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The Royal Australasian College of Physicians' submission to Manatū Hauora | Ministry of Health

Putting Patients First: Modernising health workforce regulation

Paenga-whāwhā | April 2025

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to submit feedback on the Manatū Hauora | Ministry of Health's consultation on Putting Patients First: Modernising health workforce regulation.

The RACP works across more than 40 medical specialties to educate, innovate and advocate for excellence in health and medical care. Working with our senior members, the RACP trains the next generation of specialists, while playing a lead role in developing world best practice models of care. We also draw on the skills of our 32,000 members, to develop policies that promote a healthier society. By working together, our members advance the interest of our profession, our patients and the broader community.

Background

The Health Practitioners' Competence Assurance Act (HPCA Act) was passed in September 2003 and has undergone several amendments since then. The principal purpose of the Act is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions.

The Act incorporates the basic principles of ongoing competence and the separation of the registration process from the disciplinary process. The Act includes provisions to ensure that:

- Only health practitioners who are registered under the Act can use the titles protected by the Act or claim to be practising a profession that is regulated by the Act.
- Registered health practitioners are not permitted to practise outside their scopes of practice.
- Responsible authorities are required to certify that a practitioner is competent to practise in their scope of practice when they issue an annual practising certificate.
- Certain activities are restricted and can only be performed by registered health practitioners as specified in the Act.

There are 18 regulatory authorities established under the HPCA Act. RACP specialists are regulated by Te Kaunihera Rata o Aotearoa - Medical Council of New Zealand (MCNZ).

The HPCA Act clearly outlines the responsibilities of health professional regulatory bodies in Aotearoa New Zealand, including setting standards for medical practice, ensuring practitioner competence, and maintaining public safety. Regulators do not cover recruitment or hiring processes, which are the responsibility of employers, including Health New Zealand, who oversees the employment and operational aspects of the health workforce. The Ministry of Health website provides further insight to the regulation and legislation of regulatory authorities.[1] [2]

Comment on the consultation process

The RACP is disappointed that the only avenue for feedback on this consultation is the online survey form accompanying the consultation document. The online survey does not provide

[1] Manatū Hauora | Ministry of Health. Regulation and legislation. [Internet]. MoH: Wellington. Available from: Regulation and legislation | Ministry of Health NZ Downloaded on 28 April 2024.
[2] Manatū Hauora | Ministry of Health. Health system overview and statutory framework. MoH: Wellington. [Internet]. Available from: Health system overview and statutory framework Downloaded on 28 April 2024.

the opportunity to provide all information relevant to the review. Some of the questions ask for yes or no responses only and provide no ability to give comment or provide further information.

The short submission timeframe (which includes holiday periods around Easter and ANZAC Day) does not provide the RACP and other healthcare organisations[3] an appropriate opportunity to consult with members for thorough feedback.

The RACP is concerned regarding the framing of questions in the online survey and shares the Council of Medical Colleges' view that the questions are leading and potentially designed to lead to a biased response.

The RACP thanks Manatū Hauora | Ministry of Health for the opportunity to provide feedback on this consultation and would welcome further conversation about this important work.

Specific Consultation Questions [online survey format]

Patient-centred regulation

Question 1: Would you be interested in having a say on any of the following?

☒ Changes to scopes of practice (what health practitioners can do) and how this affects patient care
☒ Qualification requirements
☒ Other professional standards (for example, codes of conduct) that impact patient experience.

Question 2: Are there any other things you think the regulators should consult the public on?

The RACP suggests that regulators should consult the public on anything that impacts the delivery of healthcare.

Whilst the RACP acknowledges the important role of the public (patients and consumers), it is important for regulators to work closely with physicians and other healthcare professionals on any proposed changes. Any changes to scopes of practice, qualification requirements and other professional standards will affect the way physicians work, the way they deliver care and the standard of that care.

The RACP acknowledges there are opportunities to improve the regulation of the healthcare workforce to better protect the public and to support the provision of safe healthcare. The RACP support certain aspects of this review and have provided feedback accordingly in this survey. Noting we wish to work with the Ministry of Health, the government and regulators, on updating and modernising our regulatory settings to meet the needs of both patients and the healthcare workforce.

Question 3: Are there any health practitioners who are currently unregulated but should be subject to regulation to ensure clinical safety and access to timely, quality care?

[3] Murton, S. Letter from the Council of Medical Colleges to Dr Joe Bourne at the Ministry of Health. 11 April 2025.

The RACP highlights that there is ample access to evidenced informed, qualified health care delivery, however an adequate and appropriate healthcare workforce is essential to ensure timely, quality healthcare can be provided.

The RACP observes that emerging professions, such as physician associates (PAs) are being proposed as solutions to workforce shortages in Aotearoa New Zealand and the decision to regulate is still under consideration. Currently, PAs are working in Aotearoa New Zealand as unregulated health practitioners under a voluntary self-regulation system, asserting that they are certified in the United States, United Kingdom or Canada. As of February 2025, about 50 imported PAs, up slightly on the 47 in July 2024, are working under doctor supervision across the country[4].

RACP position on PAs

The RACP current position on PAs is outlined in a statement on the RACP website released in October 2024. This statement calls on governments at all levels to conduct thorough consultations with physicians before considering PA roles as an option for the healthcare system.

The short statement raises concerns about

- the potential impact of the role on patient safety.
- the need for PAs to receive adequate training and certification which integrate in the existing health workforce training and registration models,
- PAs supervision and fit within multidisciplinary teams,
- PA scope of practice,
- clarity about who would be responsible for what PAs do, and
- how PAs communicate with other team members.

The statement also raises a key issue regarding the impact on the training of medical students and junior doctors. The statement also flags that the introduction of these roles widely across the healthcare system would be a complicated process that may lead to disruptions and community concern if it is done without proper planning and consultation.

In early 2025, the RACP published a media release which reiterates some of the key points from the October 2024 statement. Work on a RACP bi-national (Australia and Aotearoa NZ) position statement on PAs will commence in 2025.

Job title

Our RACP members wish to take the opportunity to raise significant concerns about the misleading job title of PAs, noting that in the United Kingdom, PAs are mistaken for doctors by the public, leading to confusion amongst the public about the level of healthcare they are receiving[5]. The RACP suggests that if the government is going to move forward with regulation it will be imperative to determine a less misleading job title.

Regulation of PAs

If the government decides to regulate PAs, then who will regulate them? Will they be regulated by an existing regulator such as the Medical Council of New Zealand or will a separate regulator for PAs be established under the HPCA Act? Noting creating a new regulator will add another layer of bureaucracy to the healthcare system.

[4] Cassie F. Decision to regulate physician associates still 'under consideration'. [Internet]. New Zealand Doctor. Thursday 20 February 2025. Available from: Decision to regulate physician associates still 'under consideration' | New Zealand Doctor Downloaded on 3 April 2025.

[5] Swainston R, Zhao Y, Harriss E, Leckcivilize A, English M, Nagraj S. Public perception of the physician associate profession in the UK: a systematic review. [Internet]. BMC Health Serv Res. 2024 Nov 29;24(1):1509. Available from: Public perception of the physician associate profession in the UK: a systematic review Downloaded on3 April 2025.

Cultural safety knowledge

Our RACP members have noted that PAs in Aotearoa New Zealand tend to be trained overseas and often work in workplaces where clinical resources are already under pressure (e.g. Emergency Departments, general practice, rural and regional settings with higher Māori populations). This situation has the potential to exacerbate existing inequities in the healthcare system, particularly related to adequate cultural safety training. The RACP suggests that if the PAs are regulated it will be crucial to equip them with cultural safety knowledge and appropriate tools to better serve patient healthcare needs.

Question 4: Do you think regulators should do more to consider patient needs when making decisions?

Yes.

Question 5: What are some ways regulators could better focus on patient needs?

Our RACP members have noted that the primary need of patients is to have competent, safe healthcare practitioners. Regulators should be aware of healthcare workforce and patient needs, but this should not compromise healthcare delivery standards.

The RACP relationship with the Medical Council of New Zealand (MCNZ) has been largely positive and we believe the MCNZ has evidenced its strong commitment to social accountability and patient safety through its consultation practices.

Systemic supports for enabling closer collaboration between Te Whatu Ora, the MCNZ and medical colleges would aid cross-sector initiatives to improve the distribution and funding of medical training positions, with improved service provision to Aotearoa New Zealand communities.

The RACP believes that cultural aspects of care can impact clinical care, and cultural requirements are not separate considerations. Cultural requirements must be seen as integrated with clinical safety and qualifications. Cultural safety for Maori is cultural safety for all.

Section 118 of the Health Practitioners Competence Assurance Act 2003 states that the functions of each authority appointed in respect of a health profession include setting standards of clinical competence, cultural competence (including competencies that will enable effective and respectful interaction with Māori), and ethical conduct to be observed by health practitioners. The government policy on Health[6] clearly identifies a commitment by the government to improving the health and wellbeing of Māori by continuing to implement Pae Tū: Hauora Māori Strategy and Whakamaua: Māori Health Action Plan, focusing on health outcomes.

Cultural impacts of healthcare are recognised and addressed through various frameworks and guidelines. The Health Quality and Safety Commission (HQSC) has developed patient experience surveys to measure culturally safe care, ensuring that healthcare providers offer care that respects and integrates patients' cultural needs and preferences[7].

[6] Manatū Hauora | Ministry of Health. 2024. Government Policy Statement on Health 2024- 2027. [Internet]. MoH: Wellington; 2024. Available from: Government Policy Statement on Health 2024–2027 | Ministry of Health NZ Downloaded on 24 April 2025.

[7] Te Tāhū Hauora | Health Quality & Safety Commission. About our patient surveys. [Internet]. HQSC: Wellington; 2024. Available from: About our patient experience surveys | Te Tāhū Hauora Health Quality & Safety Commission Downloaded on 24 April 2025.

The Medical Council of New Zealand emphasis cultural competence, which involves healthcare providers examining their own cultural biases and understanding how these might impact clinical interactions and service delivery.[8]

Extensive research has highlighted the cultural impacts on healthcare in Aotearoa New Zealand, particularly focusing on Māori health inequities. This research underscores the importance of integrating cultural safety into healthcare practices, ensuring that healthcare providers are not only aware of cultural differences but also actively work to create an environment where patients feel respected and understood.[9]

The RACP urges the government to use this review as an opportunity to reset and prioritise culturally safe practices in healthcare. Additionally, it should consider adapting models to better understand the determinants of ethnic health inequities. Racism significantly impacts contemporary public health practice by creating barriers to equitable healthcare access and delivery. These adaptations highlight colonisation and racism as fundamental causes of health disparities, affecting socioeconomic factors, health behaviours, and health outcomes.[10] Neglecting to integrate cultural safety into healthcare practices will lead to poorer health outcomes and increased inequities, especially for Māori and Pacific peoples.

Scenario D, page 8 of the consultation document, addresses overseas trained healthcare workers:

> "…This emphasis on cultural requirements seems like a distraction from the real issues facing our health system, where the focus should be on ensuring patients receive timely, quality care from the most qualified professionals."

The RACP considers this statement misleading and distracting from the real issues in the health system, including workforce shortages, burnout and health equity barriers. This concern is heightened when read alongside Health Minister Simeon Browns statement on 'reducing red tape to put patients first'[11] where he mentions:

> "…complicated approval pathways for overseas qualified doctors to practice in NZ, or imposing rules that prioritise cultural requirements over clinical safety in scopes of practices, our healthcare system is being held back by outdated and unnecessary barriers."

Cultural safety is not a 'distraction' or a 'barrier' to ensuring patients receive quality care from quality professionals. The government has an obligation to protect the health of Māori as part of 'good governance', kāwanatanga is translated as governance, meaning the authority to create laws for the country's good order while safeguarding Māori interests. Governance intended to protect the mana of the Māori people, to ensure that Māori have the right to be Māori in their own lands and retain their mana, without undermining the Queen's authority to govern and maintain **'**good order'.[12]

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[8] Te Kaunihera Rata | Medical Council of New Zealand. New report on cultural safety and health equity for Māori. [Internet]. MCNZ: Wellington; 2020. Available from: New report on cultural safety and health equity for Māori | Medical Council Downloaded on 28 April 2025.

[9] Tipene-Leach D, Simmonds S, Carter M, Haggie H, Mills V, Lyndon M. Cultural safety and the medical profession in Aotearoa New Zealand: a training framework and the pursuit of Māori health equity. [Internet]. NZMJ Vol 137 No.1607. December 2024. Available from: Cultural safety and the medical profession in Aotearoa New Zealand: a training framework and the pursuit of Māori health equity - The New Zealand Medical Journal Downloaded on 28 April 2025.

[10] Curtis, E., Jones, R., Willing, E. *et al.* Indigenous adaptation of a model for understanding the determinants of ethnic health inequities. [Internet]. Discov Soc Sci Health 3, 10 (2023). Available from: Indigenous adaptation of a model for understanding the determinants of ethnic health inequities | Discover Social Science and Health Downloaded on 28 April 2025.

[11] Minister of Health. Reducing red tape to put patients first. [Internet]. Beehive: Wellington; 28 March 2025. Available from: Reducing red tape to put patients first | Beehive.govt.nz Downloaded on 28 April 2025.

[12] Gray-Sharp K, Tawhai V (eds). 'Always speaking' – The Treaty of Waitangi and public policy. Wellington: Huia Publishers; 2012.

Equity serves as a measure of how well the government is fulfilling its treaty obligations and 'good order' to evaluate governance or Kāwantanga. The RACP finds the state of Māori health a significant concern, amplified by systemic inequities and a lack of culturally safe healthcare. Minister Brown's comment that the health system is being held back by unnecessary barriers prompts the RACP to encourage the government to review their understanding of these 'barriers' and instead refocus on a healthcare system that values whānau-centred, equitable, and safe care over speed and convenience.

Implementing mandatory cultural safety training for overseas-trained health professionals is essential to ensure they understand and can apply cultural safety principles in their practice, thereby improving patient care and outcomes. It is our responsibility to acclimatise these professionals to the local cultures and understand how this impacts cultural safety within their own cultural contexts. This work helps integrate International Medical Graduates (IMGs) into the team, making them ready to practice in Aotearoa New Zealand.

The RACP believes that providing ample resources and support systems is crucial. These resources will help overseas-trained health professionals navigate cultural safety requirements more effectively, ensuring they can integrate seamlessly into the healthcare system. Additionally, promoting ongoing professional development in cultural safety will help maintain high standards of care and keep these professionals updated on best practices.[11]

To support this, the RACP believes regulators must retain their focus on both clinical and cultural safety. Streamlining overseas qualification recognition and deregulating workforce pathways without safeguarding cultural safety opens the door to unsafe practice.

Inaccuracies noted in the consultation document

> "Regulators today often encourage or require health practitioners to consider factors beyond clinical safety. In some cases, this involves requiring certain professions to favour cultural requirements in hiring decisions, such as mandating an understanding of tikanga Māori."

The RACP strongly disagrees with the assertion, that regulators often require health practitioners to prioritise cultural requirements over clinical safety. This statement, particularly the singling out of tikanga Māori, is misleading and undermines the importance of cultural safety in healthcare.

The RACP queries what is meant by the term 'Cultural requirements' and believes this term needs to be defined by the government. If 'Cultural requirements' means cultural safety, it is important to unpack the definition of cultural safety. Cultural safety is defined by the patient's experience and focuses on the power dynamics in healthcare relationships. It requires healthcare providers to critically examine their own cultural biases and the systemic structures that perpetuate inequities. The goal is to provide care that is respectful and free from discrimination, as defined by the patients and their communities. Cultural safety emphasises accountability and the need for healthcare organisations to be held responsible for delivering culturally safe care.[13]

If, however, the reference is to cultural competency, this often centres on the healthcare provider's knowledge and skills about different cultures. It involves understanding and appropriately responding to the unique cultural needs of patients. However, cultural competency can sometimes lead to a superficial understanding and may not fully address the deeper issues of power imbalances and systemic inequities.

The RACP recommends using the defined term of cultural safety, which better informs the national and international context of the term 'cultural requirement' that does not have a clear

definition. A definition for cultural safety that is more suitable for achieving health equity should outline the essential principles and practical steps to implement this approach in healthcare organisations and workforce development.

For the purposes of this submission and to alleviate any further misunderstanding of the government's definition of 'Cultural requirements,' the RACP encourages the use of the term 'cultural safety.' This includes knowledge of tikanga Māori, which is not in opposition to clinical safety and quality. On the contrary, culturally safe care is essential for ensuring safe and effective healthcare delivery. Culturally unsafe care can lead to trauma, patient disengagement, and inequitable health outcomes.

Furthermore, the obligations under Te Tiriti o Waitangi are constitutional responsibilities that must be upheld. These are not optional add-ons but fundamental principles that guide the provision of equitable healthcare in Aotearoa New Zealand. The RACP emphasises that integrating cultural safety into healthcare practices is crucial for achieving better health outcomes for all communities.

In the RACP submission to the Justice Committee on the Principles of the Treaty of Waitangi Bill, we highlighted the importance of cultural competence and the need for healthcare practitioners to understand and respect tikanga Māori. This understanding is vital for building trust and delivering high-quality care to Māori patients[13].

The RACP encourages the Government to revisit the key themes identified during the consultation, including the principle that 'any changes to the regulatory system must not compromise clinical safety.' The RACP notes that cultural safety is integral to clinically safe care, and minimising its importance will continue to significantly impact health equity.

Question 6: What perspectives, experiences, and skills do you think should be represented by the regulators to ensure patients' voices are heard?

The RACP suggests an appropriate cross-representation advisory group be available, including both patients and carers as well as the healthcare workforce, to provide advice to the regulators.

Question 7: Do you agree that regulators should focus on factors beyond clinical safety, for example, mandating cultural requirements, or should regulators focus solely on ensuring that the most qualified professional is providing care for the patient?

Yes.

Question 8: Do you think regulators should be required to consider the impact of their decisions on competition and patient access when setting standards and requirements?

Yes.

Streamlined regulation

[13] Royal Australasian College of Physicians (RACP). The Royal Australasian College of Physicians' submission to the Justice Committee on the Principles of the Treaty of Waitangi Bill. [Internet]. RACP: Wellington; December 2024. Available from: racp-submission-to-the-justice-committee-on-the-principles-of-the-treaty-of-waitangi-bill.pdf Downloaded on 23 April 2025.

Question 1: How important is it to you that health professions are regulated by separate regulators, given the potential for inefficiency, higher costs, and duplication of tasks?

Important.

Why?
The RACP believes it is important to have a fit for purpose Medical Council of New Zealand, and that any changes to regulators require close consultation.

There may be advantages for some regulators to share resources, for example, IT platforms, but it remains important for leaders from that profession to maintain oversight and lead the input into who they are regulating, including the experience and supervision required.

The RACP is accredited by the Medical Council of New Zealand (MCNZ) for issuing qualifications for the purposes of vocational registration. The consultation paper does not discuss the role of the MCNZ in accrediting, supporting and monitoring specialist medical colleges as qualification providers (i.e. as an Accreditation Authority). This is a vital regulatory role that supports the social accountability of training and education systems and not mentioning this is a significant oversight.

The RACP note that the Australian regulatory model works adequately; however, we stress that the Medical Board of Australia has been retained under Ahpra, in addition to the Australian Medical Council. Should a single regulator model be explored, the Accreditation Authority functions of the Medical Council of New Zealand (MCNZ) that mirror those of the Australian Medical Council in terms of accrediting, monitoring and improving the educational programs of specialist medical colleges, primary medical degrees and intern training, would need to be considered.

Question 2: To help improve efficiency and reduce unnecessary costs, would you support combining some regulators?

Unanswered (yes/no option).

Right-sized regulation

Question 1: Do you agree that these regulatory options should be available in addition to the current registration system?

- ***Accreditation***
- ***Credentialing***
- ***Certification***

Any other options
The RACP considers that this would depend on the profession and context.

Question 2: Do you think New Zealand's regulatory requirements for health workforce training, such as the requirement for nursing students to complete 1,000 hours of clinical experience compared to 800 hours in Australia, should be reviewed to ensure they are proportionate and do not create unnecessary barriers to workforce entry?

Unanswered (yes/no option).

Question 3: Should the Government be able to challenge a regulator's decision if it believes the decision goes beyond protecting patient health and safety, and instead creates strain on the healthcare system by limiting the workforce?

No. The safety of a workforce should be a regulator's priority, not speed.

Question 4: Do you support the creation of an occupations tribunal to review and ensure the registration of overseas-trained practitioners from countries with similar or higher standards than New Zealand, in order to strengthen our health workforce and deliver timely, quality healthcare?

No.

Comments

The ongoing collaboration of the RACP with the Medical Council of New Zealand (MCNZ) to expediate the recognition of qualifications for overseas-trained physicians is vital and needs strengthening.

International Medical Graduate (IMG) workforce

Aotearoa New Zealand has the highest dependency on IMGs in the OECD, filling 43.3% of the medical workforce. The Medical Council of New Zealand data shows IMGs made up 71% (1,318) of new registrations in 2023-24, a 16% increase in registration from the previous year[14]. IMGs are more highly represented outside of the larger city centres, for example, West Coast has the highest percentage of IMGs (64.8%), followed by Wairarapa (63.4%), and Whanganui (62.8%). Local doctors accounted for 29% of new registrations (535), a slight decrease of 4.5% from the number registered the previous year[15].

Overseas Trained Physicians (OTP) assessment

During the application process, the RACP works with the MCNZ as a Vocational Education Advisory Body (VEAB) to:

- assess the equivalency of qualifications, training and experience compared to an Australasian-trained physician or paediatrician, and
- provide a recommendation to the MCNZ.

See the RACP Policy on the assessment of OTPs and Overseas Trained Physicians (OTP) Guidelines. Noting the MCNZ make the final decision on whether someone is granted registration.

The RACP considers there is potential for the MCNZ to streamline assessment processes to reduce costs and timeframes for OTPs. The MCNZ could create a new process to conduct interviews without prior paper-based assessments. This would be more viable for some applicants than doing a paper-based assessment with no interview-based assessment. For example, this approach would be suitable for OTPs who completed training in the United States and South Africa, where the scope of practice varies significantly between OTPs in public versus private practice and an interview is vital to accurately assess their comparability against standards in Aotearoa New Zealand. This approach could also be used for OTPs from countries that we do not historically receive many applications from.

IMG expedited pathway

[14] Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand (MCNZ). Update on the Medical Council's registration pathways and trends. [Internet]. MCNZ: Wellington; 13 November 2024. Available from: Update on the Medical Council's registration pathways and trends | Medical Council Downloaded on 16 April 2025.
[15] Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand (MCNZ). Workforce Survey Report 2024. [Internet]. MCNZ: Wellington; 2024. Available from: https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/Workforce_Survey_Report_2024.pdf Downloaded on 16 April 2025.

The MCNZ has an expedited pathway for IMGs with an approved postgraduate medical qualification. This pathway is designed to make it easier and quicker for eligible IMGs to gain specialist registration in the following approved areas of medicine: anesthesia, dermatology, emergency medicine, general practice, internal medicine, pathology (anatomical) and psychiatry.

This pathway allows eligible IMGs with approved specialist qualifications from the United Kingdom, Ireland, and Australia to have their applications processed by the MCNZ within 20 working days.

Supporting the IMG workforce

The RACP maintains that IMGs should be set up to succeed in the Aotearoa New Zealand environment. While we attract many IMGs only about 60% remain practising here after one year, dropping to 40% after two years and 25% after ten years – a significant cost to the healthcare system, including recruitment and training expenses.[16] IMGS are frequently recruited to address shortages in rural and regional areas where attracting local doctors is difficult but crucial to meet the needs of high-needs populations, including Māori.

A significant number of international doctors leave Aotearoa New Zealand because they have not had the right support or development of their cultural capabilities. The RACP believes enhanced support and integration should be prioritised, including language support, cultural orientation, peer support networks, settlement assistance and supervision. Aotearoa New Zealand's healthcare system must improve integration practices for international doctors. To truly put patients first and ensure consistency and continuity of care, the government needs to put its efforts into encouraging IMGs to want to stay in the country.

A study published in 2023 shows that IMGs struggle with cross-cultural code-switching due to professional and cultural differences that might affect their ability to practise effectively and influence whether they remain in Aotearoa New Zealand. Many leave their employment because they experience stress, loss of identity or loss of confidence brought on by the struggle to adjust culturally. Cultural differences can impact their ability to practise effectively and on wellbeing – it is critical to support not only their integration into medical practice but also their cultural integration, to improve retention rates.

- In relation to interactions with Māori, some IMGs noticed a difference in the way Māori patients communicated and interacted compared to non-Māori, and found they needed to adjust to be effective.
- IMGs experienced a lack of support or interest in their code-switching dilemma from local counterparts, with most commenting on a sense of isolation and a lack of social support that meant they usually ended up socialising together where possible.
- Although IMGs expect to and are willing to adapt to the Aotearoa NZ setting, a lack of cultural orientation and support leads to frustration and can result in resentment at either not being valued for their experience or not being accepted for themselves.
- Medical systems differ considerably across countries related to disease patterns, treatment options and how health services are organised.
- The relationships within health care teams are often less hierarchical than in other countries. Adjusting to all these differences requires effective transition arrangements which often must be targeted to the doctor's background.

[16] Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand. Update on the Medical Council's registration pathways and trends, 13 November 2024. [Internet]. MCNZ: Wellington; 2024. Available from: Update on the Medical Council's registration pathways and trends | Medical Council Downloaded from 17 April 2025.

- Although IMGs come from comparable and incomparable health systems, they are all culturally diverse relative to Aotearoa NZ.
- Understanding cultural differences and their impact on IMGs is crucial for implementing support programmes that will help them fit in without losing themselves[17].

Cultural safety training for IMGs

The RACP calls for cultural safety training for IMGs to support the provision of high-quality care to communities throughout Aotearoa New Zealand, and this to be both mandatory and readily available. There is limited and varied support for the provision of cultural safety proficiency and education for IMGs in Aotearoa New Zealand[18]. Our RACP members note that similar to PAs, IMGs often work in rural and regional settings with more diverse and high-needs populations where culturally safe practice is crucial.

A culturally safe workforce

The RACP makes an additional call for the government to focus efforts to Māori and Pasifika medical graduates to ensure we have a healthcare system that reflects the populations being served. Increasing the number of Māori and Pasifika doctors is difficult with a reliance on importing twice as many doctors as we train, i.e. the MCNZ registered more than 1,000 doctors trained overseas last year and just over 500 domestic graduates.

In 2024, 5.1% of doctors identified as Māori. However, Māori make up 17.8% of the population, so there is still more work needed to achieve a Māori medical workforce proportionate to population and needs[19]. In the RACP, just 3.5% of general physicians and 4.8% of paediatricians identify as Māori, and Pasifika doctors make up a further 1% and 2% respectively[20]. The RACP supports efforts by initiatives like the Māori and Pacific Admission Scheme (MAPAS) to equitably represent Māori and Pasifika medical students and trainees[21].

Question 5: Should the process for competency assessments such as the Competence Assessment Programme (CAP) for nurses, be streamlined to ensure it is proportionate to the level of competency required, allowing experienced professionals who have been out of practice for a certain period to re-enter the workforce more efficiently, while still maintaining clinical safety and quality of care?

Unanswered (yes/no option).

If so, what changes should be made?

Our RACP members consider this should continue to be done within the remit of the current regulatory framework. Please refer to the Medical Council of New Zealand's Policy-on-returning-to-practice-after-three-years.

Question 6: Do you believe there should be additional pathways for the health workforce to start working in New Zealand?

[17] Mannes M, Thornley, D & Wilkinson, T. Cross-cultural code-switching – the impact on international medical graduates in New Zealand. [Internet]. BMC Med Educ 23, 920 (2023). Available from: Cross-cultural code-switching – the impact on international medical graduates in New Zealand | BMC Medical Education | Full Text Downloaded on 17 April 2025.
[18] Toro A, McDonald, G, Crampton P. Cultural safety support and requirements for international medical graduates in Aotearoa New Zealand. [Internet]. NZMJ Vol137(1606). Available from: 6525.pdf Downloaded on 17 April 2025.
[19] Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand. The New Zealand Medical Workforce 2024. [Internet]. MCNZ: Wellington; 2024. Available from: The New Zealand Medical Workforce in 2024 Downloaded on 17 April 2025.
[20] Royal Australasian College of Physicians (RACP). The Presidents Message. - 7 April 2025. [Internet]. Available from: The Presidents Message Downloaded on 17 April 2025.
[21] Royal Australasian College of Physicians (RACP). Heal Healthcare RACP Aotearoa NZ Election Statement 2023. [Internet]. RACP: Wellington; 2023. Available from 2023-heal-healthcare-workforce-statement.pdf Downloaded on 17 April 2025.

No.

Comments
The RACP considers there needs to be a demonstrable need for additional pathways for the health workforce to start working in Aotearoa New Zealand.

Future-proofed regulation

Question 1: Do you think regulators should consider how their decisions impact the availability of services and the wider healthcare system, ensuring patient needs are met?

No.

Comments
The RACP sees evidence that this is currently considered by the Medical Council of New Zealand.

Question 2: Do you think the Government should be able to give regulators general directions about regulation? This could include setting priorities for the regulator to investigate particular emerging professions, or qualifications from a particular country to better serve patients' healthcare needs.

Unanswered (yes/no option).

Comments
Under the current legislative framework, regulators exist and operate in a subject matter expert-led manner, independent of political incentives. The RACP sees there is scope for principles to be drawn from the legislation which could guide regulators in their strategic directions, and contribute to performance monitoring and public accountability, but do not support the development of these if divorced from the current legislative framework. For example, the Australian Health Practitioner Regulation Authority (Ahpra), working with 15 National Boards, is responsible for implementing the National Registration and Accreditation Scheme in accordance with National Law and built from this has associated regulatory principles, five core functions for Ahpra, and a governance and accountability framework along with a data access and research arm. These work together to build strong, transparent and collaborative regulatory functions upon the established legislative foundation, allowing for a bi-partisan approach to these important and impartial regulatory practices.

The RACP believes it is vital that Aotearoa New Zealand maintains a healthcare professions regulatory model that builds upon the strengths of established profession-specific councils/boards, effectively empowers the voice of professionals as subject matter experts for their fields, allows for accountability and stability per the legislation but also allows for some national profession-wide synergies. The RACP stresses that the success of any model relies on collaboration and partnerships and is focussed on systems and governance rather than specifics of individual decisions.

Question 3: Do you think the Government should be able to issue directions about how workforce regulators manage their operations, for example, requiring regulators to establish a shared register to ensure a more efficient and patient-focused healthcare system?

Unanswered (yes/no option).

Comments
Please refer to our answer for Question 2 in this section.

Question 4: Do you think the Government should have the ability to appoint members to regulatory boards to ensure decisions are made with patients' best interests in mind and that the healthcare workforce is responsive to patient needs?

No. Appointment of members can drive agendas and regulators should be independent but guided by legislation.

Comments
The medical profession values the ability to elect 4 of the 12 members of the Medical Council of New Zealand. It is not clear how the quality of regulation would be improved by removing this and moving to Ministerial appointments. The Ministry of Health would need to show how making Ministerial appointments would be better for patient needs.

This goal would be best served through effective design of a regulatory system, rather than specific appointment delegations. Reliance on individual representatives to be the voice of patients is problematic as it does not address the systemic and institutional barriers that inhibit positive change.

Conclusion

The RACP thanks Manatū Hauora | Ministry of Health for the opportunity to provide feedback on this consultation and would welcome further conversation about this important work. To discuss this submission further, please contact the RACP's Aotearoa NZ Policy and Advocacy Unit at policy@racp.org.nz.

Nāku noa, nā

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