year end 30 June

Outcome Types	2022	2023	2024	2025	2026*
HPDT hearings held	9	12	7	8	5
HPDT charges proven	9	10	6	2	2
Awaiting decision on charge	0	2	1	6	3
Withdrawn	2	0	0	0	0

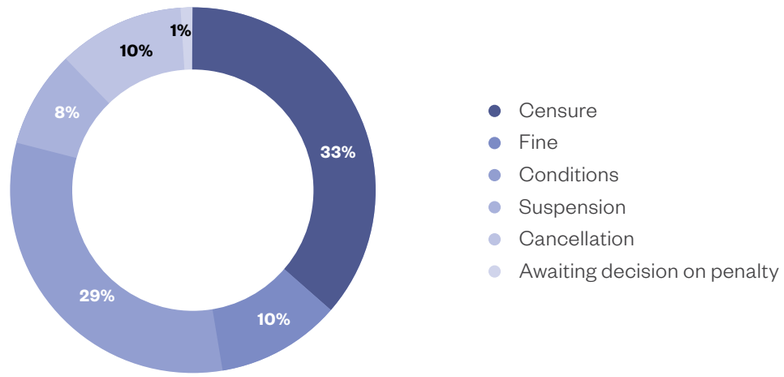
**One Tribunal decision is under appeal.*

Table 10: HPDT Prosecution Penalties for year end 30 June

Penalty Types	2022	2023	2024	2025	2026*
Censure	9	10	5	3	6
Fine	3	3	3	0	1
Conditions	8	10	5	3	3
Suspension	1	3	2	1	1
Cancellation	3	3	2	0	2
Awaiting decision on penalty	0	0	1	0	0

**One penalty decision is under appeal.*

Figure 8: HPDT Prosecution Penalties 2022–2026



Statement of service performance

Te tauākī whakatutukitanga ā-ratonga

Audit and Risk Committee



Miss Ming-chun Wu
CMInstD, MBA (1st Hons), BSc, BBus, BEd, BA

The Audit and Risk Committee is a standing committee of Council to support Council meet its financial accountability and risk management responsibilities. Its membership comprises Council members and an external member with audit and accounting experience. Areas of focus during the year included:

Business transformation

The Committee supported Council by overseeing work to determine the future of Council's core regulatory system. This included:

- Assessing whether to retain and enhance the existing system or replace it.
- Overseeing the request for information process and the subsequent endorsement of the replacement pathway, product selection and due diligence, with business engagement throughout.
- Endorsing a discovery phase, subsequently approved by Council, to confirm the scope, costs, timing and benefits before deciding whether to proceed.

The programme aims to deliver a secure, resilient and fit-for-purpose regulatory system that improves efficiency and responds to future legislative, regulatory and operational needs.

Financial governance

The Committee maintained oversight of Council's financial sustainability and accountability by:

- Monitoring financial performance, forecasts and reserves.
- Reviewing the 2026/27 annual budget and fees, including provision for system modernisation for cost recovery and prudent use of reserves.
- Overseeing the request for information process and the subsequent endorsement of the replacement pathway, product selection and due diligence, with business engagement throughout.
- Engaging with the external auditors on the 2025 audit, which resulted in an unqualified audit opinion.

Risk management

The Committee oversaw Council's risk management programme, including legislative compliance, cyber security, privacy, and health, safety and wellbeing. Management regularly updates the key risk register for consideration by the Committee and reporting to Council, ensuring key risks and mitigations remain visible and are managed effectively.

Acknowledgements

I thank Committee members and Council staff for their contribution throughout the year. I also acknowledge Simon Watt, whose term as Chair of the Committee ended in June 2026, for his leadership and service.



Miss Ming-chun Wu

Statement of service performance

1 July 2025 to 30 June 2026

Entity information

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand is established under the Health Practitioners Competence Assurance Act 2003. The Medical Council's primary purpose is to protect the health and safety of the public by ensuring practitioners are competent and fit to practise.

Council is guided by the principles of right-touch regulation in all decisions it makes, that is being proportionate, consistent, targeted, transparent, accountable and agile – an internationally recognised principle-based regulatory model.

In practice, this means that all decisions, whether relating to strategy, policy, an individual practitioner's application for registration or concerns about a practitioner's competence, conduct or health, are guided by the principle that any regulatory action is proportionate to the level of risk involved.

Council currently regulates the medical profession (doctors). In addition to this, over the past 12 months it has been establishing a regulatory framework for the regulation of physician associates. Regulation of physician associates will commence over the coming year, with physician associate registration applications being accepted from 1 October 2026. While the basic elements for regulation will be implemented by 1 October 2026, remaining work will continue over the next financial year and beyond, including establishing a framework for physician associate recertification, physician associate graduate outcomes, and accreditation standards for training providers of physician associate training and education in Aotearoa New Zealand. These aspects of regulation are not required to be implemented for the initial period of regulation. The results of service performance information for physician associates will be reported in the next financial year.

For more on our functions and how we make decisions see page 9.

Disclosure of judgements

The performance measures used in this report are measured against the Medical Council's strategic directions as shown in Te Mahere Rautaki | Strategic Plan 2022–2027. We have used judgement to identify the appropriate performance measures for assessment of progress towards the achievement of Council's strategic outcomes. These include a mix of qualitative and quantitative indicators.

Comparative information

Comparative information from the previous year has been included where available for specific performance measures. Some long-term outcomes, medium-term intentions, and short-term outputs (initiatives) were updated for the current year. Where the underlying measure and approach remain substantially the same as the previous year, comparative information has been provided, even if the description has been refined.

Strategic Plan

Our strategic plan (2022–2027) has three strategic directions | pou:

- Demonstrate accountability to the public, the profession, and stakeholders
- Promote equity of health outcomes
- Demonstrate proactive, right-touch regulation in all we do.

These strategic directions are supported by a foundation of:

- investing in organisational capability and culture, and
- using data to inform innovation and improvement.

From next year, our new strategic plan (2026–2031) will have four strategic directions| pou. These are: effective regulation, trust, workforce, and equity. It will be underpinned by two foundations: capability and culture, and innovation and improvement.

Performance Framework

The performance framework is structured as follows:

Long term outcomes (Enduring)

Our purpose is to protect the health and safety of the public by providing mechanisms to ensure doctors are competent and fit to practise.

Our outcomes describe, at a high level, our desired future for Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand (Council) and the medical profession in Aotearoa | New Zealand.

Medium term intentions (Three–Five Years)

Our intentions identify where we will concentrate our efforts over the next three to five years, to deliver on our strategic directions and achieve our outcomes.

Short term outputs (One–Two Years)

Our outputs are the result of short-term initiatives and mahi that help us reach our goals.

1. Demonstrate accountability to the public, the profession and stakeholders

Long term outcomes	Medium term intentions
The public have trust in the medical profession. The profession, stakeholders and government have trust in us as the medical regulator.	• Public trust in doctors is maintained, relative to other professions and international benchmarks. • The public's understanding of how to make a notification is increased. • The profession's knowledge of Council standards is increased. • The medical workforce in Aotearoa New Zealand is strengthened and supported by our leadership, in order to protect the public. • Alignment with Te Tiriti o Waitangi is increased across all our functions.

Short term outputs	Commentary	Last year 2024–25	This year 2025–26
1.1 Respond to the Government's reform of health workforce regulation.	Liaised with Minister of Health and Ministry of Health on health workforce regulation and legislative reform. Initial submission on the HPCA Amendment Bill drafted in anticipation of Select Committee. This will continue to be developed over early 2026–27. Strategic plan approved for 2026–2031 includes a new strategic direction focused on supporting a sustainable, high-quality medical and PA workforce.	**New measure**	**Achieved**
1.2 Prepare for the statutory performance review of the Medical Council.	Performance review assessed Council about how it is meeting its obligations under section 118 of the HPCA Act, based on an audit panel visit and our own written self-assessment. The review found that Council was fully achieving all the core functions and was maintaining strong, collaborative, relationships across the health sector.	**New measure**	**Achieved**
1.3 Consumer input, including from Whakawaha | Consumer Advisory Group leads to a strengthened public and consumer focus to our mahi.	Whakawaha | Consumer Advisory Group met twice, providing input into medical regulation through members' own agenda items and input into our policy work: • guidance for doctors on using AI in patient care • guidance and policy for doctors performing cosmetic procedures • cultural safety • regulatory framework for physician associates (PAs). Consumer input also informed to the implementation of Council's commitments to the Royal Commission of Inquiry into Abuse in State Care, through Whakawaha and consumer representation on the Temporary Committee. In 2026–27 we will implement a strengthened consumer engagement model that builds on our current approach to include wider input such as Health Quality and Safety Commission consumer groups, in addition to Whakawaha.	**Achieved**	**Achieved**
1.4 A regulatory framework for physician associates is established, to protect the public by ensuring the physician associate profession is competent and fit to practise.	Consultation undertaken with 1075 submissions received on the proposed regulatory framework for physician associates. Physician associate scopes of practice, qualifications and fees were gazetted and supervision requirements for physician associates published, ready for regulation of physician associates from 1 October 2026. Next steps over 2026–27 include approval of professional standards; recertification requirements; graduate outcomes and accreditation standards for training of physician associates.	**New measure**	**Achieved**
1.5 Short video guides and other tools that aim to increase public, doctor and stakeholder understanding of our standards and role are publicly available on our website.	On our website, we published: • new guidance for doctors using AI in patient care • new section of the website on PA regulation • updated content and structure to make it easier for the public to find information on how to raise a concern about a doctor's practice. A short video for patients on AI and a supporting factsheet are being developed for publication in 2026–27.	**Achieved**	**Achieved**
1.6 Monitor and respond to changes and trends in the medical workforce in Aotearoa New Zealand, and workforce and regulation internationally.	We published: • Annual workforce survey report (2025) • Data dashboard on Council's website, updated quarterly • Torohia – Medical Training Survey for New Zealand 2025 results. These have strengthened the evidence available on medical training experiences and outcomes. We started collecting data about why doctors are leaving NZ, to provide a better understanding of attrition of the workforce through a new question in the Certificate of Professional Standing application form.	**Achieved**	**Achieved**

Long term outcomes	**Medium term intentions**
We demonstrate accountability to Māori under Te Tiriti o Waitangi.	Alignment with Te Tiriti is increased across all our functions.

Short term outputs	**Commentary**	**Last year 2024–25**	**This year 2025–26**
1.7 He Anga Whakamana Tiriti (Treaty framework) and Te Kāhui Whakamana Tiriti (our expert Māori advisory group) support us to align our work with the principles of Te Tiriti o Waitangi.	We collated a resource of all work related to Te Tiriti to ensure alignment and consistency of approach across all our functions. Te Kāhui met twice and provided input into: • the review of core ethical standards for doctors • governance of Torohia – medical training survey data • the regulatory framework for physician associates (PAs).	**Achieved**	**Achieved**

Long term outcomes	**Medium term intentions**
We are efficient and transparent in our registration, professional standards and doctors' health processes.	We will meet Council's statutory obligations and service standards for timeliness.

Short term outputs	**Commentary**	**Last year 2024–25**	**This year 2025–26**
1.8 Process 90% of all registration applications in 20 working days of receipt of completed application.	92% of all applicants granted registration had their registration applications processed* within 20 working days. (*from receipt of the last piece of information to the letter of eligibility being issued). In some cases, this processing will have occurred in a prior financial year. Doctors do not always register immediately after their letter of eligibility is issued.	**New measure**	**Achieved**
1.9 Process 95% of general registration applications in 20 working days of receipt of completed application.	99% of general registration applications were processed within 20 working days. (99% was also achieved in 2024–25).	**Achieved**	**Achieved**
1.10 Complete 90% of applications for assessment of eligibility for provisional vocational registration (international medical graduates) within 6 months.	97% of applications for assessment of provisional vocational registration for international medical graduates were completed within 6 months (compared to 94% in 2024–25). The 3% improvement, compared to last year, is a result of process improvements.	**Achieved**	**Achieved**
1.11 Process 95% fast-track registration applications in 20 working days of receipt of completed application.	97% of fast-track registration applications were processed within 20 working days. This is a new measure for 2025–26.	**New measure**	**Achieved**
1.12 Complete performance assessments within 6 months.	<table><tr><th>Timeframe</th><th>2021–2022</th><th>2022–2023</th><th>2023–2024</th><th>2024–2025</th><th>2025–2026</th></tr><tr><td>Less than 6 months</td><td>2</td><td>3</td><td>6</td><td>1</td><td>7</td></tr><tr><td>6 months or more</td><td>8</td><td>9</td><td>6</td><td>17</td><td>9*</td></tr></table> *6 of the 9 assessments that took longer than 6 months were because doctors did not have suitable employment, and the assessment could not proceed. The remaining 3 were delayed due to time required to identify appropriately qualified assessors available and free from conflicts of interest. This was particularly challenging due to smaller vocational scopes, where the pool of potential assessors is limited.	**New measure**	**Partially achieved**

<table>
<tr><th>Short term outputs</th><th>Commentary</th><th>Last year 2024–25</th><th>This year 2025–26</th></tr>
<tr><td>1.13 Complete Professional Conduct Committees (PCCs) within the service standard timeframes.</td><td>
<table>
<tr><th>PCCs completed during period</th><th>Within service standard</th><th>Outside service standard</th></tr>
<tr><td>Least complex (9 months)</td><td>3</td><td>2</td></tr>
<tr><td>Moderate complexity (12 months)</td><td>5</td><td>4</td></tr>
<tr><td>Complex (18 months)</td><td>1</td><td>3</td></tr>
<tr><td>Total</td><td>9</td><td>9</td></tr>
</table>
1 PCC of moderate complexity was delayed for reasons within the PCC's control:
• it took time to find an expert in medicinal cannabis prescribing who was not conflicted for the first PCC considering this type of prescribing.
8 PCCs were delayed for reasons outside the PCC's control:
• investigations had to be put on hold pending Police/court/other Tribunal processes
• doctors and/or key witnesses were unavailable and requested more time to respond to or meet with the PCC
• doctor was in a rehabilitation clinic, resulting in delays in engagement
• delays in external organisations responding to information requests
• Council added new particulars on one PCC.</td><td>New measure</td><td>Partially achieved</td></tr>
<tr><td>1.14 Two NZREX Clinical examinations (New Zealand Registration Examination) held per year, with capacity for up to 120 candidates.</td><td>International medical graduates who do not meet the criteria for registration under any other registration pathway must sit and pass NZREX Clinical to be eligible to for registration.
This year, we held two examinations with a total of 109 candidates sitting the exam.
<table>
<tr><th></th><th>2021-2022</th><th>2022-2023</th><th>2023-2024</th><th>2024-2025</th><th>2025-2026</th></tr>
<tr><td>Examinations held</td><td>1</td><td>2</td><td>2</td><td>3</td><td>2</td></tr>
<tr><td>Candidates</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>• Sat</td><td>28</td><td>56</td><td>59</td><td>112</td><td>109</td></tr>
<tr><td>• Passed</td><td>21</td><td>37</td><td>35</td><td>77</td><td>69</td></tr>
<tr><td>• Percentage passed</td><td>75%</td><td>66%</td><td>59%</td><td>69%</td><td>63%</td></tr>
</table></td><td>New measure</td><td>Achieved</td></tr>
</table>

2. Promote equity of health outcomes

Long term outcomes

Māori experience cultural safety when receiving health services from doctors.

Our regulatory and non-regulatory levers support the achievement of health equity for Māori, Pasifika, disabled people and other groups who currently experience inequitable health outcomes.

The medical workforce is diverse, inclusive and reflective of the community it serves.

Medium term intentions

- The current experience of cultural safety amongst Māori receiving health services from doctors is improved, as demonstrated in an evaluation against the September 2020 report 'Baseline data capture: Cultural safety, partnership and health equity initiatives'.
- Guidance is provided to the profession to support the achievement of health equity for groups who currently experience poorer health outcomes.

Short term outputs	Commentary	Last year 2024–25	This year 2025–26
2.1 Accreditation standards for training providers across the medical education continuum are strengthened to demonstrate our commitment to Te Tiriti o Waitangi and health equity.	Australasian vocational training accreditation standards strengthened. Prevocational medical training work was paused while Council considers the wider environment, including the intersection of the new Australian Medical Council standards relating to cultural safety.	**Achieved**	**Partially achieved**
2.2 Cultural safety is embedded in Council's systems and processes for all regulatory functions.	Our new resource of recent activities (see 1.7) demonstrated that cultural safety is embedded in Council's systems and processes.	**Achieved**	**Achieved**
2.3 The experience of cultural safety amongst Māori is evaluated against the October 2020 report 'Baseline data capture'.	Council deferred the decision whether to undertake this work to December 2026. Given the significant commitment and cost of completing this initiative, Council wanted to wait until the vacant positions on Council had been filled so that new members would be included in the decision.	**New measure**	**Not achieved**
2.4 Doctors' responsibilities under Te Tiriti o Waitangi are defined and incorporated in Council's statements.	8,587 submissions received in response to consultation on draft statements. Council decided the feedback will inform the development of future standards and guidance, in line with new secondary legislation requirements coming into effect November 2027.	**Achieved**	**Partially achieved**
2.5 Engagement with Pasifika stakeholders is strengthened.	The Pasifika Medical Association (PMA) was represented on the Good Medical Practice advisory group, and at the Annual colleges and stakeholders meeting. Pasifika consumers are represented on Whakawaha – our Consumer Advisory Group, and the PMA CEO to presented to the WHO Collaborating Centre for Health Workforce Regulation (Western Pacific Regional Network). In 2026–27 we will strengthen engagement with Pasifika consumers through the Health Quality and Safety Commission to support full achievement of this measure.	**Partially achieved**	**Partially achieved**

3. Demonstrate proactive, right-touch regulation in all we do

Long term outcomes	Medium term intentions
The principles of right-touch regulation are used in all Council's decision-making	• The principles of right-touch regulation are embedded in Council's strategic, policy and case-related decisions. • Notifiers are placed at the centre of Council's processes. • We consider the option of taking a restorative approach in response to notifications, where appropriate. • We maintain a strong focus on risk and patient safety while minimising distress to doctors under Council's processes.

Short term outputs	Commentary	Last year 2024–25	This year 2025–26
3.1 An internal data and regulatory intelligence function is established to provide insight into emerging regulatory issues.	Registration and workforce data has informed changes to registration processes. New data on workforce retention has been collected through a survey in the certificate of professional status process. This survey will continue over future years. Outcome reporting for competence and conduct processes was completed for 2025–26, with comparison over five years, demonstrating trends and emerging issues over time. In 2026–27 the business transformation project will focus on continuous improvement of systems for efficient data reporting	**New measure**	**Achieved**
3.2 Improvements are made to our processes and decision-making related to sensitive notifications.	An online form for notifiers was developed, to improve timely handling and data collection about all notifications, including sensitive notifications. This will be implemented in 2026–27. Staff were provided with training on tailoring their communication with notifiers by a specialist consumer advocate. The MOU with the Health and Disability Commissioner on serious misconduct referrals continues to function effectively, supporting fast turnaround of these cases.	**Achieved**	**Partially achieved**
3.3 Notifiers report that our communications and engagement with them meet their needs and are carried out in a culturally safe manner.	We tailored our communications and engagement with notifiers to meet their needs, including offering face to face meetings, arranging interpreters/translators, and supporting people to engage with the process in a way that works best for them. In 2026/27, a survey of notifiers will be completed to provide feedback to inform whether we have achieved this measure.	**Not achieved**	**Partially achieved**

Long term outcomes	Medium term intentions
Council's registration policies are fit for purpose and responsive to the changing nature of the medical workforce.	Our registration pathways for international medical graduates (IMGs) continue to be flexible, innovative and agile.

Short term outputs	Commentary	Last year 2024–25	This year 2025–26
3.4 Registration pathways for IMGs are reviewed to ensure they are fit for purpose and enabling.	Changes were made to IMG registration pathways to ensure they remain appropriate, accessible and enabling. This included changes to the English language policy and extending the fast-track vocational registration pathway to include obstetrics and gynaecology, and paediatrics (general).	**Achieved**	**Achieved**

Long term outcomes	Medium term intentions
Medical education and training prepare and enable the medical profession to provide high quality medical care.	• Accreditation systems and standards drive the provision of high-quality medical education and training across the training continuum. • We carry out an annual survey of all doctors in training, publish an analysis of the data, and take appropriate action from results obtained.

Short term outputs	Commentary	Last year 2024–25	This year 2025–26
3.5 The accreditation framework is reviewed to ensure that there are clear accountabilities for training providers of prevocational training.	Accountabilities across HNZ districts, regions and national office and were defined and approved. The first accreditation visits and monitoring reports under the new framework will take place in early 2026–27.	**Achieved**	**Achieved**
3.6 Torohia – Medical Training Survey for New Zealand is developed and implemented.	The survey was developed and launched. The overall response rate for 2025 was 23.5%. Results were made available in online reports and dashboards and are informing training provider accreditation processes.	**Achieved**	**Achieved**

Long term outcomes	Medium term intentions
Council collaborates and cooperates with other health professions in the regulation of health professionals and the delivery of health services.	Joint strategic initiatives with other Responsible Authorities (RAs) are carried out each year.

Short term outputs	Commentary	Last year 2024–25	This year 2025–26
3.7 Collaborative work is undertaken with other Responsible Authorities (Ras).	We attended quarterly meetings with all the RAs and hosted a joint RA staff training event.	**Achieved**	**Achieved**

Sustainability

Sustainability vision

'Te Āraihaumaru as a kaitiaki (guardian) requires us to meet the needs of the present without compromising the resources of future generations'.

Council is mindful and deliberate as we evolve to become an organisation that normalises environmental sustainability in public protection.

Sustainability mission

'Protecting the environment as we carry out our mahi of protecting the public'.

We are committed to minimising Council's impact on the environment as we carry out our mahi of public protection and will be guided by our organisational values.

Priorities and progress

During the year Council:

- Continued implementing the Environmental Sustainability Strategy, with a focus on strengthening emissions reporting.
- Identified key sources of emissions and independently verified its carbon footprint for the year ended 30 June 2026.
- Reported gross emissions of 404 tonnes of carbon dioxide equivalent (tCO_2e).
- Improved the quality and consistency of emissions data, including data provided by the lessor for leased premises.
- Switched to Ecotricity, a climate-positive electricity provider, and joined the Extraordinary public transport scheme to encourage greater use of public transport by staff.

Toitū Carbon Reduce certification

In its third year of Toitū carbonreduce certification under ISO 14064–1:2018, Council continued to embed emissions measurement and reduction activities into business-as-usual operations, while improving data collection and supporting emissions reduction initiatives.

Reported emissions decreased by 160 tCO_2e in 2026, representing a 16% reduction compared with Council's base year. This decrease reflects changes in organisational activity and expenditure during the reporting period. Ongoing reporting continues to improve Council's understanding of its emissions profile, helping to identify priorities and inform future emissions reduction efforts.

Financial Statements

Ngā tauākī pūtea

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Statement of comprehensive revenue and expenses

For the year ended 30 June 2026

	Notes	2026 (000's)	2025 (000's)
Revenue from non-exchange transactions			
Practising certificate (PC) fees and disciplinary levies		17,883	17,003
Disciplinary recoveries		401	92
Total non-exchange revenue		**18,284**	**17,095**
Revenue from exchange transactions			
Fees received		6,435	5,969
Interest income		414	638
Other income		1,269	755
Total exchange revenue		**8,118**	**7,362**
Total revenue		**26,401**	**24,457**
Expenses per schedules	**5**		
Administration expenses		17,207	16,236
Council and profession expenses		5,407	5,210
Disciplinary expenses		3,445	4,127
Examination expenses		312	276
Total expenses		**26,371**	**25,849**
Total surplus/(deficit) for the year		**30**	**(1,392)**
Other comprehensive revenue and expense for the year		–	–
Total comprehensive revenue and expense for the year		**30**	**(1,392)**

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

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Statement of changes in net assets

For the year ended 30 June 2026

	Notes	General Reserves (000's)	Disciplinary Reserves (000's)	Examination Reserve (000's)	Capital Asset Reserve (000's)	Total Equity (000's)
Opening equity balance 1 July 2025		5,736	3,888	196	3,551	13,371
Total surplus / (deficit) for the year		1,587	(258)	1	(1,300)	30
Transfers during the year		46	–	(159)	113	(0)
Closing equity balance 30 June 2026	**13**	**7,369**	**3,630**	**38**	**2,364**	**13,401**
Opening equity balance 1 July 2024		9,013	5,559	191	–	14,763
Total surplus / (deficit) for the year		274	(1,671)	5	–	(1,392)
Transfer during the year		206	–	–	(206)	–
Transfer to capital assets reserve		(3,757)	–	–	3,757	–
Closing equity balance 30 June 2025	**13**	**5,736**	**3,888**	**196**	**3,551**	**13,371**

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

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Statement of financial position

As at 30 June 2026

	Notes	2026 (000's)	2025 (000's)
Current assets			
Cash and cash equivalents		2,555	2,383
Short term investments		11,000	10,033
Prepayments		520	591
Receivables from exchange transactions	7	483	301
Receivables from non-exchange transactions	7	45	3
Total current assets		**14,603**	**13,311**
Non-current assets			
Intangible assets	8	1,301	1,574
Work in progress	9	–	555
Property, plant and equipment	10	1,063	1,422
Total non-current assets		**2,364**	**3,551**
Total assets		**16,967**	**16,862**
Current liabilities			
Payables	11	1,477	1,747
Employee entitlements	12	879	776
Revenue received in advance	17	1,111	881
Total current liabilities		**3,467**	**3,404**
Non-current liabilities			
Employee entitlements	12	99	87
Total non-current liabilities		**99**	**87**
Total liabilities		**3,566**	**3,491**
Net assets		**13,401**	**13,371**
Equity	13		
General reserves		7,369	5,736
Disciplinary reserves		3,630	3,888
Examination reserve		38	196
Capital asset reserve		2,364	3,551
Total Equity		**13,401**	**13,371**

Authorised for issue for and on behalf of the Council on 22 October 2026.
These financial statements should be read in conjunction with the notes to the financial statements.



Dr Kenneth Clark
Chair



Ming-chun Wu
Deputy Chair

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Statement of cash flows

For the year ended 30 June 2026

	2026 (000's)	2025 (000's)
Cash flows from operating activities		
Receipts		
Receipts from PC fees (non-exchange)	12,988	12,468
Receipts from disciplinary levies (non-exchange)	4,894	4,532
Receipts from other non-exchange transactions	371	341
Receipts from exchange transactions	7,729	7,159
Payments		
Payments to suppliers and employees	(25,255)	(24,163)
GST	107	53
Net cash flows from operating activities	**834**	**390**
Cash flows from/(to) investing activities		
Receipts		
Interest received	417	778
Redemption of investments	16,067	16,000
Payments		
Purchase of property, plant and equipment	(104)	(477)
Purchase of intangible assets	(8)	(843)
Investments in short term deposits	(17,034)	(15,033)
Net cash flows from/(to) investing activities	**(662)**	**425**
Net increase in cash and cash equivalents	**172**	**815**
Cash and cash equivalents at 1 July	2,383	1,568
Cash and cash equivalents at 30 June	**2,555**	**2,383**
Represented by:		
Bank accounts	2,555	2,383
Cash and cash equivalents	**2,555**	**2,383**

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

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Notes to the financial statements

For the year ended 30 June 2026

1. Reporting entity

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

These financial statements and the accompanying notes summarise the financial results of the activities carried out by the Council. To protect the health and safety of the New Zealand public, the Council provides mechanisms to ensure that medical practitioners are competent and fit to practise in their professions. The Council is a charitable organisation registered under the Charities Act 2005 (registration number CC35628).

These financial statements have been approved and were authorised for issue by the Council on 22 October 2026.

2. Statement of compliance

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

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

3. Summary of Accounting Policies

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

3.1 Basis of measurement

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

3.2 Functional, presentational currency and rounding

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

3.3 Revenue

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

Revenue from non-exchange transactions

Practicing certificate (PC) fees and disciplinary levies

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

Disciplinary recoveries

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

Once awarded by the HPDT, disciplinary recoveries are reflected in the accounts at the amount determined by the HPDT.

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Notes to the financial statements

For the year ended 30 June 2026

3.3 Revenue (continued)

Revenue from exchange transactions

Fees received

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

- New Zealand registration examination fees which are recognised when the examination is held.
- Vocational registration income is recognised at the time of invoicing, however a portion equivalent to 3 months (2025: 3 months) is assessed and held as payments in advance.

Interest income

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

Other income

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

3.4 Financial instruments

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

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

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

Financial assets

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

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

Receivables from exchange and non-exchange transactions

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

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

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

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Notes to the financial statements

For the year ended 30 June 2026

3.4 Financial instruments (continued)

Receivables from exchange and non-exchange transactions

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

Impairment of financial assets

During the year certain amounts were written off against the allowance for expected credit losses. Additionally, certain amounts were recovered from debtors previously considered doubtful. These movements have been appropriately reflected in the overall expected credit losses allowance. There were no other impairments of financial assets for the year.

Financial liabilities

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

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

3.5 Cash and cash equivalents

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

3.6 Short term investments

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

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

3.7 Property, plant and equipment

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

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

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

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

3.8 Intangible assets

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

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

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

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

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Notes to the financial statements

For the year ended 30 June 2026

3.8 Intangible assets (continued)

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

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

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

	Useful life	Amortisation rate	Remaining useful life (average)
Medsys (Practitioner registration database and workflows)	5 to 10 years	10%–20% p.a.	1.6 years
MyMCNZ (Practitioner & Council agent portal)	5 to 10 years	10%–20% p.a.	2.8 years
Document management system	5 years	20% p.a.	Fully amortised
Website (MCNZ)	5 years	20% p.a.	Fully amortised
Website (Torohia)	2.5 years	40% p.a.	1.5 years
Purchased software	10 years	10% p.a.	10 months

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Notes to the financial statements

For the year ended 30 June 2026

3.9 Leases

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

3.10 Work in progress

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

3.11 Employee entitlements

Short term employee entitlements

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

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

Long term employee entitlements

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

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

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

3.12 Provisions

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

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

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

3.13 Income tax

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

3.14 Goods and services tax (GST)

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

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

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

3.15 Equity

Equity is measured as the difference between total assets and total liabilities. Equity is the accumulation of reserves made up of the following components:

General reserves

General reserves are used to separate all funding and expenditure related to the operational activities for each profession group. General reserves are primarily funded from annual practising certificate fee revenue after each profession's share of Council costs has been provided for.

Disciplinary reserves

Disciplinary reserves are used to separate all funding and expenditure related to disciplinary matters known or anticipated in any one year. Disciplinary reserves are funded from disciplinary levy revenue for each profession group.

Examination reserve

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

Capital asset reserve

The capital asset reserve is represented by the net book value of fixed and intangible assets already purchased and liquid assets set aside for capital expenditure to meet future capital replacement requirements.

4. Significant accounting judgements, estimates and assumptions

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

Judgements

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

Estimates and assumptions

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

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

Accrued expenses

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

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2026

Useful lives and residual values

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

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

The estimated useful lives of the asset classes held by the Council are listed in Notes 3.7 and 3.8. The Council has not made any changes to past assumptions concerning useful lives.

Recoverability of receivables

The recoverability of receivables is a significant estimate. For information on how these are assessed refer to 3.4 above.

Long service leave

The measurement of long service lease was based on a number of assumptions. An assessment of eligible employees employed at 30 June 2026 was undertaken as to which employees would reach the long service criteria. 8 employees had entitlements and this is reflected as the current portion. The non-current portion reflects the assessment of the probability of employees earning long service leave in the future. Due to the number of employees affected and relatively low length of service, discount rates and salary inflation factors were not incorporated into the calculation.

Service performance information

Disclosure judgments related to the service performance information included under statement of service performance section. Refer to page 38.

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Notes to the financial statements

For the year ended 30 June 2026

5. Expenses

	2026 (000's)	2025 (000's)
Administration		
Administration	1,122	479
Amortisation of intangible assets	836	974
Communication	81	157
Depreciation of physical assets	464	363
Insurance	55	60
IT & systems	2,063	1,566
Premises	1,708	1,546
Staff general	1,083	780
Staff remuneration & contractors	9,794	10,311
Total administration expenses	**17,207**	**16,236**
Council and profession		
Council	777	935
Disciplinary and legal	232	165
Education committee	108	87
Education general	1,373	1,197
Health committee	95	87
Health general	203	200
Professional standards	548	601
Registration	1,884	1,650
Strategy	188	288
Total council and profession expenses	**5,407**	**5,210**
Disciplinary		
Administration	74	170
Disciplinary and legal	863	1,471
HPDT disciplinary	593	756
Staff general	22	14
Staff remuneration & contractors	1,893	1,716
Total disciplinary expenses	**3,445**	**4,127**
Examination		
NZREX Clinical	237	235
Staff remuneration & contractors	75	41
Total examination expenses	**312**	**276**

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Notes to the financial statements

For the year ended 30 June 2026

6. Auditor's remuneration

Baker Tilly Staples Rodway Audit Limited provide audit services to the Council on behalf of the Auditor-General. The total amount recognised for audit fees is $42k (2025: $41k). No non-audit services have been provided by the auditor.

7. Receivables

	2026 (000's)	2025 (000's)
Interest receivable – exchange	162	165
Receivables from exchange transactions	359	155
Provision for expected credit losses – exchange	(38)	(19)
Receivables from exchange transactions	**483**	**301**
Receivables from non-exchange transactions	146	116
Provision for expected credit losses – non-exchange	(101)	(113)
Receivables from non-exchange transactions	**45**	**3**
Total receivables	**528**	**304**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Notes to the financial statements

For the year ended 30 June 2026

8. Intangible assets

2026	Cost (000's)	Accumulated amortisation (000's)	Net book value (000's)
Medsys	8,110	(7,928)	182
MyMCNZ	5,458	(4,399)	1,059
Document management system	464	(464)	–
Website (MCNZ)	278	(278)	–
Website (Torohia)	99	(40)	59
Purchased software	30	(29)	1
Total	**14,438**	**(13,137)**	**1,301**
2025			
Medsys	8,110	(7,769)	341
MyMCNZ	4,994	(3,763)	1,231
Document management system	464	(464)	–
Website (MCNZ)	278	(278)	–
Website (Torohia)	–	–	–
Purchased software	30	(28)	2
Total	**13,876**	**(12,302)**	**1,574**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Notes to the financial statements

For the year ended 30 June 2026

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

2026	Opening balance (000's)	Additions (000's)	Disposals (000's)	Amortisation (000's)	Closing balance (000's)
Medsys	341	–	–	(159)	182
MyMCNZ	1,231	464	–	(636)	1,059
Document management system	–	–	–	–	–
Website (MCNZ)	–	–	–	–	–
Website (Torohia)	–	99	–	(40)	59
Purchased software	2	–	–	(1)	1
Total	**1,574**	**563**	**–**	(836)	**1,301**

9. Work in progress

	2026 (000's)	2025 (000's)
Developed Software–MyMCNZ	–	456
Website (Torohia)	–	99
Total work in progress	**–**	**555**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Notes to the financial statements

For the year ended 30 June 2026

10. Property, plant and equipment

2026	Computer hardware (000's)	Equipment, furniture and fittings (000's)	Office alterations (000's)	Total (000's)
Cost	1,945	1,243	2,547	5,735
Less: Accumulated depreciation and impairment	(1,599)	(1,047)	(2,027)	(4,672)
Net book value	**346**	**197**	**520**	**1,063**
2025				
Cost	1,848	1,236	2,547	5,631
Less: Accumulated depreciation and impairment	(1,405)	(959)	(1,845)	(4,209)
Net book value	**443**	**277**	**702**	**1,422**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Notes to the financial statements

For the year ended 30 June 2026

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

2026	Computer hardware (000's)	Equipment, furniture and fittings (000's)	Office alterations (000's)	Total (000's)
Opening balance	443	277	702	1,422
Additions	97	7	–	105
Disposals	–	–	–	–
Depreciation	(194)	(88)	(182)	(464)
Impairment	–	–	–	–
Closing balance	**346**	**197**	**520**	**1,063**

11. Payables

	2026 (000's)	2025 (000's)
Creditors	149	594
Accrued expenses	1,153	1,085
GST payable	175	68
	1,477	**1,747**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Notes to the financial statements

For the year ended 30 June 2026

12. Employee entitlements

	2026 (000's)	2025 (000's)
Current portion		
Accrued salaries and wages	232	184
Annual leave	613	558
Long service leave	34	34
Total current portion	**879**	**776**
Non-current portion		
Long service leave	99	87
Total non-current portion	**99**	**87**
Total employee entitlements	**978**	**863**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Notes to the financial statements

For the year ended 30 June 2026

13. Movement in equity

2026	Medical (000's)	Physician Associates (000's)	Total (000's)
General reserves – Profession			
Balance 1 July 2025	5,736	–	5,736
Surplus / (deficit) for the year	1,586	1	1,587
Transfers during the year	46	–	46
Closing equity	**7,368**	**1**	**7,369**
Disciplinary reserves – Profession			
Balance 1 July 2025	3,888	–	3,888
Surplus / (deficit) for the year	(258)	–	(258)
Closing equity	**3,630**	**–**	**3,630**
Examination reserve – Profession			
Balance 1 July 2025	196	–	196
Surplus / (deficit) for the year	1	–	1
Transfer during the year	(159)	–	(159)
Closing equity	**38**	**–**	**38**
Capital asset reserve – Council			
Balance 1 July 2025			3,551
Surplus / (deficit) for the year			(1,300)
Transfer from general reserve during the year			113
Closing equity			**2,364**
Total net assets attributable to the Council			**13,401**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Notes to the financial statements

For the year ended 30 June 2026

13. Movement in equity (continued)

2025	Medical (000's)	Physician Associates (000's)	Total (000's)
General reserves – Profession			
Balance 1 July 2024	9,013	–	9,013
Surplus / (deficit) for the year	274	–	274
Transfer to capital assets reserve	(3,757)	–	(3,757)
Transfer during the year	206	–	206
Closing equity	**5,736**	**–**	**5,736**
Disciplinary reserves – Profession			
Balance 1 July 2024	5,559	–	5,559
Surplus / (deficit) for the year	(1,671)	–	(1,671)
Closing equity	**3,888**	**–**	**3,888**
Examination reserve – Profession			
Balance 1 July 2024	191	–	191
Surplus / (deficit) for the year	5	–	5
Closing equity	**196**	**–**	**196**
Capital asset reserve – Council			
Balance 1 July 2024			–
Transfer from general reserve			3,757
Transfer from general reserve during the year			(206)
Closing equity			**3,551**
Total net assets attributable to the Council			**13,371**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Notes to the financial statements

For the year ended 30 June 2026

14. Categories of financial assets and liabilities

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

	2026 (000's)	2025 (000's)
Financial assets		
Cash and cash equivalents	2,555	2,383
Short term investments	11,000	10,033
Receivables from exchange transactions	483	301
Receivables from non-exchange transactions	45	3
Total financial assets	**14,083**	**12,720**
Financial liabilities		
Payables	1,302	1,679
Employee entitlements	879	776
Total financial liabilities	**2,182**	**2,455**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Notes to the financial statements

For the year ended 30 June 2026

15. Related party transactions

Fees paid to the Council members

The Council has related party transactions with respect to fees paid to Council members and with respect to Council members who pay practising certificate fees and disciplinary levies to the Council in their professional capacity as health practitioners.

Council members hold a range of responsibilities over and above their governance role as a Council member. Listed below, are the total fees earned by each Council member, including for the work they undertake as members or Chairs of Council's committees, accreditation panels, and expert advisory groups.

Fees paid to Council members

	2026 (000's)	2025 (000's)
M Bismark	41	46
K Clark *(Chair of Council from 4 June 2026 and Chair of Education Committee)*	79	81
S Child	46	46
A Cook*	–	–
A Goodman *(Chair of Health Committee until 17 February 2026)*	78	100
P Hale	–	1
C Hornabrook**	40	50
D Ivory**	56	65
M Kalupahana*	–	–
R Love *(Chair of Council until 1 June 2026)***	196	200
H Lutui	43	34
A Muthu	48	58
K Ngarimu	–	22
R Paterson *(Chair of Health Committee from 17 February 2026)*	58	54
D Sherwood*	–	–
S Watt *(Deputy Chair of Council & Chair of Audit & Risk Committee until 1 June 2026)***	58	80
M Wu *(Deputy Chair of Council & Chair of Audit & Risk Committee from 4 June 2026)*	42	35
Total fees paid to Council members	**785**	**872**
Full time equivalents basis (FTE)	2.3	2.7

Council member full time equivalents were calculated by dividing total claimed hours by 2,080 annual hours, being the average hours worked by a full-time employee.

* These members were appointed with effect from 1 June 2026, with the appointments subsequently gazetted on 21 July 2026.

** Term ended during the reporting period.

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Notes to the financial statements

For the year ended 30 June 2026

15. Related party transactions (continued)

Key management personnel

The key management personnel, as defined by PBE IPSAS 20 *Related Party Disclosures*, are Council members and the Executive Leadership Team (ELT), comprising the Chief Executive Officer, Deputy Chief Executive, Registrar, Deputy Registrar, Chief Financial Officer, Chief Adviser, Director – Regulatory Operations, Director – Strategy and Engagement, Health Manager and Kaitiaki Mana Māori.

During the year, an ELT reorganisation resulted in the Manager – Strategy and Policy role being retitled Director – Strategy and Engagement and the establishment of the new Director – Regulatory Operations role.

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

	2026 (000's)	2025 (000's)
Total key management personnel remuneration	**2,206**	**2,045**
Number of persons	10	10
Full time equivalents basis (FTE)	9.2	8.5

16. Capital and other commitments

During the reporting period, the Council renewed a contract with an IT vendor for the support and development of its information systems. The Council also has a separate contract for IT managed services. The total commitment under these contracts is $517k (2025: $922k) for the financial year ending 30 June 2027.

The Council has no other capital commitments at the reporting date (2025: None).

Non cancellable operating lease commitments

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

	2026 (000's)	2025 (000's)
Not later than 1 year	1,617	1,603
Later than 1 year no later than 5 years	1,378	2,921
Total minimum lease payments	**2,995**	**4,524**

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

17. Revenue in advance

	2026 (000's)	2025 (000's)
Physician Associates funding	354	527
Vocational registration income	563	346
NZ Rex clinical exam fees	193	8
Total revenue in advance	**1,111**	**881**

On 19 June 2025, the Council signed an agreement with Health New Zealand (HNZ) to provide funding to develop a regulatory framework for the Physician Associate profession. An initial payment was received in the prior year to cover onboarding costs, and the final instalment was received in May 2026 to support the implementation and initial operational phase.

At balance date, the unspent portion of the funding received is recorded as revenue in advance, reflecting the residual funds held to support implementation and operational activities in future periods.

18. Contingent assets and liabilities

There are no contingent assets at the reporting date. The Council is involved in several legal proceedings. Based on legal advice received, no damages exposure is expected in relation to these proceedings. If any of the proceedings result in an adverse outcome, the Council may be liable for other parties' legal costs. The estimated exposure to such legal costs is in the range of $40,000 to $80,000. The Council also holds insurance that limits its exposure to the costs of defending eligible claims. (2025: Council was involved in several legal proceedings. No damages exposure was expected and estimated legal costs ranged from $15,000 to $30,000.)

19. Subsequent events

Health Practitioners Competence Assurance Amendment Bill

On 19 May 2026, the Health Practitioners Competence Assurance Amendment Bill was introduced to Parliament. If enacted, the Bill may result in changes to the governance, reporting obligations, and operational arrangements of responsible authorities. As the Bill had not been enacted as at 30 June 2026, it has been treated as a non-adjusting subsequent event. The financial and operational impacts, if any, cannot be reliably estimated at this time.

Other than the matter noted above, no events have occurred subsequent to the reporting date that require adjustment to, or disclosure in, the financial statements.

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INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF THE MEDICAL COUNCIL OF NEW ZEALAND'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2026

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

Opinion

We have audited:

- the financial statements of the Council on pages 51 to 74 that comprise the statement of financial position as at 30 June 2026, the statement of comprehensive revenue and expenses, the statement of changes in net assets and the 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; and
- the performance information of the Council on pages 38 to 48.

In our opinion, the financial statements and performance information of the Council:

- present fairly, in all material respects:
  - its financial position as at 30 June 2026; and
  - its financial performance, cash flows and performance information 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 Reporting Standards Reduced Disclosure Regime (the applicable financial reporting framework).

Our audit was completed on 22 October 2026. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. We also outline the responsibilities of the Members of the Council and our responsibilities relating to the financial statements and performance information, comment on other information, and explain our independence.

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the 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.

Baker Tilly Staples Rodway Audit Limited, incorporating the audit practices of Christchurch, Hawkes Bay, Taranaki, Tauranga, Waikato and Wellington.

Baker Tilly Staples Rodway Audit Limited is a member of the global network of Baker Tilly International Limited, the members of which are separate and independent legal entities.

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

Responsibilities of the Members of the Council for the financial statements and performance information

The Members of the Council are responsible on behalf of the Council for preparing financial statements and performance information that are fairly presented and that comply with the applicable financial reporting framework.

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

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

The responsibilities of the Members of the Council arise from section 134 of the Health Practitioners Competence Assurance Act 2003.

Responsibilities of the Auditor

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

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

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

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

- We identify and assess the risks of material misstatement of the financial statements and performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Council's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Council.
- We evaluate the appropriateness of the reported performance information within the Council's performance reporting framework.
- 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 Council's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and performance information 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 Council to cease to continue as a going concern.
- We evaluate the overall presentation, structure and content of the financial statements and performance information, including the disclosures, and whether the financial statements and performance information represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Members of 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 responsibilities arise from the Public Audit Act 2001.

Other information

The Members of the Council are responsible for the other information, which comprises the information included in the annual report, together with any references or links to external websites and other online information. It excludes the financial statements and performance information, and our auditor's report thereon.

Our opinion on the financial statements and performance information does not extend to the other information, including any references or links to external websites and other online information. We do not express any audit opinion or assurance conclusion on that information.

In connection with our audit of the financial statements and performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and performance information or our knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the 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: *International Code of Ethics for Assurance Practitioners (including International Independence Standards) (New Zealand) (PES 1)* issued by the New Zealand Auditing and Assurance Standards Board.

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



Zirus Zuber
Baker Tilly Staples Rodway Audit Limited

On behalf of the Auditor-General
Wellington, New Zealand

Workforce data

He raraunga kaimahi

Table 1: Scopes of practice – summary of registration status
1 July to 30 June of the year

	2022	2023	2024	2025	2026
Provisional general – NZ graduates	667	648	621	592	577
Provisional general – IMGs	526	621	770	671	762
General	6,311	6,450	6,706	6,941	7,034
Provisional Vocational	199	199	199	195	249
Vocational	11,000	11,323	11,585	11,974	12,278
Special Purpose	70	104	130	157	197
Total practising	**18,773**	**19,345**	**20,011**	**20,530**	**21,097**
Suspended	9	9	10	11	8

Table 2: Registration activities
1 July to 30 June of the year

	2022	2023	2024	2025	2026
Provisional general/vocational registrations					
Aotearoa New Zealand graduates (interns)	566	547	528	536	524
Australian graduates (interns)	3	1	1	1	1
Passed approved examination	38	61	55	46	112
Australian General Registrant	8	3	3	3	3
Graduate of a competent authority accredited medical school	402	500	636	540	480
United Kingdom General Registrant	–	–	5	6	17
Worked in comparable health system	182	177	204	206	260
Non-approved postgraduate qualification – vocational assessment	125	125	127	128	123
Non-approved postgraduate qualification – vocational eligible	92	92	61	78	117
Special purpose scope registrations					
Visiting Expert	2	11	18	37	13
Research	2	1	1	3	2
Postgraduate training or experience	15	34	53	59	71
Locum Tenens in specialist post	63	100	99	107	95
Emergency or other unpredictable short-term situation	–	–	–	–	–
Pandemic	23	–	–	–	–
Teleradiology	5	14	26	31	36
General scope registrations, after completion of supervised period					
Australian General Registrant	2	5	3	1	2
United Kingdom General Registrant	–	–	–	1	6
Aotearoa New Zealand / Australian graduates (interns)	502	566	558	545	529
Passed approved examination	26	29	64	53	44
Graduate of a competent authority accredited medical school	244	311	379	447	364
Worked in comparable health system	62	85	88	109	99

	2022	2023	2024	2025	2026
Vocational scope registrations, after completion of supervised period					
Non-approved postgraduate qualification – vocational assessment	66	67	92	115	95
Non-approved postgraduate qualification – vocational eligible	92	77	54	64	69
General scope registrations					
Aotearoa New Zealand graduates	6	6	1	3	4
Overseas graduates	83	81	79	73	63
Restorations	8	3	6	28	63
Vocational scope registrations					
Approved postgraduate qualification (VOC1)	465	567	541	566	587
Approved postgraduate qualification (VOC2)	111	56	54	59	67
Suspensions of registration					
Suspension or interim suspension	7	7	8	5	3
Revocation of suspension	7	4	5	3	2
Numbers of doctors who had conditions imposed on scope of practice					
Imposed	124	122	141	190	182
Revoked	79	53	69	54	51
Cancellations under the HPCAA					
Death – s 143	43	41	45	30	23
Discipline order – s 101(1)(a)	3	2	4	–	2
False, misleading, or not entitled – s 146	–	–	1	1	–
Revision of register – s 144(5)	2	4	4,488	5,408	1,608
At own request – s 142	148	132	269	233	160

Table 3: Doctors registered in vocational scopes of practice
1 July to 30 June of the year*

Vocational scope	2022	2023	2024	2025	2026
Anaesthesia	945	972	993	1,033	1,073
Cardiothoracic surgery	34	36	37	38	39
Clinical genetics	18	18	20	20	22
Dermatology	77	78	80	88	91
Diagnostic & interventional radiology	714	740	765	800	805
Emergency medicine	408	436	454	480	506
Family planning & reproductive health	30	29	28	27	26
General practice	3,848	3,914	3,978	4,081	4,144
General surgery	318	330	348	354	375
Intensive care medicine	116	117	126	133	142
Internal medicine	1,333	1,404	1,462	1,515	1,565
Medical administration	29	32	29	27	25
Musculoskeletal medicine	28	26	29	30	30
Neurosurgery	24	23	26	25	26
Obstetrics & gynaecology	352	358	363	370	375
Occupational medicine	64	65	62	62	61
Ophthalmology	165	176	181	188	195
Oral & maxillofacial surgery	33	36	37	39	41
Orthopaedic surgery	322	329	344	362	361
Otolaryngology head & neck surgery	129	132	133	133	136
Paediatric surgery	24	24	22	24	25
Paediatrics	445	468	479	484	503
Pain medicine	39	36	39	41	41
Palliative medicine	79	77	79	75	80
Pathology	342	343	344	357	366
Plastic & reconstructive surgery	81	83	82	83	86
Psychiatry	689	709	711	735	750
Public health medicine	186	191	195	200	198
Radiation oncology	72	71	73	75	79
Rehabilitation medicine	28	29	29	31	32
Rural hospital medicine	143	147	151	159	167
Sexual health medicine	21	20	21	21	22
Sport and exercise medicine	37	41	42	43	48
Urgent care	286	296	310	335	361
Urology	72	79	82	84	83
Vascular surgery	33	36	34	38	43
Total (all doctors with vocational scope)	**11,000**	**11,323**	**11,585**	**11,974***	**12,278**

*Doctors holding a current practising certificate

*Doctors may hold vocational registration in more than one scope of practice. There are 11,974 practising doctors holding 12,590 vocational scopes of practice. 574 doctors hold 2 vocational scopes of practice, and 21 doctors hold 3 vocational scopes of practice.

Table 4: Outcomes of applications for vocational registration assessments
1 July to 30 June of the year

	Incomplete applications	Withdrawn / lapsed	Supervision pathway	Assessment pathway	NZREX	Other	Total
Anaesthesia	9	3	0	6	2	1	**21**
Cardiothoracic surgery	1	1	0	0	0	0	**2**
Dermatology	0	0	1	3	0	0	**4**
Diagnostic & interventional radiology	6	4	1	4	2	2	**19**
Emergency medicine	7	3	8	3	0	0	**21**
General practice	6	1	3	3	1	0	**14**
General surgery	7	1	0	0	5	0	**13**
Intensive care medicine	4	1	0	1	1	0	**7**
Internal medicine	13	5	3	22	2	0	**45**
Neurosurgery	0	1	0	0	1	0	**2**
Obstetrics & gynaecology	7	1	4	4	0	0	**16**
Occupational Medicine	1	0	0	1	0	0	**2**
Ophthalmology	5	2	0	3	3	1	**14**
Oral & maxillofacial surgery	1	0	2	1	0	0	**4**
Orthopaedic surgery	4	3	0	0	4	1	**12**
Otolaryngology head & neck surgery	3	1	0	2	0	0	**6**
Paediatric surgery	0	0	0	1	1	0	**2**
Paediatrics	6	5	2	1	1	0	**15**
Palliative medicine	1	0	1	0	0	0	**2**
Pathology	2	3	2	3	0	0	**10**
Plastic & reconstructive surgery	2	0	0	1	1	1	**5**
Psychiatry	12	5	4	12	0	1	**34**
Public health medicine	0	1	0	0	0	0	**1**
Radiation oncology	0	0	0	2	0	0	**2**
Rehabilitation medicine	0	1	0	1	0	0	**2**
Sport and exercise medicine	0	0	0	2	0	0	**2**
Urology	0	0	1	0	1	0	**2**
Vascular surgery	0	0	0	0	1	1	**2**
Total	**97**	**42**	**32**	**76**	**26**	**8**	**281**

Table 5: Doctors on the Aotearoa New Zealand medical register, by country of primary qualification
1 July to 30 June of the year

	2022	2023	2024	2025	2026
Aotearoa New Zealand	10,865	11,143	11,355	11,608	11,868
England	2,324	2,433	2,623	2,673	2,658
Australia	800	808	805	829	835
South Africa	776	782	789	804	806
Scotland	631	625	645	670	661
India	533	544	559	571	590
United States of America	470	483	528	531	636
Ireland	308	322	387	404	407
Germany	189	205	207	209	217
Wales	141	144	162	167	163
Netherlands	132	145	149	151	155
Sri Lanka	120	122	121	126	144
Pakistan	97	114	115	125	133
Iraq	107	107	107	106	106
China	83	86	91	89	105
Fiji	64	73	81	85	84
Canada	79	86	85	81	77
Northern Ireland	61	60	65	77	68
Philippines	53	56	62	68	75
Russia	55	57	62	67	71
Israel	29	39	52	60	73
Egypt	53	51	48	51	53
Bangladesh	44	44	49	51	54
Belgium	36	39	43	43	53
Poland	39	40	42	41	41
Spain	33	34	35	37	41
Singapore	35	42	41	36	41
France	23	30	30	35	37
Zimbabwe	34	32	34	34	35
Malaysia	26	27	27	32	47
Italy	27	25	30	31	31
Romania	26	27	31	31	33
Hungary	21	26	29	30	33
Sweden	18	23	22	27	37
Czech Republic	24	23	26	26	31
Nigeria	17	19	21	24	25
Ukraine	17	19	20	23	30
Brazil	16	20	19	21	26
Serbia	19	22	19	20	22
Myanmar	17	17	20	20	23
Hong Kong	12	14	16	20	20
Iran	15	17	16	18	20
Denmark	8	10	11	18	19
Grenada	9	11	12	17	15
Sudan	14	12	12	16	19
Argentina	13	13	15	15	17
Other	259	273	292	311	362
Total	**18,772**	**19,344**	**20,010**	**20,529**	**21,097**

Table 6: Registration granted, by country of primary qualification
1 July to 30 June of the year

	2021–22	2022–23	2023–24	2024–25	2025–26
Aotearoa New Zealand	582	559	535	558	562
England	270	354	439	386	366
USA	94	137	170	142	220
Australia	165	122	123	135	119
Scotland	83	87	78	80	78
Ireland	46	54	97	62	66
India	37	36	39	45	57
South Africa	42	45	46	44	45
Netherlands	27	25	25	26	35
Wales	32	24	39	44	25
Sri Lanka	7	12	6	16	25
Belgium	11	11	13	13	23
Canada	19	17	20	18	21
Pakistan	7	21	10	18	19
Germany	14	18	13	16	18
Fiji	7	10	13	15	18
China	6	6	11	4	18
Malaysia	4	4	4	7	18
Israel	7	10	15	11	14
Sweden	3	13	4	13	11
Other	115	128	153	174	211
Grand Total	**1,578**	**1,693**	**1,853**	**1,827**	**1,969**


Te Kaunihera Rata
o Aotearoa
Medical Council
of New Zealand