2020 ANNUAL REPORT

Te Kaunihera Rata o Aotearoa

Medical Council of New Zealand

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

Protecting the public, promoting good medical practice.

Contents

Introduction

The Medical Council of New Zealand is pleased to submit this report, for the year ending 30 June 2020, to the Minister of Health. The report is presented in accordance with section 134 of the Health Practitioners Competence Assurance Act 2003 and includes a report on activities of the Health Practitioners Disciplinary Tribunal (doctor cases only).

Facts at a glance

(1 July 2019 to 30 June 2020)

Doctors newly registered

530
Trained in New Zealand

1,019
International medical graduates

17,671
Total practising doctors at 30 June 2020

695
Doctors newly registered with vocational scopes

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

26
Candidates sat NZREX Clinical

20
Candidates passed NZREX Clinical

31
Referrals to a professional conduct committee

19
Referrals to a performance assessment committee

8
Education programmes ordered after a performance assessment

42
Referrals to the Health Committee

Chair's Foreword

**E Rangi ki runga,
E Papa ki raro,
Ka puta te ira tāngata
ki te whai Ao, ki te Ao mārama,
Tīhei Māuri Ora!**

In considering the extraordinary year that has seen a once-in-a-century global pandemic, the essence of life prevails, and it is a privilege to present the annual report of Te Kaunihera Rata o Aotearoa | The Medical Council of New Zealand.

I would like to thank all doctors, health professionals and everyone involved in health care for their invaluable contributions to health services in New Zealand during the year. Similarly, I acknowledge the challenges all New Zealanders have faced, and will continue to face, until we return to whatever will be the new normal. Ngā mihi manaakitanga ki a koutou katoa.

I also thank those many members of the medical profession who responded to the mass casualties which resulted from the Whakaari / White Island eruption in December 2019. The skills, dedication and cohesiveness of our health care workers was a shining example of professionalism during a very dark event.

He mihi – welcomes

In late 2019 we welcomed four new members on the Council, all of whom have brought a wealth of skills and experience to Council. They are:

- Mr Richard Aston, who has extensive experience in social services and governance roles for boards, trusts and government panels. He has held Chair and CEO roles, and has an interest in promoting men's health, and the role of technology advances in health care.
- Stephen Child, an Auckland-based general physician with a special interest in respiratory medicine. Dr Child divides his time between private practice and consultancy roles, and has held numerous governance and leadership positions with medical organisations.
- Charles Hornabrook, a consultant psychiatrist with numerous directorship roles and interests in neuropsychiatry, ethics, professionalism and the collaboration of specialist services for patients with complex mental health problems.
- Giselle McLachlan is an experienced company director and chartered member of the Insitute of Directors. She has held a broad range of governance and executive leadership roles, and has practised as a lawyer for over 30 years.

Haere rā - Farewells

As new appointments were made, we farewelled three long serving Council members: former Council Chair, Andrew Connolly, Deputy Chair, Laura Mueller and Jonathan Fox. I would like to acknowledge and thank Andrew, Laura, and Jonathan, for their many, many years of dedicated service to the public of New Zealand through their terms on the Medical Council. All three members had completed their maximum-allowable three terms (9 years) i.e. 27 years of Council work when taken together! Their contributions to Council were immense. In particular, I thank Andrew Connolly for his leadership and championing of the vital role Council has come to play in advocating for cultural safety, Māori partnership and health equity. Ngā mihi nunui ki a koutou e ngā rangatira whakahirahira.

Te Urutā - COVID-19

The New Zealand Medical Council traces its founding to 1915 under the Medical Practitioner's Act 1914. Just three years later, New Zealand was struck by the 1918 influenza pandemic at a cost of 9000 lives, including 2500 Māori. Just over 100 years later, the arrival of COVID-19 challenged us as a medical profession, and tested our health system once again. Doctors and other healthcare professionals across the country were charged with the difficult task getting COVID-19 testing up and running, and of caring for those impacted by COVID-19, while continuing to deliver health care for whānau and communities under strict restrictions on physical contact.

Council played a critical role in supporting the response. We enabled the medical profession to provide healthcare whilst preparing and planning for COVID-19 responses by deferring non-urgent activities and ensuring as many practitioners as possible could be at the frontline if needed.

Council enacted a range of measures to improve the capacity and responsiveness of the profession whilst ensuring high standards of practice were maintained. Our advice on a range of matters, including the use of personal protective equipment, supported doctors to continue carrying out essential examinations, operations, and other procedures safely and effectively. Similarly, our agile approach was demonstrated in changes we made to guidance on the safe use of Telehealth, which supports consultations and essential clinical services to be safely and effectively provided by video or telephone.

We also took steps to ensure a good coverage of medical expertise across the country. Temporary changes to our internship, registration and recertification policies gave DHBs more flexibility to the profession, so they could support the COVID-19 response to their communities - directly and indirectly.

With COVID-19 restrictions affecting travel, staff's ability to work, and the prioritisation of direct clinical care, Council deferred a number of accreditation visits to Medical Colleges and DHBs. This had an effect upon Council's income from these activities. Our income through annual practising certificates remained strong, with doctors choosing to remain in New Zealand through the pandemic, and international medical graduates continuing to arrive in similar numbers overall. As a result of the reduced income, but ongoing fixed expenses, in conjunction with ongoing building expenses following the 2016 Kaikoura Earthquake, and high disciplinary case expenses, Council gazetted an increase in the practising certificate and disciplinary levy totalling 5.85%.

This step was not taken lightly, nor without significant consideration of the economic impact from COVID-19 on many medical practitioners and businesses. However, when combined with a line-by-line review of Council's annual budget and ongoing work to ensure our financial controls and policies are best practice, I am confident that Council is in a secure financial position to face the global economic uncertainties in the years ahead.

Te Ao Hou - The emergence of digital health

The practice of medicine is an essential service that needs to be accessible at all times – to anyone, anywhere, in any situation. COVID-19 has taught us that we need to be smart and agile about the way we, along with our health sector partners, use technology to provide healthcare for patients. Perhaps the most significant advancement in medical practice during the pandemic was the rapid take-off of telehealth, which enabled doctors to carry out consultations using digital technology. The explosion of this service which, pre-COVID-19, was only offered by a small number of practices, has made virtual consultations a much more commonplace, acceptable and accessible form of patient care.

What is more, further digital technologies are just around the corner and already in use. Artificial intelligence, for example, can help doctors carry out surgery with greater precision and fewer accidents. 'At home' diagnoses are now possible, in many cases, with new online tools that enable data to be sent to doctors and patients at the click of a few buttons.

But new medical technology can only improve medical practice if it's used correctly and in the best interests of patients. Heading into 2021/22, the Council will be taking a broader, more future-focussed view of its regulatory role when it comes to supporting good medical practice with new technology. Just as we did with telehealth, and with our initial consultation on the clinical use of AI in July 2020, we'll be working closely with the profession and stakeholders to ensure emerging technologies are used safely, ethically, and effectively.

Ha mana taurite - Cultural safety and health equity

Improving health care for Māori, Pasifika, people with disabilities, and other groups experiencing health disadvantage, is one of the biggest challenges facing our health sector, and every profession and organisation within it has a part to play. Doctors are often the first-port-of-call for patients entering the health system. It is therefore up to us to think about how the way we practise and interact with our Māori patients can contribute to health equity and cultural safety in Aotearoa New Zealand.

Following the Government's recent review of the health and disability system, Council and our partners, Te Ohu Rata o Aotearoa (Te ORA), released an independent report on the experiences of Māori patients visiting their doctors. Analysis of the findings has uncovered significant barriers to achieving health equity in virtually every level of our health system. They range from an insufficient understanding of the importance of patient culture, beliefs and values in clinical practice, to under-representation of Māori in health sector governance and decision-making. Further insights confirm that the number of Māori doctors numbers remains well below being proportional to population demographics, and that more needs to be done to recognise the additional demands Māori doctors experience on top of their work – known as cultural loading. On a positive note, New Zealand's two medical schools are making excellent progress in selecting and training the next generations of doctors.

Our partnership with Te ORA focuses on improving how patients experience their care. Our initial guidance for doctors – including our Statement on Cultural Safety and He Ara Hauora Māori: A Pathway to Māori Health Equity – are the beginnings of what will be a long journey for ourselves, the profession and the wider health system.

The good news is, for the first time, there is a clear consensus – both throughout the health sector and across government – that institutional racism in our health sector is a serious problem, and a concerted and collective effort is required to address it. Council looks forward to continuing our work with Māori, doctors, medical providers, training institutions, health agencies and Government to address the report's findings and to ensure the medical profession is fully contributing to achieving health equity.

He whakamutunga – in conclusion

We can be rightly proud of the high standard of medical practice in New Zealand, which is a reflection of the commitment of doctors up and down the country to training, lifelong learning, and serving patients and their whānau.

Finally, I wish to thank the hard-working staff of the Medical Council, including our Chief Executive, Joan Simeon. It is a pleasure to lead such a dedicated team of Council members and it is the staff who work so diligently that ensures that the public's trust and confidence in the medical profession continues to be well-placed.

Noho ora mai

Dr Curtis Walker
Chair
Medical Council of New Zealand

Chief Executive's Foreword

Tēnā koutou

Our primary focus is, and always will be, public safety. We're here to protect the public by promoting good medical practice and ensuring doctors are competent and fit to practise. We've continued to meet these responsibilities despite the challenges of the past year.

The speed and clarity of Council's response to COVID-19, including regular communication to support the medical profession and the health sector during the pandemic crisis, was greatly appreciated and positively received. We worked closely with our New Zealand regulatory authority colleagues and the Ministry of Health during the COVID-19 response. Changes made to our statement on telehealth and prescribing are two examples of our continued focus on public safety through guidance to the profession during this time.

Over the 2019/20 financial year we completed registrations for more than 1,500 medical graduates from here and abroad; our committees processed close to a hundred performance, conduct and health referrals; and we've updated our expectations around informed consent, cultural safety, unprofessional behaviour and several other areas of clinical practice in consultation with the public and profession.

Lifelong learning

Being an effective regulator goes beyond setting and maintaining standards for the conduct and competence of medical professionals. Equally, it is about supporting the profession to respond to the changing needs and expectations of patients and communities.

We have strengthened our requirements for doctors to confirm they are keeping up to date, and completing and continuing meaningful professional development. Our strengthened requirements for recertification are based on the latest evidence and research around what is most effective, and includes a focus on reflective practice.

Cultural safety and health equity

Improving the standard of health care for Māori, and achieving health equity, continues to be a key priority for us, and for our health sector colleagues. Council's work with our partners, Te Ohu Rata o Aotearoa (Te ORA), is about putting the interests of Māori front and centre of modern clinical practice. Our particular focus is on building stronger relationships between Māori patients and their doctors, based on trust and respect. Good doctor/patient relationships are fundamental to cultural safety and health equity in New Zealand; the better these relationships are, the better the outcomes will be – for Māori patients, whānau, and communities.

In September 2020 we are due to publish, with Te ORA, an independent research report and recommendations based on the healthcare experiences of Māori patients. This feedback will inform our ongoing and future work with Te ORA to ensure that cultural safety for Māori is embedded in the way every doctor practises as we work towards achieving health equity. This baseline data will also inform future evaluations, as we monitor and track progress.

Accountability

Council is preparing for its first ever performance review in mid-2021. Brought about by recent amendments to the Health Practitioners Competence Assurance Act, the review will be led by the Ministry of Health and will measure how well we perform our key functions. The reviews will be held every 5 years and apply to all 16 responsible authorities (RAs) in the health sector.

For Council, the reviews are a learning opportunity and will identify areas we may need to focus on and strengthen in the future. The reports will be made publically available and will help to demonstrate our role in protecting the public by ensuring that doctors are competent and fit to practise. Equally, the review will provide greater visibility of the critical leadership demonstrated by RAs, and the collaborative approach we take with our RA colleagues, as well as other health sector stakeholders and agencies.

Over the past year Council staff have been meeting regularly with Ministry of Health officials, and a small group of other RAs, to ensure the review terms of reference are focused on what matters most. We provided a joint submission, with the Nursing, Dental and Pharmacy Councils to the Ministry of Health last June.

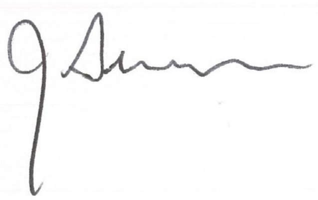
Working together

Our successes over the past year could not have been achieved without the excellent relationships we hold across the health sector. We regularly collaborate with medical schools, medical colleges, DHBs, private hospitals and doctors as we develop guidance and set standards for the profession. Our consumer advisory group plays an important role in providing important input into all aspects of our work. We also work in close partnership with the Ministry of Health and our fellow New Zealand and international health practitioner regulators.

The challenges of COVID-19 have strengthened these relationships and brought the health sector closer together. With major changes expected in health over the next few years, I look forward to continuing these partnerships as we work together to ensure a high standard of healthcare for all New Zealanders.

It has been a privilege to lead such a dedicated, committed and skilled team of people. I would like to take the opportunity to recognise our team's dedication throughout the year, and thank our Chair, Dr Curtis Walker, and Council members for their outstanding support and commitment to our work.

Ngā manaakitanga



Joan Simeon
Chief Executive
Medical Council of New Zealand

Our Key Achievements 2019/2020

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.

Doctors are competent and fit to practise

We protect public safety by setting standards of competence and professional behaviour for New Zealand's medical profession.

Key achievements:

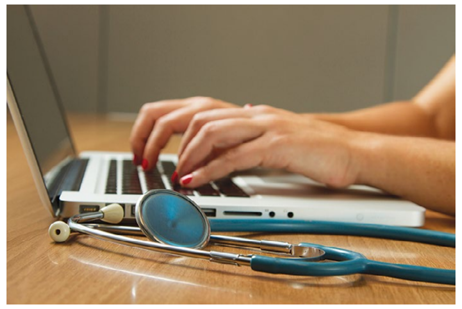
- Completed registrations for more than 1,500 medical graduates from here and abroad.
- Updated our ethical framework for the use of telehealth in delivering medical care, enabling essential clinical services to be safely and effectively delivered during COVID-19 via digital technology.
- Provided a rapid and agile COVID-19 response to support doctors, DHBs and medical practices with a range of measures, including a plan to increase the size of the medical workforce and guidance to manage our usual patient safety activities.
- Clarified doctors' responsibilities around informed consent, ensuring patients have the right information to make better informed decisions about their care.
- Strengthened patient safety by reviewing our standards to support our zero-tolerance position on sexual relationships in the doctor-patient relationship.
- Investigated about 100 concerns about doctor health and performance.

Culturally safe and equitable medical practice in New Zealand

With our partners, Te Ohu Rata o Aotearoa (Te ORA), we work with our stakeholders across the health sector to achieve health equity and improve health outcomes for Māori. Our main areas of focus include strengthening the relationships between Māori patients and their doctors, and promoting a medical workforce that reflects the communities it serves.

Key achievements:

- Co-led with our partners, Te ORA, a symposium on cultural safety and health equity. The conference featured presentations from Māori medical experts, the Minister of Health, academics and health sector leaders.
- Released two foundational documents – our Statement on Cultural Safety and He Ara Hauora Māori: A Pathway to Māori Health Equity – which provide direction on culturally-safe and equitable medical care in New Zealand.
- Commissioned, in partnership with Te ORA, an extensive, independent research report about health outcomes for Māori and the experiences of Māori patients visiting their doctors. Due for publication in September 2020, the report findings and recommendations will set the baseline for future evaluations and help shape the future of clinical practice in New Zealand.



Doctors receive the best training and education available

We promote a high standard of education across the medical profession, ensuring current doctors keep up to date with best practice and the latest medical advice.

Key achievements:

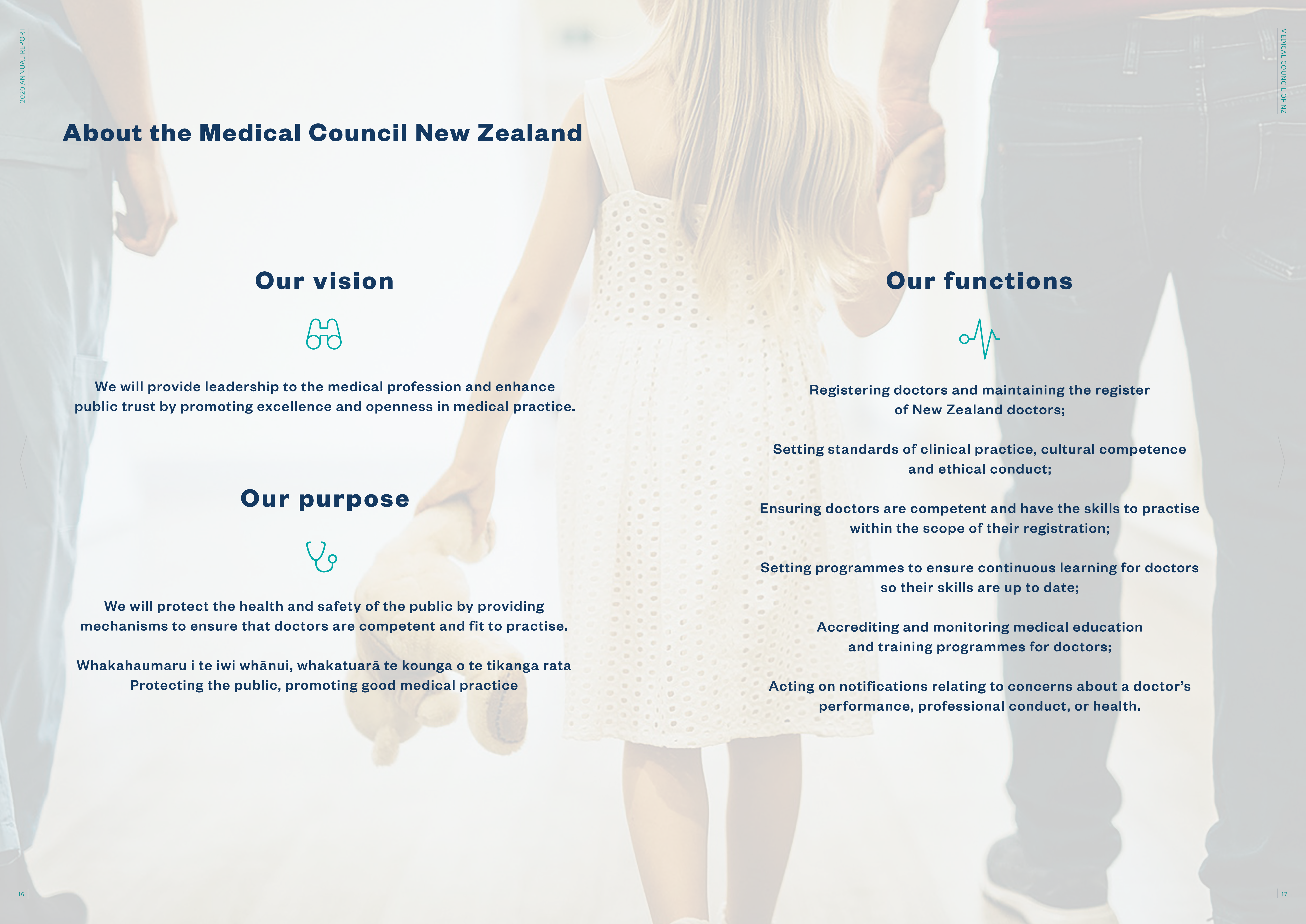
- Strengthened our accreditation processes, setting standards for medical training providers, which require them to demonstrate they are providing a high standard of training for medical students, interns in their first two years of medical practice, and doctors undertaking their specialist vocational training.
- Embedded community-based, clinical attachments (CBAs) in many of our DHB prevocational medical training programmes. This ensures that interns have an opportunity to experience how care is delivered in a wider range of clinical settings including general practice, urgent care, hospice, public health and community mental health.
- Increased the focus on cultural safety and health equity in the accreditation standards for medical training providers. This ensures consistency of approach and standards for vocational training across both New Zealand and Australasian colleges.
- Established stronger evidence-based requirements for providers of recertification programmes, supporting doctors to reflect on their practice, focus their professional development activities on identified development needs, and get more constructive feedback and peer support.

Stronger partnerships, relationships & connections

Whether we're reviewing or developing standards for doctors, or promoting cultural change to shape the future of clinical practice, we work together with the medical profession, regulatory bodies, health sector agencies and many others to raise the standard of health care for New Zealanders.

Key achievements:

- Contributed to the leadership of the International Association Medical Regulatory Authorities (IAMRA). With our Chief Executive on the Board of IAMRA, and members of Council's leadership team on key IAMRA committees, we keep up to date with evidence-based regulation, have a stronger voice in international discussions and maintain closer strategic alignment with our international counterparts.
- Worked with our partners Te Ohu Rata o Aotearoa (Te ORA) in efforts to put Māori interests front and centre of our regulatory functions, including consultations, decisions and advice to the medical profession.
- Delivered international presentations on our regulatory response to COVID-19, providing advice to medical regulatory bodies grappling with the impact of the pandemic in their jurisdictions.
- Further developed our memorandum of understanding with a range of different authorities – including with DHBs, medical schools and medical colleges – to clarify the way we work together and our roles and responsibilities related to public safety.
- Worked closely with our New Zealand health practitioner regulatory authorities, advising on best practice for clinical, cultural and ethical standards for the professions.



About the Medical Council New Zealand

Our vision

We will provide leadership to the medical profession and enhance public trust by promoting excellence and openness in medical practice.

Our purpose

We will protect the health and safety of the public by providing mechanisms to ensure that doctors are competent and fit to practise.

Whakahaumaru i te iwi whānui, whakatuarā te kounga o te tikanga rata
Protecting the public, promoting good medical practice

Our functions

Registering doctors and maintaining the register of New Zealand doctors;

Setting standards of clinical practice, cultural competence and ethical conduct;

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.

Our strategic priorities

Strategic direction one – Accountability to the public and stakeholders	
1.1	Increased public confidence that Council is transparent and fair in its decision-making and protects individuals' privacy.
1.2	Improved understanding by the profession, key stakeholders and members of the public of Council's role and functions.
1.3	Increased input from the public and stakeholders into strategy, policy and business development.
1.4	Maintained cross-health regulator liaison and collaboration – New Zealand and internationally.
1.5	Maintained effectiveness of MoUs with other entities.
1.6	Improved regulatory processes.

Strategic direction two – Cultural safety, partnership, and health equity	
2.1	Increased understanding of cultural safety and health equity, and improved self-reflection of doctors of their own attitudes, values and biases.
2.2	Increased focus by training organisations of the importance of embedding the principles of cultural safety and health equity into training and recertification programmes.
2.3	Strengthened role of Council as a health sector leader in the discussion to improve cultural safety and equity for patients.

Strategic direction three – Promoting competence	
3.1	Strengthened standards are in place that provide guidance to doctors about the expected standards of competence and their effective interactions within inter-professional teams.
3.2	Strengthened recertification programmes are in place that ensure doctors demonstrate they are actively participating in reflective practice, professional development and lifelong learning for continual improvements to practice.
3.3	Increased focus on right-touch regulation principles in all of our functions and decision-making.

Strategic direction four – Medical education	
4.1	Improved medical educational programmes across the training continuum, from medical school, during prevocational medical training and vocational training.
4.2	Strengthened support for trainees across the education continuum.
4.3	Strengthened medical school prevocational and vocational training provider accreditation standards.
4.4	Improved skills and competencies of doctors completing education programmes that equip them to transition to further training and/or career development.

Strategic direction five – Research and evidence-based regulation	
5.1	Increased use of research and evidence in the development of strategies and policies.
5.2	Increased information sharing for health sector and workforce development.
5.3	Increased use of outcome data informs process improvement.

Our Council Members - 30 June 2019

Council governance is made up of 13 members, including eight doctor's and five non-health professionals.

Back row from left to right:

Ms Giselle McLachlan, Mr Richard Aston, Dr Stephen Child, Mr David Dunbar (Registrar), Dr Charles Hornabrook, Ms Kath Fox, Ms Kim Ngārimu, Dr Lu'isa Fonua-Faeamani, Dr Pamela Hale.

Front row from left to right:

Dr Paul Hutchison, Ms Susan Hughes QC (Deputy Chair), Dr Curtis Walker (Chair), Ms Joan Simeon (Chief Executive), Professor John Nacey, Dr Ainsley Goodman.

How we make decisions

Right touch regulation

We protect public safety 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 2019-2020 and considered at 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 to impact to the profession and stakeholders in these unprecedented and challenging times.

The Council remains committed to operating in a cost effective manner and 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 both 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 and it was pleasing to see the organisation adapt seamlessly to remote working through COVID-19.
- We continue to prioritise our privacy programme and 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

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 2020

	Notes	2020 (000's)	2019 (000's)
Revenue from non-exchange transactions			
Practising certificate (PC) fees and disciplinary levies		12,936	11,945
Disciplinary fines and recoveries		331	276
Total non-exchange revenue		**13,267**	**12,221**
Revenue from exchange transactions			
Fees received		2,623	2,533
Interest income		67	137
Other income		225	103
Total exchange revenue		**2,915**	**2,773**
Total revenue		**16,182**	**14,994**
Expenses per schedules	**5**		
Administration expenses		10,641	9,594
Council and profession expenses		3,629	3,433
Disciplinary expenses		2,446	1,385
Examination expenses		82	175
Total expenses		**16,798**	**14,587**
Results before expenses incurred due to the effects of the Kaikoura eathquake		**(616)**	**407**
Net effects of the Kaikōura earthquake			
Impairment expense		-	403
Onerous lease costs and make good provision	**13**	328	2,386
Business interruption insurance proceeds	**17**	(529)	-
Total net effects of the Kaikōura earthquake		**(201)**	**2,789**
Total surplus/(deficit) for the year		**(415)**	**(2,382)**
Other comprehensive revenue and expense for the year		-	-
Total comprehensive revenue and expense for the year		**(415)**	**(2,382)**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Statement of Changes in Net Assets
For the year ended 30 June 2020

	General Reserve (000's)	Disciplinary Reserve (000's)	Examination Reserve (000's)	Total Equity (000's)
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**
Opening equity balance 1 July 2018	6,814	1,557	429	8,800
Total surplus / (deficit) for the year	(2,782)	413	(13)	(2,382)
Closing equity balance 30 June 2019	**4,032**	**1,970**	**416**	**6,418**

BTSR

BTSR

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Statement of Financial Position
As at 30 June 2020

	Notes	2020 (000's)	2019 (000's)
Current assets			
Cash and cash equivalents		1,682	1,730
Short term investments		1,250	2,500
Receivables	7	291	447
Total current assets		**3,223**	**4,677**
Non-current assets			
Intangible assets	8	3,856	4,304
Work in progress	9	671	482
Property, plant and equipment	10	1,894	2,060
Total non-current assets		**6,421**	**6,846**
Total assets		**9,644**	**11,523**
Current liabilities			
Payables	11	704	1,790
Employee entitlements	12	359	553
Provisions	13	662	605
Revenue received in advance		469	305
Total current liabilities		**2,194**	**3,253**
Non-current liabilities			
Employee entitlements	12	51	71
Provisions	13	1,396	1,781
Total non-current liabilities		**1,447**	**1,852**
Total liabilities		**3,641**	**5,105**
Net assets		**6,003**	**6,418**
Equity			
General reserve		4,010	4,032
Disciplinary reserve		1,725	1,970
Examination reserve		268	416
Total Equity		**6,003**	**6,418**

Authorised for issue for and on behalf of the Council on 13 October 2020.

Curtis Walker
Chairperson

Susan Hughes QC
Deputy Chair | Chair - Audit Committee

BTSR

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Statement of Cash Flows
For the year ended 30 June 2020

	2020 (000's)	2019 (000's)
Cash flows from operating activities		
Receipts		
Receipts from operating activities	16,896	14,703
Payments		
Payments to suppliers and employees	(17,331)	(12,494)
Net cash flows from operating activities	**(435)**	**2,209**
Cash flows from investing activities		
Receipts		
Interest received	60	155
Redemption of investments	4,000	4,250
Payments		
Purchase of property, plant and equipment	(140)	(1,953)
Purchase of intangible assets	(783)	(1,160)
Investments in short term deposits	(2,750)	(2,000)
Net cash flows from investing activities	**387**	**(708)**
Net increase/(decrease) in cash and cash equivalents	**(48)**	**1,501**
Cash and cash equivalents at 1 July	1,730	229
Cash and cash equivalents at 30 June	**1,682**	**1,730**
Represented by:		
Petty Cash	-	1
ASB Bank Account - General	17	109
ASB Bank Account - Call	1,665	1,620
	1,682	**1,730**

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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 2020

1 Reporting entity

The Medical Council of New Zealand (the Council) is a statutory body 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. In order 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 13 October 2020.

2 Statement of compliance

The financial statements 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 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 fines and 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.

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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 2020

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 (2019: 2.4 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 Public Sector (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 $100k was written off from the provision for doubtful debts. There were no other impairments of financial assets for the year.

Financial liabilities

The Council's financial liabilities include 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.

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.

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2020

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.

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 aquisition.

Depreciation is charged on a straight-line (SL) 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% SL p.a.
• Office alterations	10% SL p.a.
• Office equipment	20% SL p.a.
• Computer hardware	33% SL p.a.

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.

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% - 33% SL p.a.
• Purchased software	10% SL 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.

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2020

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.

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.

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).

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2020

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, except for the onerous lease provision outlined below.

Provisions

Onerous lease provision

Management has exercised its judgement in recognising an onerous lease provision and impairment of assets associated with 80 The Terrace, Wellington. The provision arises from a non-cancellable lease where the unavoidable costs of meeting the lease exceed the economic benefits to be received from it. Further information is provided in Note 13 and 17.

The provision recognises the discounted future lease payments over the remainder of the lease which expires in July 2023. Additionally, the Council is required at the expiry of the lease to make-good any damage caused to the premises and to remove any fixtures or fittings installed by the Council. No offsetting amounts, such as sublease recoveries, have been factored. The key assumptions in calculating the provision are as follows:

• a discount rate of 6% p.a. has been applied

• The final rent review under the lease was in July 2020 and no notice has been received or an allowance factored recognising the condition of the building.

• operational expenses incurred under the lease are assumed to increase by 5% p.a. over the remainder of the lease; and

• $300,000 has been estimated in relation to the make-good with the timing of the cash outflow to occur at the expiry of the lease.

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

• The condition of the asset

• The nature of the asset, its susceptibility and adaptability to changes in technology and processes

• The 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.

Long service leave

The measurement of long service lease was based on a number of assumptions. An assessment of 79 employees employed at 30 June 2020 was undertaken as to which employees would reach the long service criteria. 7 employees had entitlements and this is reflected as the current portion. The non-current portion reflects the assessment of the probability of employees earning long service leave in the future. Due to the number of employees affected and relatively low length of service, discount rates and salary inflation factors were not incorporated into the calculation.

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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 2020

5 Expenses

	Administration	Council and profession	Disciplinary	Examination	Total
2020	**(000's)**	**(000's)**	**(000's)**	**(000's)**	**(000's)**
Administration expenses	199	-	-	-	199
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	**10,641**	**3,629**	**2,446**	**82**	**16,798**
2019					
Administration expenses	251	-	-	-	251
Amortisation	1,077	-	-	-	1,077
Communication expenses	47	-	-	-	47
Council expenses	-	729	-	-	729
Depreciation	227	-	-	-	227
Disciplinary or legal expenses	-	195	809	-	1,004
Education committee expenses	-	85	-	-	85
Education general expenses	-	963	-	-	963
Health committee expenses	-	88	-	-	88
Health general expenses	-	224	-	-	224
HPDT disciplinary expenses	-	-	187	-	187
Insurance	47	-	-	-	47
IT & systems expenses	418	-	-	-	418
NZRex clinical expenses	-	-	-	132	132
Premises expenses	1,005	-	-	-	1,005
Professional standards expenses	-	371	-	-	371
Registration expenses	-	621	-	-	621
Staff general expenses	389	-	7	-	396
Staff remuneration	6,133	-	382	43	6,558
Strategy expenses	-	157	-	-	157
Total expenses	**9,594**	**3,433**	**1,385**	**175**	**14,587**

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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 2020

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 (2019: $29k). No non-audit services have been provided by the auditor.

7 Receivables

	2020 (000's)	2019 (000's)
GST receivable	-	247
Interest receivable	14	7
Prepayments	95	101
Receivables	463	421
Provision for doubtful debts	(281)	(329)
Total receivables	**291**	**447**

8 Intangible assets

	Developed Software (000's)	Purchased Software (000's)	Total (000's)
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**
2019			
Cost	10,652	30	10,682
Less: Accumulated amortisation and impairment	(6,375)	(3)	(6,378)
Net book value	**4,277**	**27**	**4,304**

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

	Developed Software (000's)	Purchased Software (000's)	Total (000's)
2020			
Opening balance	4,277	27	4,304
Additions	594	-	594
Disposals	-	-	-
Amortisation	(1,024)	(18)	(1,042)
Impairment	-	-	-
Closing balance	**3,847**	**9**	**3,856**

9 Work in progress

	2020 (000's)	2019 (000's)
Developed Software	671	482
Total work in progress	**671**	**482**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2020

10 Property, plant and equipment

	Computer Hardware (000's)	Furniture & Fittings (000's)	Office Alterations (000's)	Office Equipment (000's)	Total (000's)
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**
2019					
Cost	946	565	2,482	297	4,290
Less: Accumulated depreciation and impairment	(818)	(358)	(812)	(242)	(2,230)
Net book value	**128**	**207**	**1,670**	**55**	**2,060**

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

	Computer Hardware (000's)	Furniture & Fittings (000's)	Office Alterations (000's)	Office Equipment (000's)	Total (000's)
2020					
Opening balance	128	207	1,670	55	2,060
Additions	88	24	26	-	138
Disposals	-	-	-	-	-
Depreciation	(92)	(33)	(165)	(14)	(304)
Impairment	-	-	-	-	-
Closing balance	**124**	**198**	**1,531**	**41**	**1,894**

11 Payables

	2020 (000's)	2019 (000's)
Creditors	240	1,677
Accrued expenses	369	113
GST payable	95	-
	704	**1,790**

12 Employee entitlements

	2020 (000's)	2019 (000's)
Current portion		
Accrued salaries and wages	-	200
Annual leave	325	314
Long service leave	34	39
Total current portion	**359**	**553**
Non-current portion		
Long service leave	51	71
Total non-current portion	**51**	**71**
Total employee entitlements	**410**	**624**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2020

13 Provisions

	2020 (000's)	2019 (000's)
Current portion		
Onerous lease	662	605
Total current portion	**662**	**605**
Non-current portion		
Onerous lease	1,396	1,781
Total non-current portion	**1,396**	**1,781**
Total provisions	**2,058**	**2,386**
Movement of onerous lease provision:		
Opening balance	2,386	
Amounts used	(647)	
Additional provisions made	319	
Closing balance	**2,058**	

Onerous lease

The provision recognises a non-cancellable premises lease at 80 The Terrace, Wellington where the unavoidable costs of meeting the lease contract exceed the economic benefits to be received from it. The Council continues to met its obligations under the lease which expires in July 2023. At the end of the lease the Council is required to make-good any damage caused to the premises and to remove any fixtures and fittings installed. It is expected that the timing of the make good cash flow will occur at the expiry of the lease.

The provision was reviewed at the end of the current reporting year and has been adjusted to reflect the current best estimate including changes in the operating expenses payable under the lease.

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:

	2020 (000's)	2019 (000's)
Financial assets		
Cash and cash equivalents	1,682	1,730
Short term investments	1,250	2,500
Receivables	291	447
Total financial assets	**3,223**	**4,677**
Financial liabilities		
Payables	704	1,790
Employee entitlements	1,755	2,334
Total financial liabilities	**2,459**	**4,124**

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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 2020

15 Related party transactions

These expenses relate to all the activities of Council members.

Council member fees and expenses	2020 (000's)	2019 (000's)
Council fees	623	589
Council travel	126	200
Council expenses	29	46
Council development	7	2
Total Council member fees and expenses	**785**	**837**

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

Fees paid to Councillors	2020 (000's)	2019 (000's)
R Aston	31	-
S Child	22	-
A Connolly ^	6	63
A Connolly ^ (Counties Manukau DHB)	-	50
T Fonua-Faeamani	39	42
K Fox	47	14
J Fox	-	22
A Goodman	48	44
P Hale	38	48
C Hornabrook	33	-
S Hughes **	31	32
P Hutchison	28	31
G McLachlan	26	-
L Mueller ^^	13	50
J Nacey	44	45
K Ngarimu	50	54
J Quigley	-	3
C Walker *	89	62
C Walker * (MidCentral DHB)	78	29
Total fees paid to Council members	**623**	**589**

*/ ** denotes the current Chairperson / Deputy Chairperson elected in February 2019 respectively.
^ / ^^ denotes the former Chairperson / Deputy Chairperson through to Feburary 2019 respectively.

There were no other related party transactions (2019: 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.

	2020 (000's)	2019 (000's)
Total key management personnel remuneration	**1,154**	**1,089**
Number of persons	7	6
Full time equivalents basis (FTE)	6.65	5.65

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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 2020

Key management personnel (continued)

Restatement of prior year key management personnel

The Council completed an organisational realignment during the year. As a result of the realignment individuals whom Council deem to be key management personnel under the relevant standard have changed from the prior year. The prior year comparative figures have been revised to be consistent with the current year.

16 Capital commitments

The Council has no capital commitments at the reporting date (2019: None).

Non cancellable operating lease commitments

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

Premises Leases	2020 (000's)	2019 (000's)
Not later than 1 year	1,107	1,075
Later than 1 year no later than 5 years	4,429	4,298
Later than 5 years	3,137	4,119
Total minimum premises lease payments	**8,673**	**9,492**

The Council has a long term lease on premises at 1 Willis Street, Wellington. The lease expires on 30 April 2028 with a right of renewal for a further three years.

As outlined in Note 13, the Council has recognised a provision for the onerous lease on premises at 80 The Terrace, Wellington.

17 Insurance claim

During the year, the Council reached a full and final settlement on its business interruption insurance claim. This claim arose following the 14 November 2016, magnitude 7.8 Kaikōura earthquake which resulted in a significant period of displacement and disruption for Council and its staff. All insurance proceeds have been received totalling $529k excluding GST.

18 Contingent assets and liabilities

There are no contingent assets or liabilities at the reporting date (2019: Business interruption insurance claim initiated, refer to Note 17 for further information).

19 Effect of the COVID-19 pandemic

In March 2020, the World Health Organisation declared a pandemic in respect to the COVID-19 virus outbreak. Following establishment of a foothold within the New Zealand population, the New Zealand Government initiated a full societal lockdown with significant isolation requirements and movement restrictions imposed on citizens (with only essential services permitted to operate). The countrywide (Level 4) lockdown commenced on 26 March 2020 and was subsequently lifted on the 28 April 2020.

The Council is deemed an essential service and is committed to fulfilling its statutory obligations and strategic objectives, efficiently and effectively. At the date of issuing these financial statements, the Council's internal operations were not significantly affected.

Management forecast that income from practising certificates and other registration pathways are unlikely to be materially impacted by COVID-19. The Council has budgeted cost savings, including reduced travel and other Council costs and believes it has adequate reserves available to absorb any residual negative impact of the pandemic.

At this time the full financial impact of the COVID-19 pandemic is not able to be determined. However the impact of COVID-19 is not expected to significantly impact the ability of the Council to continue operating.

20 Events after the reporting period

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

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bakertilly STAPLES RODWAY

INDEPENDENT AUDITOR'S REPORT
TO THE READERS OF
MEDICAL COUNCIL OF NEW ZEALAND'S FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2020

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 2020, 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 2020; 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 19 October 2020. 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.

Emphasis of Matter – COVID-19

Without modifying our opinion, we draw attention to the disclosures about the impact of COVID-19 on the Council as set out in note 19 on page 15.

Responsibilities of the Council for the financial statements

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

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

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

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

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

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

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

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

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

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

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.

CMurray

Chrissie Murray
Baker Tilly Staples Rodway Audit Limited
On behalf of the Auditor-General
Wellington, New Zealand

Education Committee

The Education Committee is a standing Committee of the Medical Council of New Zealand. Its role is to accredit and monitor educational institutions, which deliver medical training for doctors and to promote medical education and training in New Zealand.

Much of our work over the past year has been to support DHBs, colleges and other training providers to continue their education and training for doctors during the COVID-19 pandemic. Significant progress has also been made on our accreditation and recertification programmes, with assessments completed for six DHBs, and the introduction of new standards for vocational training providers that align more closely with the Australian Medical Council's model.

On a personal note, my term of service on Council, and as Chair of Education Committee, has come to an end and I am proud of what Council has achieved, supporting the training and ongoing professional development of doctors. I have thoroughly enjoyed my time working with my colleagues on the Committee who, together with Council's Education staff, make every effort to ensure that the public can be confident that the ongoing education and training of New Zealand's doctors is of the highest standard.

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 DHBs and medical colleges that deliver education and training to doctors at all stages of a doctor's 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. This year we extended the period for which DHBs are accredited from 3 to 4 years to reflect that we are in the second cycle of accrediting providers against Council's standards.

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

- Hawke's Bay DHB
- Nelson Marlborough DHB
- Counties Manukau DHB
- Canterbury DHB
- Southern DHB
- Wairarapa DHB

Five accreditation assessments were postponed in the second half of the year due to Covid-19 restrictions.

Vocational medical training and recertification programmes

There were no full assessments of New Zealand-based vocational medical training and recertification providers.

A revised set of standards for vocational providers became effective from 1 July 2020 and we held a training workshop with the New Zealand medical colleges on the revised standards. The new standards align our accreditation process and standards more closely with those of the Australian Medical Council.

We participated in the accreditation assessment of the following Australasian colleges, which were led by the Australian Medical Council:

- The Royal Australian and New Zealand College of Radiologists
- The Royal Australian and New Zealand College of Ophthalmologists

Australian and New Zealand Prevocational Medical Education Forum (ANZPMEF)

This important annual event, which we were due to host in Auckland in October 2020 was unfortunately postponed for a year to October 2021 due to Covid-19.

Professor John Nacey
Chair
Education Committee

Health Committee

The Health Committee (the Committee) acts on behalf of the Medical Council of New Zealand by reviewing all notifications about a doctor's health that may affect the doctor's ability to safely practise medicine.

It comprises up to 5 members of Council representing different medical specialties, including a minimum of one lay person. We meet every 1-2 months.

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 2020, we received 42 new referrals. We also reviewed the 193 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.

Conditions most likely to require the Committee's 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 very fortunate to have a highly skilled team in the office to support the Committee. They perform their work with sensitivity and compassion. 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 the Committee 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 working until their health is improved.

We request assessments of some doctors, to assess whether they are safe to work independently or require supportive measures to enable safe practice. We may request assessments by psychiatrists, occupational physicians, neuropsychologists, and other specialists – their advice, which includes advice around enabling the doctor to work safely, informs our decision making. We are very grateful for the quality of these assessments and the professionalism of our regular assessors.

Over the last year we have been saddened by two reports from the coroner on suicides of doctors that we had involvement with. These cases are carefully reviewed for any learnings that may inform our ongoing practices. There have, however, been many others who, despite suffering from incapacitating illnesses, we have been able to support while they recovered and successfully returned to their medical careers.

2020 has been a challenging year with many meetings occurring by videoconferencing, rather than face-to-face.

Our fundamental role is public safety, ensuring doctors are not impaired at work, but it is also very rewarding assisting doctors to return to their profession.

Dr Pamela Hale
Chair
Health Committee

Registration Committee

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

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 was aware of the personal pressure on the students and the pressing need from DHBs for the students to get registration and take up PGY1 places.

The Committee therefore worked expeditiously to consider all applications promptly, while requiring 'in person' (Zoom) appearances where the breach had been more serious.

As soon as it was established, it developed a framework under which to consider all applications, and communicated to all applicants both what was required of them and the timeframe for committee meetings and decision-making

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, 4–6 months to confirm a doctor's eligibility.

Table 1: Scopes of practice – summary of registration status (at 30 June 2020)	
Provisional general	3,960
General	10,256
Provisional vocational	236
Vocational	13,093
Special purpose	287
Total on register	**27,832**
Total practising	17,671
Suspended	12

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

Table 2: Registration activities (1 July 2019 to 30 June 2020)

Provisional general/vocational registrations	
New Zealand graduates (interns)	521
Australian graduates (interns)	1
Passed NZREX Clinical (interns)	30
Australian general registrants	8
Graduate of competent authority accredited medical school	493
Worked in comparable health system	150
New Zealand and international medical graduates reregistration (following cancellation)	-
Non-approved postgraduate qualification – vocational assessment	77
Non-approved postgraduate qualification – vocational eligible	95
Special purpose scope registrations	
Visiting expert	10
Research	1
Postgraduate training or experience	45
Locum tenens in specialist post	109
Emergency or other unpredictable short-term situation	5
Pandemic	8
Teleradiology	-
General scope registrations, after completion of supervised period	
Australian General Registrant	1
New Zealand/Australian graduates (interns)	506
Passed NZREX Clinical	33
Graduate of competent authority accredited medical school	398
Worked in comparable health system	75
Vocational scope registrations, after completion of supervised period	
Non-approved postgraduate qualification – vocational assessment	40
Non-approved postgraduate qualification – vocational eligible	86
General scope registrations	
New Zealand graduates	3
Overseas graduates	85
Restorations	12
Vocational scope registrations	
Approved postgraduate qualification	481
Suspensions of registration	
Suspension or interim suspension	7
Revocation of suspension	3
Numbers of doctors who had conditions imposed on scopes of practice	
Imposed	7
Revoked	3
Cancellations under the HPCAA	
Death – section 143	36
Discipline order – section 101(1)(a)	3
False, misleading or not entitled – section 146	1
Revision of register – section 144(5)	256
At own request – section 142	120

[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 2019 to 30 June 2020)

Vocational scope	Vocational registration at 30/6/2019[1]	Added 2019/20	Removed 2019/20	Net change	Vocational scope at 30/6/2020 [1 2]
Anaesthesia	1,057	56	3	53	1,110
Cardiothoracic surgery	45	3	0	3	48
Clinical genetics	20	0	0	0	20
Dermatology	85	2	0	2	87
Diagnostic & Interventional Radiology	694	82	4	78	772
Emergency Medicine	419	37	4	33	453
Family Planning & Reproductive Health	38	3	1	2	40
General Practice	4,477	176	32	144	4,621
General Surgery	408	18	9	9	417
Intensive Care Medicine	120	8	0	8	128
Internal Medicine	1,466	93	10	83	1,549
Medical Administration	44	2	0	2	46
Musculoskeletal Medicine	25	2	0	2	27
Neurosurgery	31	0	0	0	31
Obstetrics & Gynaecology	426	25	4	21	447
Occupational Medicine	75	2	1	1	76
Ophthalmology	195	11	1	10	205
Oral & Maxillofacial Surgery	30	3	0	3	33
Orthopaedic Surgery	365	14	4	10	375
Otolaryngology Head & Neck Surgery	146	4	2	2	148
Paediatric Surgery	31	1	1	0	31
Paediatrics	497	27	3	24	521
Pain Medicine	32	4	1	3	35
Palliative Medicine	95	5	3	2	97
Pathology	412	14	1	13	425
Plastic & Reconstructive Surgery	90	2	2	0	90
Psychiatry	867	52	9	43	910
Public Health Medicine	223	9	2	7	230
Radiation Oncology	88	5	0	5	93
Rehabilitation Medicine	32	0	0	0	32
Rural Hospital Medicine	128	8	1	7	135
Sexual Health Medicine	25	0	0	0	25
Sport and Exercise Medicine	33	3	0	3	36
Urgent Care	256	21	0	21	277
Urology	87	2	0	2	89
Vascular Surgery	45	1	0	1	46
Total	**13,107**	**695**	**98**	**597**	**13,705**

[1] Includes doctors who may currently be inactive (have no practising certificate).
[2] Includes 582 doctors with registration in two vocational scopes and 14 doctors with registration in three vocational scopes.

Table 4: Registration granted, by country of primary qualification (1 July 2019 to 30 June 2020)

	Provisional General	Provisional Vocational	Special Purpose	Total
England	317	29	14	360
United States of America	46	24	75	145
Scotland	76	8	3	87
Ireland	76	1	2	79
South Africa	3	42	5	50
India	11	11	14	36
Netherlands	26	4	0	30
Canada	7	7	12	26
Wales	20	1	1	22
Pakistan	15	2	1	18
Australia	2	3	9	14
Germany	5	3	4	12
Belgium	8	1	0	9
Romania	5	2	1	8
Fiji	2	0	5	7
Hong Kong	1	6	0	7
Northern Ireland	6	1	0	7
Sri Lanka	4	1	2	7
Other [1]	52	20	23	95
New Zealand	521	2	7	530
Total	**1,203**	**168**	**178**	**1,549**

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

Table 5: Vocational registration granted, by vocational scope of practice
(1 July 2019 to 30 June 2020)

Vocational scope	**New Zealand**	**Overseas**	**Total**
Anaesthesia	33	23	56
Cardiothoracic surgery	0	3	3
Clinical genetics	0	2	2
Dermatology	22	60	82
Diagnostic & Interventional Radiology	9	28	37
Emergency Medicine	1	2	3
Family Planning & Reproductive Health	101	75	176
General Practice	11	7	18
General Surgery	3	5	8
Intensive Care Medicine	39	54	93
Internal Medicine	2	0	2
Medical Administration	0	2	2
Musculoskeletal Medicine	8	17	25
Neurosurgery	0	2	2
Obstetrics & Gynaecology	7	4	11
Occupational Medicine	1	2	3
Ophthalmology	6	8	14
Oral & Maxillofacial Surgery	1	3	4
Orthopaedic Surgery	0	1	1
Otolaryngology Head & Neck Surgery	15	12	27
Paediatric Surgery	3	1	4
Paediatrics	1	4	5
Pain Medicine	32	4	1
Palliative Medicine	95	5	3

Vocational scope	New Zealand	Overseas	Total
Pathology	3	11	14
Plastic & Reconstructive Surgery	2	0	2
Psychiatry	12	40	52
Public Health Medicine	6	3	9
Radiation Oncology	2	3	5
Rehabilitation Medicine	3	5	8
Rural Hospital Medicine	2	1	3
Sexual Health Medicine	17	4	21
Sport and Exercise Medicine	2	0	2
Urgent Care	0	1	1
Urology	312	383	695
Vascular Surgery	45	1	0
Total	**312**	**383**	**695**

Table 6: Outcomes of applications for vocational registration assessments
(1 July 2019 to 30 June 2020)

Branch	Incomplete applications	Pending	Withdrawn/ lapsed	Supervision path	Assessment	NZREX*	Total
Anaesthesia	29	0	4	4	6	2	45
Cardiothoracic Surgery	3	0	0	0	0	0	3
Clinical Genetics	1	0	0	1	0	0	2
Dermatology	1	1	1	1	0	0	4
Diagnostic & Interventional Radiology	25	1	9	8	6	6	55
Emergency Medicine	17	2	0	7	3	1	30
General Practice	6	1	5	0	5	0	17
General Surgery	12	0	2	2	3	1	20
Intensive Care Medicine	8	0	0	0	1	1	10
Internal Medicine	56	2	9	23	8	1	99
Neurosurgery	6	0	1	0	0	0	7
Obstetrics & Gynaecology	9	0	5	5	1	2	22
Occupational Medicine	0	0	1	0	0	0	1
Ophthalmology	9	0	3	1	0	3	16
Oral & Maxillofacial Surgery	1	0	0	0	0	0	1
Orthopaedic Surgery	12	0	4	4	4	1	25
Otolaryngology Head & Neck Surgery	5	1	1	1	1	1	10
Paediatrics	14	0	3	5	1	2	25
Palliative Medicine	1	0	0	0	0	0	1
Pathology	14	1	6	3	3	1	28
Plastic & Reconstructive Surgery	2	0	1	1	1	1	6
Psychiatry	33	1	13	13	10	2	72
Public Health Medicine	2	0	1	0	0	0	3
Radiation Oncology	1	1	0	2	1	0	5

Branch	Incomplete applications	Pending	Withdrawn/ lapsed	Supervision path	Assessment	NZREX*	Total
Rehabilitation Medicine	1	0	0	0	1	0	2
Sport and Exercise Medicine	1	0	0	0	0	0	1
Urology	6	0	3	0	0	1	10
Total	**275**	**11**	**72**	**81**	**55**	**26**	**520**
Percentages based on total number of outcomes (%)				50.0	34.0	16.0	

* 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 7: Doctors on the New Zealand medical register, by country of primary qualification
(1 July 2019 to 30 June 2020)

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificates
New Zealand	586	4,983		6,980	5	12,554	10,181
England	1,242	1,944	22	1,690	16	4,914	2,293
South Africa	57	169	36	809	7	1,078	747
Australia	7	665		555	7	1,234	652
Scotland	304	552	6	466	2	1,330	622
India	64	209	15	499	31	818	518
United States of America	581	171	57	390	133	1,332	411
Ireland	201	419	1	107	5	733	323
Germany	78	97	14	166	3	358	193
Netherlands	136	68	9	63		276	123
Wales	109	162	2	77	1	351	123
Sri Lanka	13	64	2	167	2	248	117
Iraq	5	52		120		177	105
Pakistan	32	66	3	55	2	158	90
Canada	140	35	12	75	19	281	79
China	7	35		67	1	110	78
Fiji	3	15		46	18	82	66
Northern Ireland	34	51		36	1	122	57
Russia	7	34	1	29	1	72	55
Egypt	16	19	2	51	3	91	48
Philippines	3	25	1	31		60	45
Bangladesh	4	27		72		103	44
Poland	14	20	4	28	2	68	36
Zimbabwe	1	1	1	40		43	33

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. Due to Covid-19 restrictions, two of the three examinations (in March 2020 and June 2020) were cancelled.

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 8: Candidates sitting and passing NZREX Clinical
(1 July 2019 to 30 June 2020)

		Attempt					Attempt			
Country	**Number sitting**	**1**	**2**	**3**	**4**	**Number sitting**	**1**	**2**	**3**	**4**
Bangladesh	1	-	1	-	-	-	-	-	-	-
Brazil	1	1	-	-	-	1	1	-	-	-
China	2	-	2	-	-	2	-	2	-	-
Ethiopia	1	1	-	-	-	-	-	-	-	-
Fiji	2	1	-	-	1	1	-	-	-	1
Grenada	1	1	-	-	-	1	1	-	-	-
India	4	4	-	-	-	4	4	-	-	-
Mexico	1	1	-	-	-	1	1	-	-	-
Nigeria	1	1	-	-	-	1	1	-	-	-
Pakistan	8	6	2	-	-	7	5	2	-	-
Philippines	1	-	1	-	-	-	-	-	-	-
Russia	1	1	-	-	-	-	-	-	-	-
Sri Lanka	1	1	-	-	-	1	1	-	-	-
Vietnam	1	1	-	-	-	1	1	-	-	-
Total	**26**	**19**	**6**	**-**	**1**	**20**	**15**	**4**	**-**	**1**

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificates
Singapore	11	22		28		61	32
Spain	11	12	1	17		41	30
Belgium	32	18	2	15		67	29
Italy	8	7	4	20	1	40	25
Malaysia	4	12		13	4	33	23
Romania	9	14	2	19	1	45	23
Hungary	10	9	1	15		35	20
Serbia		9	1	24		34	20
Other [1]	231	270	37	323	22	883	430
Total	**3,960**	**10,256**	**236**	**13,093**	**287**	**27,832**	**17,671**

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

Professional standards

Principal activities

Receiving referrals of concerns, supporting the Notifications Triage Team (NTT) 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, and monitoring doctors who are subject to conditions arising from competence and conduct concerns and disciplinary action.

Total notifications received	
Performance	130
Conduct	59
Total	**189**

Table 9: Referral sources to full Council for performance-related decisions (1 July 2019 to 30 June 2020)	
ACC	43
Employer (DHB)	7
Employer (private hospital or general practice)	3
Health and Disability Commissioner (HDC)	69
Internally referred within Council (Registration / Health Team)	3
Medical practitioner	3
Health practitioner	-
Member of public or patient	2
Other	-
Total	**130**

*Other = Council's Health and Registration teams

Table 10: Referral sources to full Council for conduct processes (1 July 2019 to 30 June 2020)	
ACC	2
Employer (DHB)	12
Employer (private hospital or general practice)	2
Member of public or patient	8
HDC	7
Police / Ministry of Justice	4
Internally referred within Council (Health Team)	4
Medical practitioner	7
Health practitioner	5
Ministry of Health	1
Media	1
Self-disclosure	6
Other	-
Total	**59**

*Other = Council's Health and Registration teams

Performance

Principal activities

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

Table 11 shows the number of cases considered by us 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 our 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 the year commencing 1 July 2019 and processes that continued after 30 June 2020 and illustrates the volume of work we undertake during the year in this area.

Table 11: Competence-related Council processes (1 July 2019 to 30 June 2020)	
No further action or educational letter after first consideration by Council	30
Await outcome from HDC after first consideration by Council	1
Defer decision and request further information via a Preliminary Competence Inquiry after first consideration by Council.	4
No further action or educational letter after Preliminary Competence Inquiry	2
Recertification programme ordered on first consideration by Council	5
Referral to Performance Assessment Committee (PAC) [1]	19
Doctor meets required standard of competence following PAC assessment (category 1)	8
Doctor does not meet required standard of competence following PAC assessment (category 2 or 3)	9
Educational programme ordered after PAC assessment (section 38) (category 2 or 3)	8
Conditions ordered after PAC assessment (section 38)	1
Educational programme completed satisfactorily	3
Educational programme completed unsatisfactorily	3
Follow up performance assessment ordered after unsuccessful completion of educational programme	2
Conditions ordered after unsuccessful completion of educational programme	1
Referral to health team	3

[1] 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 we receive information that raises one or more questions about the appropriateness of the conduct or the safety of the practice of a doctor, we may refer any or all of those questions to a Professional Conduct Committee (PCC).

Table 12 shows the number of cases considered by us during the year that related to a doctor's conduct and our decisions as to how those cases should be addressed. The table shows the number of our 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 the year commencing 1 July 2019 and processes that continued after 30 June 2020 and illustrate the volume of Council's work in this area.

We are prevented by the HPCAA from taking any action against a doctor while the HDC is conducting an investigation in relation to a complaint about that about a health consumer.

We may, however, make an order for interim suspension or impose conditions on the doctor's practice if we consider that the doctor poses a risk of harm to the public, while a PCC or criminal investigation is undertaken.

Table 12: Conduct-related Council processes (1 July 2019 to 30 June 2020)

No further action or educational letter on first consideration by Council	15
Recertification programme ordered on first consideration by Council	0
Referral to PCC[1]	31
New information received referred to existing PCC	1
Interim conditions ordered (section 69)	3
Interim suspension ordered (section 69)	2
PCC determined charge be brought in the Health Practitioners Disciplinary Tribunal	9
PCC recommended no further action	7
PCC recommended counselling or mentoring	13
PCC recommended review of fitness to practise (by referral to health team)	2

[1] 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.

When we receive notice that a doctor is convicted of any offence punishable by imprisonment for a term of 3 months or longer, or of an offence under certain specified Acts, the Council 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 13 shows the PCCs that were commenced as a result of a conviction, and the number of doctors referred to the Health Evaluation Pathway.

Table 13: Notice of Convictions (1 July 2019 to 30 June 2020)

Notices of conviction referred to PCC	3 [2]
Doctor referred to Health Evaluation Pathway (section 67A)	3

[2] 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.

We aim 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, our 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 14: Notifications of inability to perform required functions due to mental or physical (health) condition (1 July 2019 to 30 June 2020)

Source	HPCAA	Existing	New	Closed	Still active
Health service	section 45(1)a	–	2	–	2
Health practitioner	section 45(1)b	–	29 [1]	4	25
Employer	section 45(1)c	–	7	–	7
Medical Officer of Health	section 45(1)d	–	–	–	–
Other person	section 45(3)	–	2	–	4
Graduating doctors	section 45(5)	–	2	1	1
Total		**–**	**42**	**5**	**37**

[1] 25 of the 29 were self-referred.

Table 15: Outcomes of health notifications (1 July 2019 to 30 June 2020)

Outcomes	HPCAA	Number [1]
No further action	–	4
Order medical examination	section 49(1)	– [2]
Interim suspension	section 48(1)(a)	
Conditions	section 48(1)(b)	24 [3]
Restrictions imposed	section 50(3) or (4)	–
Restrictions imposed	section 50(3) or (4)	See note [4]

[1] There may be more than one outcome.
[2] 35 assessments agreed voluntarily (two of which are pending), and 147 reports from treating clinicians, occupational physicians, and so forth.
[3] Achieved through voluntary agreement.
[4] Requisite monitoring for 37 doctors still active achieved through informal agreement without use of statutory provisions of the HPCAA 2003.

Health Practitioners Disciplinary Tribunal

Principal activities

Disciplinary proceedings brought against doctors are heard and determined by the Health Practitioners Disciplinary Tribunal.

Medical charges before the Health Practitioners Disciplinary Tribunal

During the year, the HPDT received 10 charges relating to 7 doctors – all charges were received from a professional conduct committee.

The HPDT sat during the year to hear 13 charges relating to 12 doctors over 39 days. Nine of the 13 charges were received in 2018/19. Three charges relating to one doctor were withdrawn. Three of the ten charges received during 2019/20 are yet to be heard.

Table 16: Medical charges before the Health Practitioners Disciplinary Tribunal
(1 July 2019 to 30 June 2020)

Nature of charges	
Professional misconduct 2018/19	8
Professional misconduct 2019/20	10
Conviction 2018/19	1
Total	**19**
Source	
Prosecution of charges brought by a PCC 2018/19	9
Prosecution of charges brought by a PCC 2019/20	4
Charges brought by a PCC withdrawn	3
Charges brought by a PCC yet to be heard	3
Total	19
Total	**19**

Outcome of hearings	
Guilty – professional misconduct 2018/19	8
Guilty – conviction 2018/2019	1
Guilty – professional misconduct 2019/20	4
Withdrawn	3
Yet to be heard 2019/20	3
Total	19
Total	**19**

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

Corporate governance

Role of Council

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

Our 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, Education, and Health – each with clearly established levels of delegated authority. Members of these committees are listed on page 72. 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)
- the Accident Compensation Corporation
- the Association of Salaried Medical Specialists
- chief medical officers of DHBs
- the Council of Medical Colleges
- the Health and Disability Commissioner
- members of the profession, other regulatory authorities, medical students, and community groups
- medical colleges and associations
- the Medical Protection Society
- the Minister of Health
- the New Zealand Resident Doctors' Association
- the New Zealand Medical Association.

Council committees [1]

Council standing committees as at 30 June 2020

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
- Kath Fox
- Dr Charles Hornabrook

Registration Committee

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

Education Committee – Council members

- Professor John Nacey (Chair)
- Dr Ainsley Goodman
- Ms Kim Ngārimu

Education Committee – non-Council members

- Dr Liza Lack
  Nominee of a medical training provider and the Medical Council's representative on MedSAC
- Dr Carmen Chan
  Active consumer of education – Intern representative member (PGY2)
- Dr Mark Huthwaite
  Medical academic appointed from nominations by the Medical Schools in New Zealand
- Dr Sarah Nicolson
  Nominee of a vocational medical training provider and the Medical Council's representative on SEAC
- Dr Jonathan Albrett
  Nominee of a vocational medical training provider
- Dr John Thwaites
  Nominee of a vocational medical training provider
- Dr Suzanne Busch
  Prevocational educational supervisor representative member
- Dr Cameron Wells
  Active consumer of education – Intern representative member (PGY1) (he became the PGY2 rep on the Committee in March/May)
- Dr Bryony Nicholls
  Active consumer of education – Vocational trainee representative member
- Dr Teriana Maheno
  Active consumer of education – Vocational trainee representative member
- Dr Fraser Jeffery
  Active consumer of education – Intern representative member (PGY1)

[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

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Te Kaunihera Rata o Aotearoa

Medical Council of New Zealand