2021 ANNUAL REPORT

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Whakahaumaru i te iwi whānui, whakatuarā te kounga o te tikanga rata.

We protect the public, and promote good medical practice.

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Introduction

Te Kaunihera Rata o Aotearoa (The Medical Council of New Zealand), is pleased to submit this report, for the year ending 30 June 2021, to the Minister of Health. The report is presented in accordance with section 134 of the Health Practitioners Competence Assurance Act 2003.

Facts at a glance

(1 July 2020 to 30 June 2021)

Doctors newly registered

537

Trained in New Zealand

851

International medical graduates

18,250

Total practising doctors at 30 June 2021

708

Doctors newly registered with vocational scopes

> **We protect the public by ensuring doctors are competent and fit to practise.**

89

Candidates sat NZREX Clinical

58

Candidates passed NZREX Clinical

34

Referrals to a Professional Conduct Committee

17

Referrals to a Performance Assessment Committee

6

Education programmes ordered after a performance assessment

62

Referrals to the Health Committee

About
Te Kaunihera Rata o Aotearoa

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

Our functions

Registering doctors and maintaining the register of New Zealand doctors.

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 within the scope of their registration.

Setting programmes to ensure continuous learning for doctors so their skills are up to date.

Accrediting and monitoring medical education and training programmes for doctors.

Acting on notifications relating to concerns about a doctor's performance, professional conduct, or health.

Promoting and facilitating inter-disciplinary collaboration and cooperation in the delivery of health services.

Chair's foreword

Tuia mai i runga,
Tuia mai i raro.
Tuia mai i roto,
Tuia mai i waho.
Kia tau ki a tātou katoa
Te mauri tu me te mauri ora!
Haumi e, hui e,
Taiki e!

Fasten everything above,
Secure everything below.
Connect everything within,
Bind everything without.
Anchor and connect
The force of life within us all!
Draw it together, gather it,
Let it be so!

After a second extraordinary year of the COVID-19 pandemic, I would like to first recognise the many challenges and difficulties this has presented to the medical profession and our country at large. The pandemic's ongoing effects have affected our mahi as a regulator, with staff working from home and many Council meetings and activities held via teleconferencing.

Border restrictions, lockdowns and alert levels have affected the registration of doctors seeking to move to New Zealand, as well as placing additional stressors on the day-to-day healthcare which doctors are able to provide in hospitals and communities. In addition, there have been public concerns about COVID-19 misinformation from registered medical practitioners.

Through all of these challenges I have been enormously thankful for the medical profession's role in providing expert advice to inform our national pandemic response, and the many thousands of doctors delivering vaccinations to communities up and down the country. This is in addition to continuing to deliver all of the usual healthcare needs to New Zealanders through a combination of hard work, dedication and innovation.

As a Council, we remain committed to operating efficiently and effectively at all times. We have delivered a positive budget result which re-establishes Council's financial security and sustainability, all with a minimal CPI. The only increase is in the annual practising certificate (APC) fee.

The registration team has seen record numbers of doctors with an APC (18,250 as of June 30), and interest from doctors overseas seeking to be registered in Aotearoa New Zealand remains strong. There were 851 doctors newly registered from overseas in comparison to 537 newly registered who have trained in New Zealand. Council's staff have worked incredibly hard to deliver these results.

At a governance level, all four sitting Council members were returned and reappointed by Health Minister Hon Andrew Little following the February election. This was welcome continuity, given the other global uncertainties, with invaluable experience retained on Council. Equally, the expertise of the lay

Council members and appointed medical members continue to serve the public well as we regulate a medical profession that all New Zealanders can trust.

We farewelled long-serving Council member Professor John Nacey this year who served as Chair of Council's Education Committee. Ngā mihi maioha ki a koe nā tōu mahi nunui, e hoa.

It continues to be a privilege to serve on the Medical Council, and especially so as its Chair. Guiding Council's deliberations on cases, and setting a refreshed strategic direction have been highlights this year.

We have affirmed key Council values of kotahitanga (teamwork), manaakitanga (support for each other), whakapono (integrity), whakamārama (transparency) and kaitiakitanga (to protect), and apply a "right touch, human touch" approach to all we do.

Our expectations for culturally safe medical practice and health equity, delivered under the principles of Te Tiriti o Waitangi, will continue into 2022. We will continue to work with other national and international health practitioner regulators to ensure innovative, interdisciplinary care is well regulated as part of the health system reforms.

On behalf of Te Kaunihera Rata and my fellow Council members, I thank you all for the opportunity to contribute to a safe, trusted health system through excellence in medical practice.

Noho ora mai

Dr Curtis Walker
Chair
Medical Council of New Zealand

Chief Executive's foreword

Tēnā koutou katoa

Public safety has continued to be our primary focus throughout the past year – a year of unprecedented challenge and change for all health professions and regulators of those professions. Our agility and responsiveness have been paramount in meeting our responsibilities during this time. We have worked with the medical profession and across a wide range of health sector agencies and stakeholders to support and promote good medical practice and ensure doctors are competent and fit to practise. It is the relationships we have with our colleagues across the health sector that have enabled us to work together to achieve the greater good.

COVID-19

COVID-19 has provided challenges that none of us would have ever anticipated. I would like to recognise the thousands of medical professionals who have worked incredibly hard, at both patient and system level, to keep us safe and well over this turbulent time.

As an organisation, we continued to be impacted by COVID-19 over the course of the year. As part of Council's COVID-19 response, we published joint guidance with the Dental Council on the COVID-19 vaccination and professional responsibilities for doctors and dentists. In liaison with the Director-General of Health, we extended our pandemic special purpose scope of practice to allow doctors who were no longer on the register to gain registration quickly. We also provided further clarification around the delivery of telehealth to ensure safe and effective care for patients. Additional flexibility was also provided to enable interns to support the COVID-19 response.

The pandemic has impacted medical regulation in a number of ways, including an unprecedented increase in notifications about ethical conduct. The registration of international medical graduates (IMGs) has also been affected.

Registration of international medical graduates

We saw a change to the usual flow and registration of IMGs compared to historical trends, with a slight drop in some pathways to registration and a steep increase in the number of IMGs applying for vocational (specialist) registration. An increase from around 250 in 2018 to around 430 in the year ending 30 June 2021.

In response, we reviewed and streamlined aspects of the application process for IMGs seeking vocational registration. These challenges highlighted our heavy reliance on IMGs in our medical workforce.

We responded with agility, putting in place a range of policy changes to support workforce needs. This included an agreement to extend scopes of practice for those with vocational registration in rural hospital medicine, or general practice who have demonstrated the required competencies to allow them to provide obstetrics services. We have also worked closely with the Royal New Zealand College of General Practitioners in considering policy changes to the comparable health system pathway that balance the easing of some requirements and public safety.

Despite the change in flow of IMGs, there has been a steady increase in doctors holding a current practising certificate through the COVID-19 period for both New Zealand trained doctors and international medical graduates. There were 18,250 doctors holding current practising certificates at 30 June 2021 compared to 17,671 the year before.

Te Tiriti o Waitangi

We are developing a Te Tiriti o Waitangi framework and will soon be appointing a Kaitiaki Mana Māori to support us in this. In partnership with Te Ohu Rata O Aotearoa, we were very pleased to publish the independent Cultural Safety Baseline Data report (October 2020). Based on the experiences of Māori, the report includes findings of the current state of cultural safety and health equity delivered by doctors in Aotearoa New Zealand, and experienced by patients and whānau. The report offers an insight into current practice, that we can all learn from. Not only does it provide essential baseline data for future evaluation, but it also it contains useful information for us as an organisation, for the profession, and for all those working in the health sector as we strive towards health equity.

Our team

We could never have predicted the impact of COVID-19 on us as an organisation. I am very proud of our highly skilled and experienced team at Te Kaunihera Rata o Aotearoa Medical Council of New Zealand, who have demonstrated outstanding commitment and resilience in responding to changing priorities and an unexpected increased workload. They have worked tirelessly with a key focus on public safety.

I would like to express thanks to all staff and to our Chair, Dr Curtis Walker, Deputy Chair, Susan Hughes and Council members for going above and beyond in their support to me and commitment to our work. I would like to particularly acknowledge the extraordinary contribution of Professor John Nacey, whose term on Council finished in August 2020. As well as serving on Council for 9 years, John was also the Chair of Council's Education Committee and made an outstanding contribution to medical education during this time.

We enter a new year with many unknowns still in front of us. However, we can be confident that our principled approach to medical regulation will support us to be best prepared over the next year for the changing landscape of COVID-19 and the important health sector reforms.

Ngā manaakitanga

Joan Simeon
Chief Executive
Medical Council of New Zealand

Our key achievements 2020/2021

Everyone should receive a high standard of medical care and professionalism when visiting a doctor in Aotearoa New Zealand. We're here to protect public safety by ensuring doctors are competent and fit to do their jobs. We promote good medical practice, which reflects the needs and expectations of our communities.

Accountability to the public and stakeholders

We engage with the public and stakeholders to raise awareness of Council's role and functions, obtain valuable feedback into our strategy, policy and business development and improve how we perform our functions.

Key achievements:

- We have embedded the principles of 'right touch regulation' in everything we do – we are proportionate, consistent, targeted, transparent, accountable and agile. These principles guide all Council's decisions across our strategic, policy and operational functions.
- We have gathered valuable input from our Consumer Advisory Group that has informed our refreshed strategy as well as the standards we set for the medical profession. This relationship is based on mutual trust and respect.
- We refreshed and reviewed how we communicate with the profession and the public. Publicly accessible information for our audiences was updated. Council has a website that is user-friendly and easy to access with audience-targeted content.
- We worked closely with the Ministry of Health, Health and Disability Commissioner, District Health Boards, medical training providers and other Responsible Authorities as we implemented our stakeholder engagement and communication plan. We worked collaboratively across all key stakeholders, the profession, and the public. This has contributed to us carrying out our responsibilities effectively.
- We revised our Memorandum of Understanding with a number of stake-holders, DHB's Colleges and medical schools, defining our relationship and how we work together to protect public health and safety. This included the information we will share together.
- We have worked collaboratively with other Responsible Authorities to ensure a consistent approach to the regulation of all practitioners and to ensure best practice for clinical, cultural and ethical standards for all professions.
- We increased engagement in our e-newsletter, MCNZ news, which is our main channel for communicating with the medical profession. The e-newsletter has been refreshed and content is more aligned to our audience insights.

Cultural safety, partnership and health equity

We contribute to an improvement in health equity and public health outcomes, through Council's role as the medical regulator responsible for setting professional standards.

Key achievements:

- With our partners Te Ohu Rata o Aotearoa (Te ORA), we published the independent Cultural Safety Baseline Data report (October 2020). Based on the experiences of Māori, the report includes findings of the current state of cultural safety and health equity delivered by doctors in Aotearoa New Zealand and experienced by patients and whānau.

- We strengthened the accreditation standards related to cultural safety and health equity for providers of vocational medical training and recertification programmes.

- We developed a strengthened support framework for Māori medical graduates as they transition into an internship in the District Health Board environment, with the input of an expert advisory group.

- We hosted a hui for all Responsible Authorities focused on how our role as regulators of health professions can embed into the principles of Te Tiriti o Waitangi in all the work we do.

- We reviewed our processes for performance assessments and professional conduct committees to ensure that they met our commitment to the principles of Te Tiriti o Waitangi.

- We strengthened the accreditation standards related to cultural safety and health equity for providers of prevocational medical training programmes.

- We have reflected the expected standards related to cultural safety in statements and standards for the profession.

- Te Tiriti o Waitangi is reflected in our refreshed strategy and a Te Tiriti framework is under development, to guide Council in honouring its responsibilities under Te Tiriti.

- We have established a new Kaitiaki Mana Māori role to support Council's commitment to Te Tiriti o Waitangi.

Promoting competence

We provide leadership to the profession and work collaboratively and constructively with key stakeholders, including colleges, DHBs, primary health organisations, and the Ministry of Health using preventative regulation to continually improve the current high quality of medical practice in New Zealand.

Key achievements:

- We published joint guidance with the Dental Council about the COVID-19 vaccination and professional responsibilities for doctors and dentists.

- We reviewed and published five of our statements during the year, setting standards for the profession that address: Unprofessional behaviour; Telehealth; Ending a doctor-patient relationship; Managing patient records; and A doctor's duty to help in a medical emergency.

- We extended our pandemic special purpose scope of practice to allow doctors who were no longer on the register to gain registration quickly, to support the COVID-19 response.

- We provided further clarification about the expectations around the delivery of telehealth to ensure safe and effective care for patients.

- We provided flexibility to allow interns to work in broader settings to best support the COVID-19 response.
- We established an online platform to collect supervision reports for IMGs new to Aotearoa New Zealand, to ensure they are supported safely into practice here.
- We established an online platform to collect supervision reports for IMGs new to Aotearoa New Zealand, to ensure they are supported safely into practice here.
- A 'Welcome to practice' workshop has been developed to support IMGs new to working in Aotearoa New Zealand, for creating greater understanding of Council's standards and statements.
- We provided training for all performance assessment and professional conduct committee members to ensure consistency and effectiveness of Council's assessment and investigation processes.

Medical education

We ensure a quality educational experience for medical students, doctors in prevocational medical training and vocational trainees, and protect the health and safety of the public by ensuring all doctors are competent and fit to practise across the training continuum.

Key achievements:

- We further embedded community-based attachments (CBAs) in the prevocational medical training programme to ensure that each intern will complete one clinical attachment in a community setting over the course of their two-year internship.
- One year post-implementation, we reviewed the use of multisource feedback (MSF) as a tool to inform intern learning and development.
- We provided training for all prevocational educational supervisors, who provide over sight to interns over the course of each intern's postgraduate first and second years.
- We completed four prevocational medical training provider accreditation assessments to ensure interns are receiving a high quality of training and education (Hutt Valley, Capital and Coast, MidCentral and Tairawhiti District Health Boards).
- We implemented the final phase of a new intern learning model for the prevocational medical training programme, embedding a reflective model of learning activities to guide intern learning.
- We completed accreditation assessments of two New Zealand-only vocational medical training providers and participated in one Australasian medical college accreditation, to ensure that high quality training is being delivered.

Research and evidence-based regulation

Our strategic and policy decisions are supported by valid and reliable evidence, utilising evaluation outcome data where possible, with the publics interest and public health and safety at the center.

Key achievements:

- We have used our data to inform all of our work, including strategic, policy and operational (for example anonymised

collated ePort data to inform accreditation assessments, collated performance assessment and professional conduct data to inform training of panels and accreditation data to inform training providers).

- We have established evaluation frameworks and baselines to ensure new initiatives are appropriately assessed for efficacy over time. This will ensure a robust evaluation and business improvement process is embedded in our work programmes (for example MSF for intern training).

- We have collected workforce data on behalf of the Ministry of Health and shared data for health sector and workforce development.

- We have maintained close strategic alignment with international regulatory colleagues, and ensured that international regulatory best practice informs all of our strategic, policy and operational work. We are represented on the International Association of Medical Regulatory Authorities (IAMRA); the CEO is on the Board and members of Council's Executive Leadership team sit on IAMRA Committees.

What guides and aligns us

Our values

Whakapono

We act with integrity

Honesty and transparency are at the heart of everything we do.

Kotahitanga

We are a team

Great things happen when we are unified.

Whakamārama

We lead by listening

Always learning, forever innovating.

Manaakitanga

We support each other

Our environment is inclusive, diverse and respectful.

Kaitiakitanga

We protect the public

This is our primary purpose and the touchstone for all decision-making.

2021 - 2025

Our strategy at a glance

Tā Mātou Matakite | Our Vision

He mahi rata e whakawhirinakitia e tātou

A medical profession all New Zealanders can trust.

Tā Mātou Kaupapa | Our Purpose

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

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.

- **Accountability**
  Demonstrate accountability to the public, the profession, and stakeholders.
- **Equity**
  Promote equity of health outcomes.
- **Right-touch regulation**
  Demonstrate proactive, right-touch regulation in all we do.
- **Innovation and improvement**
  Use data to inform innovation and improvement.
- **Capablity and culture**
  Invest in organisational capability and culture.

Our values will guide and align us.

Kotahitanga	-	**We are a team**
Manaakitanga	-	**We support each other**
Whakapono	-	**We act with integrity**
Whakamārama	-	**We lead by listening**
Kaitiakitanga	-	**We protect the public**

Our Council Members - 30 June 2021

Council governance is made up of 12 members, including eight doctors and five non-health professionals.

Back row from left to right:

Dr Pamela Hale, Dr Lu'isa Fonua-Faeamani, Dr Stephen Child, Dr Charles Hornabrook, Dr Kenneth Clark, Mr David Dunbar (Registrar), Dr Ainsley Goodman, Dr Rachelle Love, Ms Giselle McLachlan.

Front row from left to right:

Ms Kim Ngārimu, Mr Richard Aston, Ms Susan Hughes QC (Deputy), Dr Curtis Walker (Chair), Ms Joan Simeon (Chief Executive), Ms Kath Fox.

How we make decisions

Right touch regulation

We protect the health and safety of the public by ensuring doctors working in Aotearoa New Zealand are competent and fit to practise.

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

- **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.

Audit and Risk Committee

The Audit and Risk Committee (the Committee) is a standing committee of Council that assists in assuring financial accountability and risk management.

The Committee consists of four members of Council and one external member with audit and accounting experience.

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

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

As part of the annual work plan, the Committee met four times during 2020/2021 and considered a number of issues including the following:

- Budget and reserves management strategy; consideration of the 2020/2021 annual budget and fees review; and recommending this to Council for final approval.

This annual budget was particularly challenging because of the need to prioritise financial sustainability while being mindful of the impact to the profession and stakeholders in these unprecedented and challenging times.

The Council remains committed to operating in a cost-effective manner. In preparing the budget fresh consideration was given to how we work. Several cost saving initiatives were identified and adopted following a line-by-line budget review and consideration of governance matters.

Risk management

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

- Continuing to take an active role in seeking to be informed about health and safety issues. It was pleasing to see the organisation adapt seamlessly to remote working through COVID-19.

- Continuing to prioritise our privacy programme. We have made significant progress towards driving a culture of privacy awareness and achieving our privacy maturity goals as an organisation.

- Initiating a refresh of our financial policy statements and having these independently reviewed to ensure they remain fit for purpose.

Insurance matter

In October 2019, the Council settled the business interruption insurance claim lodged in the previous financial year. Insurance proceeds of $529k (excluding GST) were received for additional costs incurred as a result of the displacement and disruption following the Kaikōura earthquake.

Annual financial statements

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

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

Ms Susan Hughes QC
Chair
Audit and Risk Committee

Education Committee

The Education Committee is a standing Committee of the Medical Council of New Zealand. Its primary role is to accredit and monitor medical educational providers. This ensures students and doctors are receiving high quality education and training across the education continuum of medical school, and then prevocational and vocational training.

Much of our work over the past year has been focused on introducing strengthened accreditation standards for vocational training and recertification providers.

These standards reflect the work that Council has done to strengthen recertification programmes to ensure doctors are maintaining and continuing to improve their standard of medical practice. A focus on cultural safety and health equity is now embedded across these accreditation standards.

Accreditation and ongoing monitoring of medical training providers

Under the HPCAA, we are required to promote medical education and training in New Zealand. This includes accrediting and monitoring the medical schools, DHBs and medical colleges that deliver education and training to medical students and doctors at all stages of a medical career.

Prevocational medical training

We accredit the 19 DHBs that provide education and training to postgraduate year 1 and 2 (PGY1 and PGY2) interns against Council's standards.

The following training providers have been assessed by one of our appointed accreditation teams:

- Southern DHB
- Hutt Valley DHB
- Mid Central DHB
- Capital and Coast DHB
- Tairāwhiti DHB

Vocational medical training and recertification programmes

We assessed the following training providers against our revised and strengthened accreditation standards.

Our accreditation process and standards now more closely align with those of the Australian Medical Council:

- The New Zealand Association of Musculoskeletal Medicine
- Royal New Zealand College of Urgent Care

We participated in the follow-up accreditation assessments of two Australasian colleges. These assessments were led by the Australian Medical Council:

- The Royal Australasian College of Surgeons
- The Australasian College of Emergency Medicine

Australian and New Zealand Prevocational Medical Education Forum (ANZPMEF)

I wish to recognise the previous Chair of the Education Committee, Professor John Nacey who retired as Chair in November 2020. In his nine years as Chair, Professor Nacey made an outstanding contribution to undergraduate, prevocational and vocational medical education in New Zealand. I most sincerely thank Professor Nacey for his dedication and commitment to this critical area of Council's work.

Dr Kenneth Clark
Chair
Education Committee

Health Committee

The Health Committee (the Committee) acts on behalf of Council by reviewing all notifications about a doctor's health that may affect their ability to safely practise medicine. It is comprised of five members of Council. Currently these are two lay members, and three doctors – a specialist physician, a general practitioner and a psychiatrist. We have meetings approximately monthly.

Most doctors do not require any oversight by the Committee – they manage their health appropriately by taking time off work when they cannot function safely.

In the year ending 30 June 2021, we received 62 new referrals – see tables 17 and 18. We also reviewed 239 disclosures doctors made about their health on their registration and practising certificate applications.

We receive referrals/notifications, either from the doctor themselves, or others such as a worried colleague. Our role is to decide whether the health condition could adversely affect their work and whether any protective measures are required.

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

We are ably supported by a team in the office. They perform their work with sensitivity, compassion and professionalism. The work can be stressful especially when dealing with vulnerable and distressed doctors. The team liaises directly with the doctors, organising assessments, coordinating treatment and any work supervision needed. They may need to arrange drug and alcohol screening, respond to any concerns or health crises, and keep us informed.

We carefully balance any risks to patient safety with compassionate management of the doctor, encouraging and facilitating treatment of their health condition. It is unusual that a doctor may be required to stop work until their health improves.

We ask some doctors to have assessments. These could be with psychiatrists, occupational physicians, neuropsychologists, or other specialists. They report on whether the doctor is safe to work independently or requires supportive measures to enable safe practice. We are very grateful for the quality of these assessments and the professionalism of our regular assessors.

2021 has been a challenging year with only a few meetings being held face-to-face. The rest have occurred by means of video conferencing, which makes meeting the doctors somewhat inopportune when trying to establish a trustworthy relationship.

Dr Pamela Hale
Chair
Health Committee

Registration Committee

Dr Curtis Walker (Chair), Susan Hughes QC, Dr Charles Hornabrook.

The Registration Committee (the Committee) was established in November 2019.

Its role was to consider applications for registration from medical students identified by medical schools' Fitness to Practise Committees as having missed several weeks of elective practice.

The Committee met once in April 2021, for one registration application during this reporting period.

Dr Curtis Walker
Chair
Registration Committee

Registration of doctors and practising certificates

Principal activities

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

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

We provide confirmation of eligibility for doctors seeking registration in the General and Special Purpose scopes of practice within 20 working days of receiving a completed application. For registration within a Vocational scope of practice, we must first consult with the relevant vocational education and advisory body. This means it takes, on average, 4 to 6 months to confirm a doctor's eligibility.

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

	2017	2018	2019	2020	2021
Provisional general	3,598	3,804	3,905	3,960	3,951
General	8,562	9,052	9,713	10,256	10,456
Provisional vocational	265	256	260	236	302
Vocational	11,549	12,077	12,534	13,093	13,593
Special purpose	218	226	241	287	286
Total on register	**24,192**	**25,415**	**26,653**	**27,832**	**28,588**
Total practising	15,744	16,343	16,925	17,671	18,250
Suspended	13	12	10	12	12

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

Table 2: Registration activities (1 July to 30 June of the year)					
	2017	**2018**	**2019**	**2020**	**2021**
Provisional general/vocational registrations					
New Zealand graduates (interns)	474	466	507	521	527
Australian graduates (interns)	6	13	4	1	2
Passed NZREX Clinical (interns)	15	43	26	30	18
Australian general registrants	-	-	2	8	4
Graduate of competent authority accredited medical school	490	460	527	493	325
Worked in comparable health system	185	199	186	150	160
New Zealand and international medical graduates reregistration (following cancellation)	-	-	-	-	-
Non-approved postgraduate qualification – vocational assessment	98	91	81	77	118
Non-approved postgraduate qualification – vocational eligible	88	82	74	95	108
Special purpose scope registrations					
Visiting expert	15	37	21	10	-
Research	-	2	3	1	5
Postgraduate training or experience	45	42	43	45	19
Locum tenens in specialist post	112	93	111	109	92
Emergency or other unpredictable short-term situation	-	-	-	5	-
Pandemic	-	-	-	8	15
Teleradiology	-	-	-	-	2
General scope registrations, after completion of supervised period					
Australian general registrant	-	-	-	1	2
New Zealand/Australian graduates (interns)	413	462	483	506	502
Passed NZREX Clinical	30	22	33	33	20
Graduate of competent authority accredited medical school	360	329	442	398	250
Worked in comparable health system	100	92	94	75	82

	2017	2018	2019	2020	2021
Vocational scope registrations, after completion of supervised period					
Non-approved postgraduate qualification – vocational assessment	37	54	50	40	45
Non-approved postgraduate qualification – vocational eligible	61	84	74	86	74
General scope registrations					
New Zealand graduates	1	9	5	3	2
Overseas graduates	66	85	85	85	72
Restorations	25	15	22	12	19
Vocational scope registrations					
Approved postgraduate qualification (VOC1)	467	478	421	481	491
Approved postgraduate qualification (VOC2)	-	-	-	-	2
Suspensions of registration					
Suspension or interim suspension	6	5	2	7	4
Revocation of suspension	2	-	1	3	2
Numbers of doctors who had conditions imposed on scope of practice[1]					
Imposed	110	109	82	91	114
Revoked	84	40	59	52	100
Cancellations under the HPCAA					
Death - section 143	32	23	43	36	43
Discipline order - section 101 (1)(a)	2	3	2	3	1
False, misleading or not entitled - section 146	1	1	-	1	-
Revision of register - section 144(5)	217	98	147	256	527
At own request - section 142	178	167	188	120	80

[1] These are imposed as part of the registration process, to reflect differences between a registering doctor's previous overseas practice and their proposed practice in New Zealand. The conditions are not a result of formal assessments of the doctors competence or conduct.

Table 3: Doctors registered in vocational scopes of practice (1 July 2020 to 30 June 2021)

Vocational scope	Vocational registration at 30/6/2020[1]	Added 2020/21	Removed 2020/21	Net change	Vocational scope at 30/6/2021[1,2]
Anaesthesia	1,110	60	16	44	1,154
Cardiothoracic Surgery	47	4	-	4	51
Clinical Genetics	20	-	-	-	20
Dermatology	87	4	-	4	91
Diagnostic & Interventional Radiology	772	94	13	81	853
Emergency Medicine	453	50	-	50	503
Family Planning & Reproductive Health	40	3	-	3	43
General Practice	4,621	179	58	121	4,742
General Surgery	417	19	10	9	426
Intensive Care Medicine	128	6	-	6	134
Internal Medicine	1,549	100	17	83	1,632
Medical Administration	46	1	-	1	47
Musculoskeletal Medicine	27	-	1	-1	26
Neurosurgery	31	1	2	-1	30
Obstetrics & Gynaecology	447	23	3	20	467
Occupational Medicine	76	2	1	1	77
Ophthalmology	205	4	6	-2	203
Oral & Maxillofacial Surgery	33	1	-	1	34
Orthopaedic Surgery	375	16	6	10	385
Otolaryngology Head & Neck Surgery	148	6	3	3	151
Paediatric Surgery	31	2	-	2	33
Paediatrics	519	33	9	24	543

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

[2] Includes 610 doctors with registration in two vocational scopes and 15 doctors with registration in three vocational scopes.

Vocational scope	Vocational registration at 30/6/2020[1]	Added 2020/21	Removed 2020/21	Net change	Vocational scope at 30/6/2021[1,2]
Pain Medicine	35	4	-	4	39
Palliative Medicine	97	6	2	4	101
Pathology	425	14	6	8	433
Plastic & Reconstructive Surgery	90	4	1	3	93
Psychiatry	909	22	14	8	917
Public Health Medicine	230	3	2	1	231
Radiation Oncology	93	4	1	3	96
Rehabilitation Medicine	32	3	2	1	33
Rural Hospital Medicine	135	6	-	6	141
Sexual Health Medicine	25	1	-	1	26
Sport and Exercise Medicine	36	3	-	3	39
Urgent Care	277	24	-	24	301
Urology	89	6	1	5	94
Vascular Surgery	46	-	-	-	46
Total	**13,701**	**708**	**174**	**534**	**14,235**

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

[2] Includes 610 doctors with registration in two vocational scopes and 15 doctors with registration in three vocational scopes.

Table 4: Doctors registered in vocational scopes of practice (1 July to 30 June of the year)

Vocational scope	2017	2018	2019	2020	2021
Anaesthesia	974	1,020	1,057	1,110	1,154
Cardiothoracic Surgery	40	41	45	48	51
Clinical Genetics	16	19	20	20	20
Dermatology	76	84	85	87	91
Diagnostic & Interventional Radiology	627	659	694	772	853
Emergency Medicine	355	390	419	453	503
Family Planning & Reproductive Health	34	34	38	40	43
General Practice	4,242	4364	4482	4,621	4742
General Surgery	377	397	408	417	426
Intensive Care Medicine	109	116	120	128	134
Internal Medicine	1,323	1,392	1,466	1,549	1,632
Medical Administration	38	42	44	46	47
Musculoskeletal Medicine	25	25	25	27	26
Neurosurgery	29	30	31	31	30
Obstetrics & Gynaecology	388	411	426	447	467
Occupational Medicine	68	70	75	76	77
Ophthalmology	175	185	195	205	203
Oral & Maxillofacial Surgery	24	27	30	33	34
Orthopaedic Surgery	338	351	365	375	385
Otolaryngology Head & Neck Surgery	133	140	146	148	151
Paediatric Surgery	26	29	31	31	33
Paediatrics	461	480	497	521	543
Pain Medicine	28	31	32	35	39
Palliative Medicine	77	85	95	97	101
Pathology	368	391	412	425	433

Vocational scope	2017	2018	2019	2020	2021
Plastic & Reconstructive Surgery	82	86	90	90	93
Psychiatry	778	838	867	910	917
Public Health Medicine	215	222	223	230	231
Radiation Oncology	81	84	88	93	96
Rehabilitation Medicine	29	31	32	32	33
Rural Hospital Medicine	119	125	128	135	141
Sexual Health Medicine	24	24	25	25	26
Sport and Exercise Medicine	31	31	33	36	39
Urgent Care	216	237	256	277	301
Urology	85	86	87	89	94
Vascular Surgery	41	43	45	46	46
Total	**12,052**	**12,620**	**13,112**	**13,705**	**14,235**

Table 5: Registration granted, by country of primary qualification (1 July 2020 to 30 June 2021)

	Provisional general	Provisional vocational	Special purpose	Total
England	207	37	14	258
United States of America	65	52	53	170
South Africa	3	55	7	65
Scotland	50	8	3	61
Ireland	45	2	1	48
India	19	14	12	45
Canada	7	4	9	20
Netherlands	13	5	1	19
Wales	14	1	-	15
Belgium	9	1	1	11
Northern Ireland	10	-	-	10
Israel	4	4	1	9
Pakistan	6	2	1	9
Germany	4	3	-	7
Other[1]	53	29	22	104
New Zealand	527	2	8	537
Total	**1,036**	**219**	**133**	**1,388**

[1] Other represents 46 countries that had fewer than seven registrations in the reporting period.

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

	2017	2018	2019	2020	2021
New Zealand	480	470	512	530	537
England	366	341	375	359	257
United States of America	178	163	161	145	170
South Africa	18	33	31	51	65
Scotland	129	112	119	87	61
Ireland	59	49	95	79	48
India	41	38	36	36	45
Canada	29	27	30	26	20
Netherlands	28	26	31	30	19
Wales	21	24	17	22	15
Belgium	8	7	7	9	11
Northern Ireland	15	8	7	7	10
Pakistan	5	13	7	18	9
Israel	5	3	4	4	9
Germany	23	23	19	12	7
Sri Lanka	3	5	2	7	6
Sweden	12	12	6	1	6
Other[1]	110	175	128	126	93
Total	**1,530**	**1,529**	**1,587**	**1,549**	**1,387**

[1] Other represents countries who had less than 6 registrations in 2020/2021.

Table 7: Vocational registration granted, by vocational scope of practice
(1 July 2020 to 30 June 2021)

Vocational scope	New Zealand	Overseas	Total
Anaesthesia	31	29	60
Cardiothoracic Surgery	1	3	4
Clinical Genetics	-	-	-
Dermatology	2	2	4
Diagnostic & Interventional Radiology	17	77	94
Emergency Medicine	12	38	50
Family Planning & Reproductive Health	1	2	3
General Practice	114	65	179
General Surgery	10	9	19
Intensive Care Medicine	3	3	6
Internal Medicine	43	57	100
Medical Administration	1	-	1
Neurosurgery	-	1	1
Obstetrics & Gynaecology	11	12	23
Occupational Medicine	1	1	2
Ophthalmology	1	3	4
Oral & Maxillofacial Surgery	1	-	1
Orthopaedic Surgery	8	8	16
Otolaryngology Head & Neck Surgery	3	3	6
Paediatric Surgery	1	1	2
Paediatrics	19	14	33
Pain Medicine	-	4	4
Palliative Medicine	3	3	6

Vocational scope	New Zealand	Overseas	Total
Pathology	8	6	14
Plastic & Reconstructive Surgery	-	4	4
Psychiatry	4	18	22
Public Health Medicine	1	2	3
Radiation Oncology	1	3	4
Rehabilitation Medicine	2	1	3
Rural Hospital Medicine	5	1	6
Sexual Health Medicine	1	-	1
Sport and Exercise Medicine	2	1	3
Urgent Care	11	13	24
Urology	3	3	6
Total	**321**	**387**	**708**

Table 8: Outcomes of applications for vocational registration assessments
(1 July 2020 to 30 June 2021)

Branch	Incomplete applications	Pending	Withdrawn/ lapsed	Supervision path	Assessment	NZREX*	Total
Anaesthesia	30	-	14	9	9	3	65
Cardiothoracic Surgery	1	-	1	2	-	-	4
Clinical Genetics	-	-	-	1	-	-	1
Dermatology	-	-	3	1	3	1	8
Diagnostic & Interventional Radiology	27	2	4	12	7	3	55
Emergency Medicine	17	-	5	16	8	-	46
General Practice	8	9	11	1	4	-	33
General Surgery	13	-	4	1	1	3	22
Intensive Care Medicine	5	-	5	1	3	1	15
Internal Medicine	43	1	24	19	22	6	115
Neurosurgery	4	-	4	-	-	1	9
Obstetrics & Gynaecology	13	2	13	4	4	1	37
Occupational Medicine	3	-	-	-	-	-	3
Ophthalmology	11	1	7	5	1	-	25
Oral & Maxillofacial Surgery	1	-	-	1	1	-	3
Orthopaedic Surgery	13	1	5	-	2	2	23
Otolaryngology Head & Neck Surgery	15	1	2	-	1	-	19
Paediatric Surgery	-	-	1	-	-	-	1
Paediatrics	15	-	11	5	2	3	36
Pain Medicine	1	-	-	-	-	-	1
Palliative Medicine	-	-	-	-	1	-	1
Pathology	13	1	3	3	4	1	25
Plastic & Reconstructive Surgery	3	-	2	-	-	1	6
Psychiatry	54	2	10	9	21	-	96

Branch	Incomplete applications	Pending	Withdrawn/ lapsed	Supervision path	Assessment	NZREX*	Total
Public Health Medicine	1	-	-	1	1	1	4
Radiation Oncology	3	-	3	-	1	-	7
Rehabilitation Medicine	-	-	-	1	-	-	1
Sexual health Medicine	1	-	-	-	-	-	1
Sport & Exercise Medicine	1	-	-	-	-	-	1
Urology	3	-	1	3	1	-	8
Total	**299**	**20**	**133**	**95**	**97**	**27**	**671**
Percentages based on total number of outcomes (%)				43.4	44.3	12.3	

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

Table 9: Doctors on the New Zealand medical register, by country of primary qualification
(1 July 2020 to 30 June 2021)

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificates
England	1,188	1,956	23	1,753	15	4,935	2,291
United States of America	604	183	77	401	128	1,393	461
Scotland	308	545	10	486	2	1,351	623
Australia	6	692	1	618	6	1,323	708
South Africa	57	158	54	835	9	1,113	767
India	75	203	23	516	32	849	536
Ireland	204	425	1	116	3	749	317
Germany	77	99	16	167	3	362	187
Wales	100	161	2	80	1	344	131
Netherlands	125	77	14	68	1	285	130
Canada	133	36	7	83	20	279	84
Sri Lanka	15	63	1	166	2	247	120
Iraq	4	51	-	120	1	176	106
Pakistan	30	66	3	64	2	165	92
Northern Ireland	39	52	-	38	1	130	59
China	5	36	2	69	-	112	78
Bangladesh	4	26	-	71	-	101	44
Sweden	55	16	8	20	-	99	19
Egypt	13	21	3	52	2	91	49
Fiji	4	13	-	50	19	86	63
Belgium	37	18	2	17	1	75	34
Russia	6	35	1	30	2	74	54
Poland	16	17	4	31	4	72	37
Denmark	32	24	2	8	-	66	7

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificates
Singapore	13	24	-	27	-	64	33
Philippines	3	24	1	31	1	60	46
Zimbabwe	1	1	2	41	1	46	33
Romania	5	17	2	20	1	45	24
Spain	11	14	-	18	-	43	30
Italy	9	7	4	21	1	42	23
Nigeria	8	16	2	16	-	42	16
Hungary	9	10	1	16	-	36	22
Malaysia	5	10	1	15	5	36	25
Czech Republic	8	10	1	15	-	34	22
Serbia	-	9	-	25	-	34	18
Switzerland	14	9	-	11	-	34	10
Austria	10	11	4	7	-	32	13
France	7	13	2	10	-	32	20
Israel	7	8	4	11	1	31	25
Myanmar	2	9	-	13	1	25	15
Brazil	3	4	3	10	3	23	15
Ukraine	1	12	-	10	-	23	17
Iran	1	11	2	6	1	21	11
Other[1]	87	127	19	201	14	448	268
New Zealand	610	5,137	-	7,211	3	12,961	10,567
Total	**3,951**	**10,456**	**302**	**13,594**	**286**	**28,589**	**18,250**

[1]Other represents 87 countries with fewer than 20 registered doctors.

Table 10: Doctors on the New Zealand medical register, by country of primary qualification
(1 July to 30 June of the year - Doctors with a current practising certificate)

	June 2017	June 2018	June 2019	June 2020	June 2021
New Zealand	9,046	9,370	9,731	10,181	10,567
England	2,013	2,102	2,189	2,289	2,290
South Africa	715	724	738	746	767
Australia	483	528	575	651	708
Scotland	582	604	617	620	623
India	489	481	509	519	536
United States of America	384	389	385	411	461
Ireland	234	245	290	322	317
Germany	187	183	191	193	187
Wales	108	113	115	121	131
Netherlands	99	103	115	122	130
Sri Lanka	130	124	115	117	120
Iraq	109	109	109	105	106
Pakistan	73	79	78	89	92
Canada	76	82	85	79	84
China	74	75	75	78	78
Fiji	68	68	64	65	63
Northern Ireland	55	57	54	57	59
Russia	50	53	54	55	54
Egypt	43	45	43	49	49
Philippines	41	42	44	45	46
Bangladesh	46	43	44	44	43
Poland	30	35	38	36	37
Belgium	16	23	28	29	34

	June 2017	June 2018	June 2019	June 2020	June 2021
Singapore	27	28	30	31	33
Zimbabwe	36	36	36	33	33
Spain	23	25	28	30	30
Israel	12	14	16	17	25
Malaysia	18	24	22	23	25
Romania	17	19	18	22	24
Italy	20	24	23	24	23
Czech Republic	16	15	19	18	22
Hungary	16	22	20	20	22
France	16	17	20	19	20
Sweden	15	23	20	14	19
Serbia	21	21	23	20	18
Ukraine	17	17	16	17	17
Nigeria	15	14	13	14	16
Brazil	5	7	10	12	15
Myanmar	16	15	16	14	15
Other[1]	273	294	291	303	309
Total	**15,714**	**16,292**	**16,907**	**17,654**	**18,248**

[1] Other represents countries with less than 15 registered doctors in 2020/2021.

Examinations

Principal activities

Ensuring that international medical graduates who wish to be registered in New Zealand are qualified and competent to practise medicine.

New Zealand Registration Examination – NZREX Clinical

We require international medical graduates to sit and pass NZREX Clinical if they are not eligible for registration under any other registration pathway.

NZREX Clinical is a 16-station objective-structured clinical examination that tests various competencies including history, clinical examination, investigating, management, clinical reasoning, communication, and professionalism. The examination is set at the level of a recent New Zealand medical graduate.

NZREX is usually held three times a year. The prerequisites for applying to sit NZREX Clinical are:

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

Table 11: Candidates sitting and passing NZREX Clinical (1 July 2020 to 30 June 2021)

		Attempt					Attempt			
Country	**# sitting**	**1**	**2**	**3**	**4**	**# passed**	**1**	**2**	**3**	**4**
Algeria	1	1	-	-	-	1	1	-	-	-
Bangladesh	6	6	-	-	-	2	2	-	-	-
Belarus	2	2	-	-	-	1	1	-	-	-
Brazil	1	1	-	-	-	1	1	-	-	-
China	9	7	1	1	-	6	4	1	1	-
Egypt	2	2	-	-	-	1	1	-	-	-
Ethiopia	1	-	1	-	-	-	-	-	-	-
Fiji	4	3	1	-	-	3	2	1	-	-
Grenada	1	1	-	-	-	1	1	-	-	-
Hungary	1	1	-	-	-	1	1	-	-	-
India	13	9	4	-	-	10	6	4	-	-
Indonesia	1	1	-	-	-	1	1	-	-	-
Iran	1	1	-	-	-	1	1	-	-	-
Iraq	4	3	1	-	-	3	3	-	-	-
Kyrgyzstan	1	1	-	-	-	-	-	-	-	-
Nigeria	1	1	-	-	-	1	1	-	-	-
Pakistan	17	12	3	2	-	9	5	2	2	-
Philippines	9	6	-	2	1	7	5	-	1	1
Russia	4	2	2	-	-	2	-	2	-	-
Serbia	1	1	-	-	-	1	1	-	-	-
South Africa	4	4	-	-	-	4	4	-	-	-
Sri Lanka	1	-	1	-	-	1	-	1	-	-
Tanzania	1	1	-	-	-	1	1	-	-	-
Ukraine	1	1	-	-	-	-	-	-	-	-
UAE	2	1	1	-	-	-	-	-	-	-
Total	**89**	**68**	**15**	**5**	**1**	**58**	**42**	**11**	**4**	**1**

Professional standards

Principal activities

Receiving notifications and referrals of concerns, supporting the Notifications Triage Team and Council processes for performance assessments, establishing individual education programmes and recertification programmes, maintaining assessment tools, developing policy on performance assessment, setting up Professional Conduct Committees (PCCs), and monitoring doctors who are subject to conditions arising from competence and conduct concerns and disciplinary action.

Total notifications received[1]	
Performance	146
Conduct	104
Total	**250**

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

Table 12: Referral sources to full Council for performance-related decisions
(1 July 2020 to 30 June 2021)

ACC	40
Employer (DHB)	1
Employer (private hospital or general practice)	-
Health and Disability Commissioner (HDC)	88
Internally referred within Council (Registration / Health Team)	1
Medical practitioner	13
Health practitioner	1
Member of public or patient	2
Other	-
Total	**146**

Table 13: Referral sources for conduct-related notifications (1 July 2020 to 30 June 2021)	
ACC	1
Employer (DHB)	1
Employer (private hospital or general practice)	2
Member of public or patient	9
HDC	7
Police / Ministry of Justice	3
Internally referred within Council (Health Team)	4
Medical practitioner	41
Health practitioner	4
Ministry of Health	2
Media	1
Self-disclosure	6
Other[1]	23
Total	**104**

[1] Other sources, for example, Council's Registration team or an overseas regulator.

Performance

Principal activities

We implement mechanisms to ensure doctors are competent to practise. When receiving notifications or referrals that relate to a doctor's competence to practise, we do not investigate specific incidents (that is the role of the HDC) but do consider whether the circumstances raise questions about deficiencies in the doctor's competence.

Table 14 shows the number of cases considered by Council during the year that related to a doctor's competence to practise and our decisions as to how those cases should be addressed. The table shows the number of processes during the year rather than the number of individual doctors, as many doctors will have been the subject of more than one decision or process. The numbers include processes that commenced before 1 July 2020 and processes that continued after 30 June 2021. It illustrates the volume of work undertaken during the year in this area.

Table 14: Competence-related Council processes[2] (1 July 2020 to 30 June 2021)	
No further action or educational letter after first consideration	52
Await outcome from HDC after first consideration	29
Request a Preliminary Competence Inquiry (PCI)	15
No further action or educational letter after PCI	9
Recertification programme ordered on first consideration	1
Referral to Performance Assessment Committee (PAC)	17
Doctor meets required standard of competence following PAC assessment (category 1)	6
Doctor does not meet required standard of competence following PAC assessment (category 2 or 3)	6
Educational programme ordered after PAC assessment (section 38) (category 2 or 3)	6
Conditions imposed after PAC assessment (section 38)	-
Educational programme completed satisfactorily	2
Educational programme completed unsatisfactorily	1
Recertification programme completed satisfactorily	2
Follow up performance assessment ordered after completion of educational programme	-
Conditions ordered after unsuccessful completion of educational programme	-
Referral to health team	1

[2] Table includes decisions made in current reporting year - including those made by Council (full meeting), by the Notification Triage Team (NTT) and by the Registrar/Deputy Registrar under delegation.

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

Conduct

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

Table 15 shows the number of cases considered during the year that related to a doctor's conduct and our decisions as to how those cases should be addressed. It shows the number of processes during the year rather than the number of individual doctors, as many of these doctors will have been the subject of more than one decision or processes. The numbers include processes that started before 1 July 2020 and processes that continued after 30 June 2021 and illustrate the volume of Council's work in this area. Council is prevented by the Health Practitioners Competence Assurance Act 2003 from taking any action under Part 4 of the Act (conduct-related action) against a doctor while the Health and Disability Commissioner is conducting an investigation in relation to a complaint about that doctor.

We may, still take action in relation to competence concerns. We may also still however, make an order for interim suspension or impose conditions on the doctor's practise if it considers that the doctor poses a risk of harm to the public, while a PCC or criminal investigation is undertaken.

Table 15: Conduct-related Council processes[4] (1 July 2020 to 30 June 2021)	
No further action or educational letter on first consideration	53
Referral to PCC	34
New information received referred to existing PCC [5]	8
Interim conditions ordered (section 69)	-
Interim suspension ordered (section 69 or section 69A)	3
PCC determined charge be brought in the Health Practitioners Disciplinary Tribunal (HPDT)	10
PCC recommended no further action	5
PCC recommended counselling or mentoring	18
PCC recommended review of fitness to practise (by referral to Health Committee)	4
Referred to the Health Committee	7
PCC charges heard in the (HPDT)	5
PCC charges proved in the (HPDT)	5
PCC charges withdrawn prior to hearing	1
PCC charges filed but yet to be heard (as at 30 June 2021)	10

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

[5] Council's processes can extend over 12 months, so the number of referrals to PCCs, and PCC outcomes, may not necessarily correlate with outcomes within the same year (or outcomes from the previous year).

If we receive notice that a doctor is convicted of any offence punishable by imprisonment for a term of three months or longer, or of an offence under certain specified Acts, then we must consider whether to refer the notice of conviction to a PCC, or alternatively refer the doctor to the Health Evaluation Pathway. This can involve ordering the doctor to undergo any specified medical or psychiatric examination or treatment, counselling or therapy (with the doctor's consent).

Table 16 shows the PCCs that were commenced as a result of a conviction, and the number of doctors referred to the Health Evaluation Pathway.

Table 16: Notice of convictions (1 July 2020 to 30 June 2021)

Notices of conviction referred to PCC[6]	1
Doctor referred to Health Evaluation Pathway (section 67A)	7

[6] This does not include ongoing PCC processes during which a conviction is received.

Doctors' health

Principal activities

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

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

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

If a doctor has an issue with their own health, wherever possible, our health team try to help them to remain in practice while it is being resolved. That said, the primary objective is to protect the health and safety of the public, which may mean that the doctor will be unable to practise safely or will be limited in what they can do until they are well enough to fully resume practice.

Table 17: Notifications of inability to perform required functions due to mental or physical (health) condition (July 2020 - 30 June 2021)

Source	HPCAA	Existing	New	Closed	Still active
Health service	section 45(1)a	-	2	2	-
Health practitioner	section 45(1)b[1]	-	31	2	29
Employer	section 45(1)c	-	16	7	9
Medical Officer of Health	section 45(1)d	-	-	-	-
Other person	section 45(3)	-	-	-	-
Education programme	section 45(5)[2]	-	2	-	-
Council		-	11	3	8
Total		**-**	**62**	**14**	**48**

[1]All self-notifications.

[2]18 notifications in total – two were referred to the Health Committee, and 16 were managed under Council/Health Committee delegations.

Table 18: Outcomes of health notifications (1 July 2020 to 30 June 2021)

Outcomes	HPCAA	Number [1]
No further action	–	9
Order medical examination	section 49(1)	-[2]
Interim suspension	section 48(1)(a)	34[3]
Conditions	section 48(1)(b)	-
Restrictions imposed	section 50(3) or (4)	1[4]

[1] There may be more than one outcome.

[2] 24 assessments agreed voluntarily.

[3] Achieved through voluntary agreement.

[4] Requisite monitoring for 48 doctors still active achieved through informal agreement without use of statutory provisions of the HPCAA 2003.

Annual financial statements

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Statement of Comprehensive Revenue and Expenses
For the year ended 30 June 2021

	Notes	2021 (000's)	2020 (000's)
Revenue from non-exchange transactions			
Practising certificate (PC) fees and disciplinary levies		14,109	12,936
Disciplinary recoveries		288	331
Total non-exchange revenue		**14,397**	**13,267**
Revenue from exchange transactions			
Fees received		3,419	2,623
Interest income		26	67
Other income		565	344
Total exchange revenue		**4,010**	**3,034**
Total revenue		**18,407**	**16,301**
Expenses per schedules	5		
Administration expenses		10,137	10,760
Council and profession expenses		3,300	3,629
Disciplinary expenses		2,325	2,446
Examination expenses		140	82
Total expenses		**15,902**	**16,917**
Results before expenses incurred due to the effects of the Kaikōura earthquake		**2,505**	**(616)**
Net effects of the Kaikōura earthquake			
Reversal of onerous lease provision	13	(665)	-
Onerous lease costs and make good provision		-	328
Business interruption insurance proceeds		-	(529)
Total net effects of the Kaikōura earthquake		**(665)**	**(201)**
Total surplus/(deficit) for the year		**3,170**	**(415)**
Other comprehensive revenue and expense for the year		-	-
Total comprehensive revenue and expense for the year		**3,170**	**(415)**

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 2021

	General Reserve (000's)	Disciplinary Reserve (000's)	Examination Reserve (000's)	Total Equity (000's)
Opening equity balance 1 July 2020	4,010	1,725	268	6,003
Total surplus / (deficit) for the year	2,720	429	21	3,170
Closing equity balance 30 June 2021	**6,730**	**2,154**	**289**	**9,173**
Opening equity balance 1 July 2019	4,032	1,970	416	6,418
Total surplus / (deficit) for the year	(22)	(245)	(148)	(415)
Closing equity balance 30 June 2020	**4,010**	**1,725**	**268**	**6,003**

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

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Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Statement of Financial Position
As at 30 June 2021

	Notes	2021 (000's)	2020 (000's)
Current assets			
Cash and cash equivalents		2,093	1,682
Short term investments		3,000	1,250
Prepayments		115	95
Receivables from exchange transactions	7	141	78
Receivables from non-exchange transactions	7	117	118
Total current assets		**5,466**	**3,223**
Non-current assets			
Intangible assets	8	3,789	3,856
Work in progress	9	229	671
Property, plant and equipment	10	1,680	1,894
Total non-current assets		**5,698**	**6,421**
Total assets		**11,164**	**9,644**
Current liabilities			
Payables	11	1,246	704
Employee entitlements	12	400	359
Provisions	13	-	662
Revenue received in advance		269	469
Total current liabilities		**1,915**	**2,194**
Non-current liabilities			
Employee entitlements	12	76	51
Provisions	13	-	1,396
Total non-current liabilities		**76**	**1,447**
Total liabilities		**1,991**	**3,641**
Net assets		**9,173**	**6,003**
Equity			
General reserve		6,730	4,010
Disciplinary reserve		2,154	1,725
Examination reserve		289	268
Total Equity		**9,173**	**6,003**

Authorised for issue for and on behalf of the Council on 7 December 2021.

Curtis Walker
Chair

Giselle McLachlan
Chair - Audit and Risk Committee

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

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Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Statement of Cash Flows
For the year ended 30 June 2021

	2021 (000's)	2020 (000's)
Cash flows from operating activities		
Receipts		
Receipts from PC fees (non-exchange)	11,016	10,526
Receipts from disciplinary levies (non-exchange)	3,090	2,752
Receipts from other non-exchange transactions	258	331
Receipts from exchange transactions	3,710	3,406
Payments		
Payments to suppliers and employees	(15,307)	(17,450)
Net cash flows from operating activities	**2,767**	**(435)**
Cash flows from investing activities		
Receipts		
Interest received	36	60
Redemption of investments	6,000	4,000
Payments		
Purchase of property, plant and equipment	(76)	(140)
Purchase of intangible assets	(566)	(783)
Investments in short term deposits	(7,750)	(2,750)
Net cash flows from investing activities	**(2,356)**	**387**
Net increase/(decrease) in cash and cash equivalents	**411**	**(48)**
Cash and cash equivalents at 1 July	1,682	1,730
Cash and cash equivalents at 30 June	**2,093**	**1,682**
Represented by:		
ASB Bank Account - General	93	17
ASB Bank Account - Call	2,000	1,665
	2,093	**1,682**

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

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Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2021

1 Reporting entity

The Medical Council of New Zealand (the Council) is a body corporate constituted under the Health Practitioners Competence Assurance Act 2003.

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

These financial statements have been approved and were authorised for issue by the Council on 7 December 2021.

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 time those costs were incurred and 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 2021

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 (2020: 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 financial liabilities are recognised 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 29 (PS) Financial Instruments: Recognition and Measurement are classified as financial assets at fair value through surplus or deficit, loans and receivables, held-to-maturity investments or available-for-sale financial assets. The classifications of the financial assets are determined at initial recognition.

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

Impairment of financial assets

During the year $5k was written off from the provision for doubtful debts. Additional amounts were provided for as doubtful against specific debtors as outlined in Note 3.7, totalling $32k. There were no other impairments of financial assets for the year.

Financial liabilities

The Council's financial liabilities include trade and other creditors (excluding goods and services (GST)) and pay as you earn (PAYE) tax 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.

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.

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2021

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

3.7 Receivables
Receivables are recorded at their fair value, less any provision for impairments.

Impairment of a receivable is established when there is objective evidence that the Council will not be able to collect amounts due according to the original terms of the receivable. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership or liquidation and default in payments are considered indicators that the debtor is impaired. The impairment is the difference between the assets carrying amount and the present value of amount expected to be collected.

A provision has been made in the Statement of Comprehensive Revenue and Expense for those receivables that are deemed impaired. Impairment has been provided for 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%

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

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

- Furniture and fittings 0% - 20% p.a.
- Office alterations 10% p.a.
- Office equipment 20% 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.

3.9 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. The Council does not hold any intangible assets that have an indefinite life.

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 2021

3.9 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 amortisation periods for the Council's assets are as follows:
- Developed software 10% - 20% p.a.
- Purchased software 10% p.a.

3.10 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.

3.11 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.

3.12 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.

3.13 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 than 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.

3.14 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.

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3.15 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.

3.16 Equity

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

General reserve

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

Disciplinary reserve

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

Examination reserve

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

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.

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 estimates useful lives of the asset classes held by the Council are listed in Notes 3.8 and 3.9. The Council has not made any changes to past assumptions concerning useful lives.

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2021

4 Significant accounting judgements, estimates and assumptions (continued)

Long service leave

The measurement of long service lease was based on a number of assumptions. An assessment of 81 employees employed at 30 June 2021 was undertaken as to which employees would reach the long service criteria. 5 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.

Changes to comparative figures

Recoveries of credit card fees in administration expenses (Note 5) have been reclassified to other income for an amount of $119k to match current year disclosure.

5 Expenses

2021	Administration (000's)	Council and profession (000's)	Disciplinary (000's)	Examination (000's)	Total (000's)
Administration expenses	306	-	-	-	306
Amortisation	975	-	-	-	975
Communication expenses	62	-	-	-	62
Council expenses	-	505	-	-	505
Depreciation	290	-	-	-	290
Disciplinary or legal expenses	-	169	1,025	-	1,194
Education committee expenses	9	42	-	-	51
Education general expenses	-	830	-	-	830
Health committee expenses	-	54	-	-	54
Health general expenses	-	264	-	-	264
HPDT disciplinary expenses	-	-	492	-	492
Impairment expense	100	-	-	-	100
Insurance	60	-	-	-	60
IT & systems expenses	807	-	-	-	807
NZRex clinical expenses	-	-	-	110	110
Premises expenses	1,180	-	-	-	1,180
Professional standards expenses	-	372	-	-	372
Registration expenses	-	968	-	-	968
Staff general expenses	217	-	12	-	229
Staff remuneration	6,131	-	796	30	6,957
Strategy expenses	-	96	-	-	96
Total expenses	**10,137**	**3,300**	**2,325**	**140**	**15,902**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2021

5 Expenses (continued)

2020	Administration (000's)	Council and profession (000's)	Disciplinary (000's)	Examination (000's)	Total (000's)
Administration expenses	318	-	-	-	318
Amortisation	1,042	-	-	-	1,042
Communication expenses	38	-	-	-	38
Council expenses	-	699	-	-	699
Depreciation	304	-	-	-	304
Disciplinary or legal expenses	-	206	1,106	-	1,312
Education committee expenses	-	58	-	-	58
Education general expenses	-	985	-	-	985
Health committee expenses	-	69	-	-	69
Health general expenses	-	236	-	-	236
HPDT disciplinary expenses	-	-	568	-	568
Insurance	50	-	-	-	50
IT & systems expenses	947	-	-	-	947
NZRex clinical expenses	-	-	-	57	57
Premises expenses	1,194	-	-	-	1,194
Professional standards expenses	-	394	-	-	394
Registration committee expenses	-	2	-	-	2
Registration expenses	-	700	-	-	700
Staff general expenses	310	-	10	-	320
Staff remuneration	6,557	-	762	25	7,344
Strategy expenses	-	280	-	-	280
Total expenses	**10,760**	**3,629**	**2,446**	**82**	**16,917**

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 $30k (2020: $30k). No non-audit services have been provided by the auditor.

7 Receivables

	2021 (000's)	2020 (000's)
Interest receivable - exchange	4	14
Receivables from exchange transactions	164	90
Provision for doubtful debts - exchange	(27)	(26)
Receivables from exchange transactions	**141**	**78**
Receivables from non-exchange transactions	403	373
Provision for doubtful debts - non-exchange	(286)	(255)
Receivables from non-exchange transactions	**117**	**118**
Total receivables	**258**	**196**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2021

8 Intangible assets

	Developed Software (000's)	Purchased Software (000's)	Total (000's)
2021			
Cost	12,018	30	12,048
Less: Accumulated amortisation and impairment	(8,237)	(22)	(8,259)
Net book value	**3,781**	**8**	**3,789**
2020			
Cost	11,246	30	11,276
Less: Accumulated amortisation and impairment	(7,399)	(21)	(7,420)
Net book value	**3,847**	**9**	**3,856**

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

	Developed Software (000's)	Purchased Software (000's)	Total (000's)
2021			
Opening balance	3,847	9	3,856
Additions	1,008	-	1,008
Disposals	-	-	-
Amortisation	(974)	(1)	(975)
Impairment	(100)	-	(100)
Closing balance	**3,781**	**8**	**3,789**

Impairment losses of $100k (2020: $Nil) have been recognised for intangible assets which are not in use. The impairment loss has been recognised in the Statement of Comprehensive Revenue and Expense in the line item administration expenses.

9 Work in progress

	2021 (000's)	2020 (000's)
Developed Software	229	671
Total work in progress	**229**	**671**

10 Property, plant and equipment

	Computer Hardware (000's)	Furniture & Fittings (000's)	Office Alterations (000's)	Office Equipment (000's)	Total (000's)
2021					
Cost	1,102	598	2,509	297	4,506
Less: Accumulated depreciation and impairment	(989)	(419)	(1,151)	(267)	(2,826)
Net book value	**113**	**179**	**1,358**	**30**	**1,680**
2020					
Cost	1,035	589	2,509	297	4,430
Less: Accumulated depreciation and impairment	(911)	(391)	(978)	(256)	(2,536)
Net book value	**124**	**198**	**1,531**	**41**	**1,894**

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Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2021

10 Property, plant and equipment (continued)

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

2021	Computer Hardware (000's)	Furniture & Fittings (000's)	Office Alterations (000's)	Office Equipment (000's)	Total (000's)
Opening balance	124	198	1,531	41	1,894
Additions	67	9	-	-	76
Disposals	-	-	-	-	-
Depreciation	(78)	(28)	(173)	(11)	(290)
Impairment	-	-	-	-	-
Closing balance	**113**	**179**	**1,358**	**30**	**1,680**

11 Payables

	2021 (000's)	2020 (000's)
Creditors	456	240
Accrued expenses	698	369
GST payable	92	95
	1,246	**704**

12 Employee entitlements

	2021 (000's)	2020 (000's)
Current portion		
Accrued salaries and wages	27	-
Annual leave	352	325
Long service leave	21	34
Total current portion	**400**	**359**
Non-current portion		
Long service leave	76	51
Total non-current portion	**76**	**51**
Total employee entitlements	**476**	**410**

13 Provisions

	2021 (000's)	2020 (000's)
Current portion		
Onerous lease	-	662
Total current portion	**-**	**662**
Non-current portion		
Onerous lease	-	1,396
Total non-current portion	**-**	**1,396**
Total provisions	**-**	**2,058**
Movement of onerous lease provision:		
Opening balance	2,058	2,386
Provisions used (including settlement)	(1,393)	(647)
Reversal of onerous lease provision	(665)	319
Closing balance	**-**	**2,058**

Onerous lease

During the year the Council and landlord negotiated a Deed of Surrender in respect of the non-cancellable premises lease at 80 The Terrace, Wellington. On 30 April 2021, the Council paid a surrender fee in consideration for the surrender, and in satisfaction of all outstanding liabilities and obligations under the lease. The residual provision was reversed on settlement.

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Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2021

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:

	2021 (000's)	2020 (000's)
Financial assets		
Cash and cash equivalents	2,093	1,682
Short term investments	3,000	1,250
Prepayments	115	95
Receivables from exchange transactions	141	78
Receivables from non-exchange transactions	117	118
Total financial assets	**5,466**	**3,223**
Financial liabilities		
Payables	1,246	704
Employee entitlements	400	1,755
Total financial liabilities	**1,646**	**2,459**

15 Related party transactions

These expenses relate to all the activities of Council members.

Council member fees and expenses	2021 (000's)	2020 (000's)
Council fees	542	623
Council travel	47	126
Council expenses	25	29
Council development	2	7
Total Council member fees and expenses	**616**	**785**

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

Fees paid to Councillors	2021 (000's)	2020 (000's)
R Aston	37	31
K Clark	37	-
S Child	24	22
A Connolly	-	6
T Fonua-Faeamani	35	39
K Fox	46	47
A Goodman	40	48
P Hale	36	38
C Hornabrook	36	33
S Hughes (Deputy Chair)	30	31
P Hutchison	5	28
R Love	22	-
G McLachlan	32	26
L Mueller	-	13
J Nacey	8	44
K Ngarimu	24	50
C Walker (Chair)	65	89
C Walker (MidCentral DHB)	65	78
Total fees paid to Council members	**542**	**623**

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Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2021

15 Related party transactions (continued)

Te Ohu Rata o Aotearoa (Te Ora) provided services to the Council related to the jointly published Cultural Safety Baseline Data Report (October 2020). Te Ora is a related party as the Chair of Council is also the Deputy Chair of Te Ora. The value of services provided in the year was $6k (2020: $Nil). At year-end, $Nil was owed to Te Ora by the Council (2020: $Nil).

There were no other related party transactions (2020: None).

Key management personnel

The key management personnel, as defined by PBE IPSAS 20 *Related Party Disclosures,* are the members of the governing body comprising Council members, the Chief Executive Officer, Deputy Chief Executive, Registrar, Deputy Registrar, Finance Manager, Strategic Manager and Health Manager.

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.

	2021 (000's)	2020 (000's)
Total key management personnel remuneration	**1,296**	**1,154**
Number of persons	7	7
Full time equivalents basis (FTE)	6.65	5.83

16 Capital and other commitments

During the reporting period, the Council has renewed a contract with an IT vendor to support and develop our information systems. The Council is committed to incur $820k (2020: $800k) during the financial year ending 30 June 2022.

The Council has no other capital commitments at the reporting date (2020: None).

Non cancellable operating lease commitments

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

	2021 (000's)	2020 (000's)
Not later than 1 year	1,155	1,107
Later than 1 year no later than 5 years	4,611	4,429
Later than 5 years	2,087	3,137
Total minimum lease payments	**7,853**	**8,673**

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

17 Contingent assets and liabilities

There are no contingent assets or liabilities at the reporting date (2020: None).

18 Events after the reporting period

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

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

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

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INDEPENDENT AUDITOR'S REPORT
TO THE READERS OF THE MEDICAL COUNCIL OF NEW ZEALAND'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2021

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

Opinion

We have audited the financial statements of the Medical Council, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive revenue and expenses, the statement of changes in net assets and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information.

In our opinion the financial statements of the Medical Council,

- present fairly, in all material respects:
  - its financial position as at 30 June 2021; and
  - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Standards – Reduced Disclosure Regime.

Our audit was completed on 10 December 2021. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

Responsibilities of the Council for the financial statements

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

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

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

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

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

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

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

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

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

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

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

- We conclude on the appropriateness of the use of the going concern basis of accounting by the governing body and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Medical Council's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Medical Council to cease to continue as a going concern.

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

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

Our responsibility arises from the Public Audit Act 2001 and section 134(1) of the Health Practitioners Competence Assurance Act 2003.

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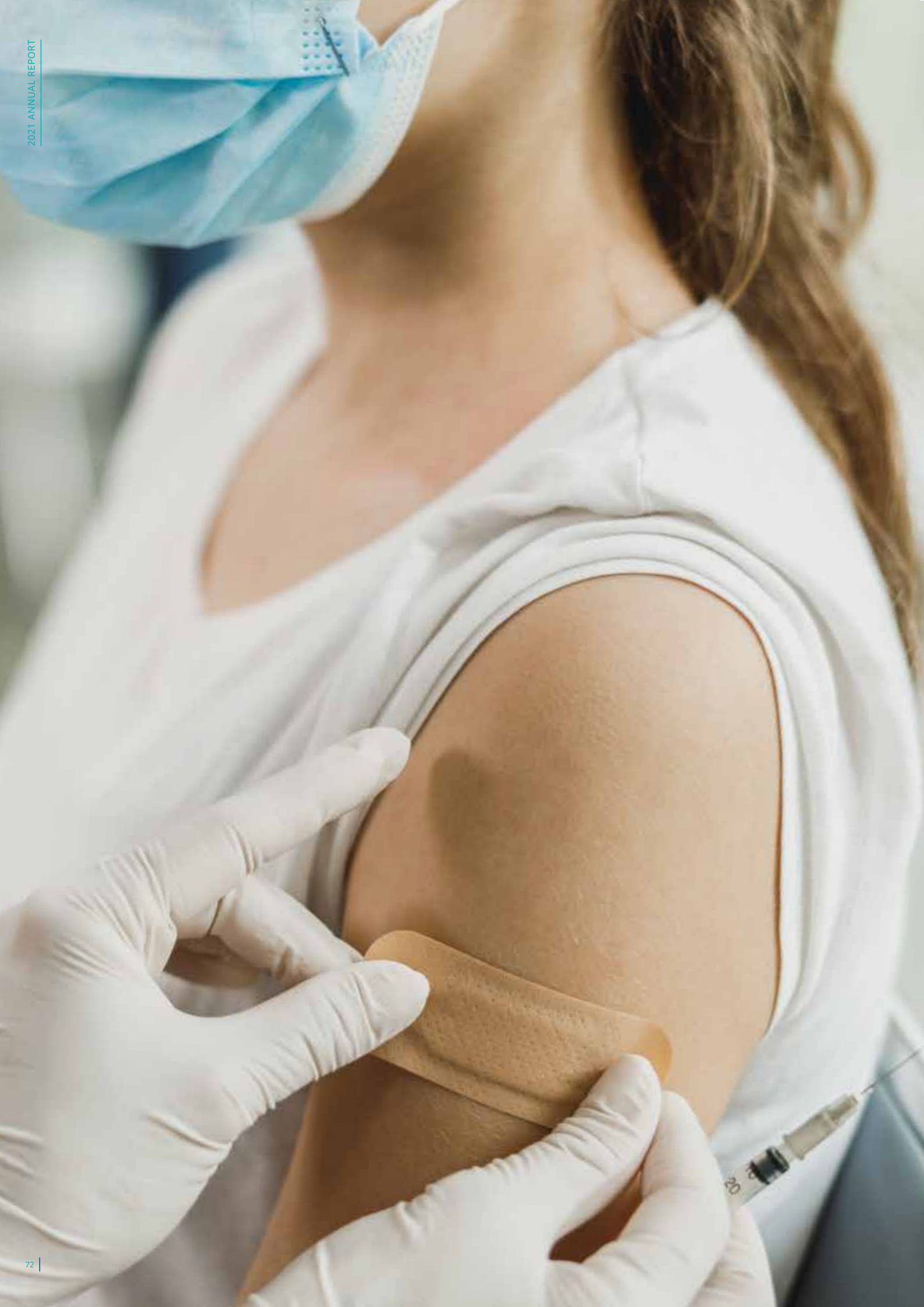
Independence
We are independent of the Medical Council in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1(Revised): *Code of Ethics for Assurance Practitioners* issued by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

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

Chrissie Murray
Baker Tilly Staples Rodway Audit Limited

On behalf of the Auditor-General
Wellington, New Zealand



Corporate governance

Role of Council

Members of Council set the strategic direction of the organisation, monitor the CEO's performance, and ensure Council fulfils the requirements of the HPCAA 2003 and meets other statutory obligations.

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

Council membership

Although the Minister of Health appoints Council members, we aim to have members who represent a broad mix of doctors and laypeople of different ages, genders, and ethnicities that reflect the diversity of New Zealand society, and who have a wide general knowledge and breadth of vision as well as having one of the following:

- Broad health sector knowledge
- Experience in one of the main vocational scopes of practice
- Experience in health service delivery in a variety of provincial and tertiary settings
- Experience in medical education and assessment
- Experience in financial management.

Council committee structure

Council operates three standing committees – Audit and Risk, Education and Health – each with clearly established levels of delegated authority. A smaller, specific committee – the Registration Committee – was established in December 2019. The membership of these committees is listed on page 74. Council receives committee meeting minutes at its formal meetings and, in approving those minutes, confirms the decisions made.

Links with medical regulatory bodies

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

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

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

- Te Ohu Rata o Aotearoa (Te ORA)
- Accident Compensation Corporation
- Association of Salaried Medical Specialists
- Chief Medical Officers of DHBs
- Council of Medical Colleges
- Health and Disability Commissioner
- Members of the profession, other regulatory authorities, medical students, and community groups
- Medical colleges and associations
- Medical Protection Society
- Minister of Health
- New Zealand Resident Doctors' Association
- New Zealand Medical Association.

Council committees [1]

Council standing committees as at 30 June 2021

Chairperson - Dr Curtis Walker
Deputy Chairperson - Ms Susan Hughes QC

Audit and Risk Committee
- Ms Susan Hughes QC (Chair)
- Dr Paul Hutchison
- Ms Giselle McLachlan
- Mr Roy Tiffin (independent / non-Council member)

Health Committee
- Dr Pamela Hale (Chair)
- Richard Aston
- Dr Lu'isa Fonua-Faeamani
- Ms Kath Fox
- Dr Charles Hornabrook

Registration Committee
- Dr Curtis Walker (Chair)
- Dr Charles Hornabrook
- Ms Susan Hughes QC

Education Committee – Council members
- Dr Kenneth Clark (Chair)
- Dr Curtis Walker
- Dr Stephen Child
- Dr Ainsley Goodman
- Ms Kim Ngārimu

Education Committee – non-Council members
- Dr Jonathan Albrett

Nominee of a Vocational training provider

- Dr Sarah Nicolson

Nominee of a Vocational training provider and Council's representative on SEAC

- Dr Suzanne Busch

Prevocational Educational Supervisor

- Dr Teriana Maheno

Active consumer of education – Vocational trainee representative member

- Dr Fraser Jeffery

Active consumer of education – Intern representative member (PGY2)

- Dr Emma Espiner

Active consumer of education – Intern representative member (PGY1)

- Dr Cameron Wells

Active consumer of education – Intern rep Member (PGY2)

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

Contact details

Bankers

ASB Bank Limited
PO Box 11966
Wellington 6011

Auditors

Baker Tilly Staples Rodway
PO Box 1208
Wellington 6140

Office of the Auditor-General
Private Box 3928
Wellington 6140

Te Kaunihera Rata o Aotearoa

Medical Council of New Zealand
Level 24
Aon Centre
1 Willis Street
Wellington 6011

PO Box 10509
Wellington 6011

Phone: (64) 4 384 7635, 0800 286 801
Email: mcnz@mcnz.org.nz
Web: www.mcnz.org.nz

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