

# Medical licensing for international medical graduates in Aotearoa New Zealand since 1849: overview and timeline

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## ABSTRACT

**AIM:** This paper aims to contextualise the current state of medical registration for international medical graduates (IMGs) in Aotearoa New Zealand by providing a historical overview of medical licensing policies for IMGs since 1849.

**METHOD:** This paper and accompanying timeline were prepared from a document analysis of 306 historical and current medical licensing policy documents and other grey literature, including parliamentary Acts and Bills, annual reports, workforce surveys and media reports.

**RESULTS:** Medical licensing policies originated in the colonial era and have historically privileged doctors from the United Kingdom, Ireland and other Commonwealth countries. The New Zealand Registration Examination pathway for IMGs who did not qualify or work in accepted countries was established in the 1990s, although its origins can be seen in policies from as early as 1905.

**CONCLUSION:** Although medical licensing policies have been adapted over the past 175 years, these changes tend to follow a pattern of oscillation between stringency and leniency, rather than linear progression. As a result, there are striking similarities between contemporary and colonial medical licensing policies in the way IMGs are categorised and distinguished that could benefit from further clarification and consideration by policymakers.

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In light of chronic medical staffing shortages, almost 900 new doctors are needed annually for a modest 3% workforce increase in Aotearoa New Zealand.<sup>1</sup> However, local medical schools only produce approximately 550 doctors per year, meaning Aotearoa New Zealand continues to “rely on importing doctors from other countries.”<sup>1</sup> International medical graduates (IMGs) thus constitute over 40% of Aotearoa New Zealand’s medical workforce and play a crucial role in national healthcare provision.<sup>2</sup> Within this context, policies relating to medical registration differentiate between IMGs depending on their country of training, creating a complex landscape with varied professional outcomes.<sup>3,4</sup> With growing public attention on the challenges some IMGs face with medical licensing,<sup>5</sup> particularly those required to take the New Zealand Registration Examination (NZREX), one stated aim of the 2023 governmental coalition agreement between the National and Act Parties is to “better recognise people with overseas medical qualifications and experience for accreditation in New Zealand.”<sup>6</sup> In seeking to understand where these current challenges with recognition of IMGs originated, this paper provides a historical overview of medical

licensing policies since 1849.

## Method

This paper and accompanying timeline (see Appendix) were prepared based on a document analysis of 306 historical and current medical licensing policy documents and other grey literature that concluded in October 2023. This analysis occurred as part of a broader project exploring the experiences of IMGs of different backgrounds with medical licensing in Aotearoa New Zealand,<sup>7</sup> with the purpose of contextualising these experiences.

All distinct parliamentary acts and bills related to medical licensing for IMGs on the New Zealand Legal Information Institute database ( $n=30$ ) were included, along with the *Gazette* notices associated with this legislation ( $n=23$ ). Furthermore, all annual reports ( $n=40$ ), medical workforce surveys ( $n=22$ ) and newsletters since 2021 ( $n=18$ ) published on the Medical Council of New Zealand (MCNZ) website were reviewed. In addition, media reports spanning historical (1849–1979,  $n=61$ ) and contemporary (1980–2023,  $n=112$ ) periods were analysed. Key sources for these reports included *Papers Past*, the *NZ Doctor*

online archives and prominent news sites (*NZ Herald, RNZ, Stuff, 1News* and *Newshub*). News articles were identified with the search terms “doctor\* OR medic\* AND overseas OR international OR foreign” and then filtered for relevance to IMGs in Aotearoa New Zealand.

## Results

Historical medical registration policies set the scene for contemporary licensing pathways. This section first summarises the contemporary context of medical registration for IMGs, before providing a historical overview.

### Specialist registration

The MCNZ provides two main specialist registration pathways for IMGs with a recognised postgraduate specialist qualification beyond their primary medical qualification. First, the Vocational 3 licensing pathway is designed for specialist IMGs without prior accreditation in Australia or Aotearoa New Zealand. Vocational 1 and Vocational 2 registration pathways are applicable to medical doctors with postgraduate qualifications from a specialist college in Australia or Aotearoa New Zealand. Although these specialists may have originally completed their undergraduate qualifications overseas, those trained in Australia are generally considered equivalent to those trained in Aotearoa New Zealand, owing to joint accreditation processes between the MCNZ and the Australian Medical Council (AMC). As such, this discussion focusses on the Vocational 3 pathway, designed for specialist IMGs without prior accreditation in Australia or Aotearoa New Zealand. This pathway has no definitive registration requirements, as the MCNZ makes licensing decisions for these IMGs on a case-by-case basis, in collaboration with the respective New Zealand or Australasian specialist college.<sup>8</sup>

Second, *locum tenens* registration of up to 12 months is available for specialists in a narrower list of fields. This option is limited to those licensed with specific medical boards and colleges from Australia, Aotearoa New Zealand, the United Kingdom (UK), Ireland, Canada, the United States of America (USA) and South Africa, provided they have worked for at least 20 hours per week for at least 22 of the last 36 months.<sup>9</sup>

### General registration

In addition, the MCNZ offers five general registration pathways. First, Australian medical

graduates typically undergo a licensing process similar to New Zealand medical graduates (NZMGs). They work under supervision in either Australia or Aotearoa New Zealand for 2 years after graduation to achieve full registration, facilitated by joint MCNZ and AMC accreditation processes.<sup>10</sup> Second, the competent authority pathway operates in a similar way, but is designated for doctors who trained in the UK or Ireland and worked there for at least 1 year.<sup>11</sup> The key requirement of these two general registration pathways is the origin of an IMG's primary medical qualification, with different available options depending on their years of experience.

In contrast, the third pathway requires doctors to demonstrate recent clinical experience in a country deemed to have a “comparable health system” (CHS), regardless of the country of primary qualification. According to publicly available information, the MCNZ determines whether a country is considered as having a CHS based on public health indicators such as life expectancy, mortality rates, the doctor-to-population ratio, the similarity of the registration system and public health expenditure per capita.<sup>12</sup> There may be additional factors that impact MCNZ decision making in this space behind the scenes. However, publicly available information suggests that the determination of CHS countries is based on these indicators of human and economic development, rather than being directly related to the nature of the training of the practitioners. A fourth pathway that has been recently established for general registrants is also available to IMGs who have successfully gained full registration and worked for 1 year in Australia or the UK.<sup>13</sup>

The fifth pathway, NZREX, is considered the final recourse if an IMG is not eligible for any of the pathways discussed above. These candidates are required to complete additional international medical knowledge examinations, and have their clinical skills assessed in the NZREX or, as of 2023, the UK's Professional and Linguistic Assessments Board clinical examination (PLAB 2).<sup>13</sup> They must then complete supervised work (Postgraduate Year 1 [PGY1] and Postgraduate Year 2 [PGY2]) alongside NZMGs to obtain their full registration.<sup>14</sup> Due to the limited number of PGY1 positions, which are prioritised for NZMGs, NZREX doctors often face significant delays obtaining a supervised placement,<sup>4</sup> which can result in them being unemployed for several years or failing to become registered before their NZREX pass expires after 5 years.

## Timeline of medical licensing history

Figure 1 offers an overview of medical licensing policies since Aotearoa New Zealand became a British colony in 1840, organised to reflect their correspondence with current processes and categorisations. A detailed timeline of medical licensing policies can be found in the Appendix.

### The colonial era

The historical evolution of medical registration in Aotearoa New Zealand has provided the foundation for current medical licensing policies, such as the competent authority<sup>11</sup> and CHS<sup>12</sup> pathways, which distinguish between IMGs based on country of training and/or experience, rather than their individual qualifications. Aotearoa New Zealand's first *Medical Practitioners Act* of 1849 (enacted in the province of New Munster) defined a “medical practitioner” as someone recognised by a college of physicians or surgeons in Great Britain or Ireland, or those who had served as medical officers in the British armed forces.

1867 saw the first overarching national policy on medical registration in Aotearoa New Zealand. The *Medical Practitioners Act 1867* mandated the creation of Aotearoa New Zealand's first medical board and the publication of a public register of accepted practitioners in the *Gazette* newspaper. Legally qualified practitioners from the UK and Ireland were entitled to automatic registration, while all other applicants were required to demonstrate completion of a medical qualification with at least 3 years of training for assessment by a medical board. However, the 1867 *Act* was soon repealed and replaced by the *Medical Practitioners' Registration Act 1869*, following Parliament's relocation from Auckland to Wellington, and the need for a medical board was removed.<sup>15</sup> It was only with the onset of the First World War that the *Medical Practitioners Act 1914* finally established a new medical board to oversee medical practitioner regulation, known after the enactment of the *Medical Practitioners Amendment 1924* as the “Medical Council of New Zealand” (MCNZ).

As outlined in Table 1, the *Medical Practitioners Registration Act 1905* shares significant parallels with contemporary medical licensing pathways, with automatic recognition of NZMGs, and UK and Irish graduates and registrants. The *Act* further included a prepared list of overseas qualifications and experience deemed “equal in status to that of New Zealand” by the governor-general.<sup>16</sup> Today, the CHS registration pathway aims to recruit IMGs from countries where the health

system and standard of medicine are considered to be “equivalent”,<sup>17</sup> bearing clear similarities to the colonial notion of qualifications that were “equal in status”. For IMGs not meeting these criteria, the option was available to take an examination at the University of Otago medical school, representing the earliest iteration of the concept of the NZREX medical licensing examination.

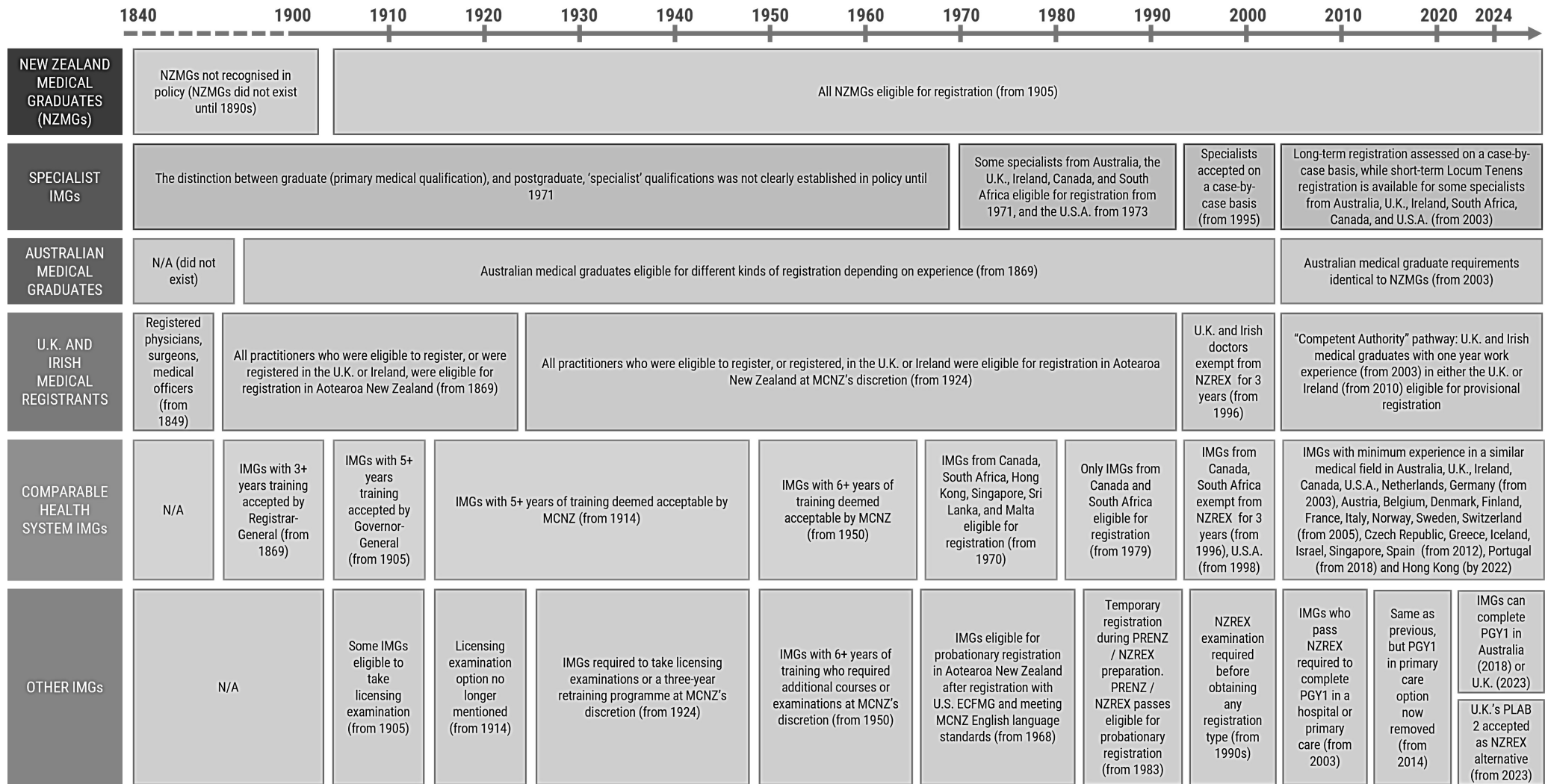
### An influx of IMGs

The next significant development in medical registration occurred with the enactment of the *Medical Practitioners Act 1950*, which introduced the concept of “conditional registration” (now known as *provisional registration*). As a prerequisite to obtaining full registration, conditionally registered doctors were required to work at an approved hospital or institution for a duration specified by the minister for health.<sup>15</sup> This essentially constituted a compulsory internship, akin to PGY1. Apart from this change, licensing pathways remained nearly identical to earlier policies. Doctors eligible for registration in the UK or Ireland, including Australian medical graduates, were considered eligible to practice in Aotearoa New Zealand, although they could be refused at the MCNZ's discretion. Graduates with diplomas from other foreign universities approved by the MCNZ required a minimum 6 years of study and, at the MCNZ's discretion, were required to take further courses or examinations in Aotearoa New Zealand, or may have simply been refused.

Medical services in Aotearoa New Zealand were said to be in a “state of crisis” by the beginning of the 1970s<sup>18</sup> due to staffing shortages. This crisis prompted changes that allowed more than 200 IMGs per year to enter the country and work.<sup>19</sup> As a result, IMGs became instrumental in the local medical landscape, with a notable surge in the 1960s and 1970s, particularly from the UK, Ireland, Canada, Sri Lanka and South Africa.<sup>20</sup> By 1980, IMGs constituted 33% of the medical workforce, triggering concerns about an oversupply of doctors.<sup>21</sup> The contentious decision was made to reduce medical school admissions in Aotearoa New Zealand by a quarter<sup>22</sup> and, alongside this, immigration applications from doctors required approval from the Department of Health before a visa was granted.<sup>23</sup> This shift reflected a move from actively encouraging medical migration to address local workforce shortages, to restricting the inflow of IMGs.

Despite these fears of a surplus, however,

**Figure 1:** Historical overview of key policies indicating who was eligible for medical licensing in Aotearoa New Zealand since 1849 (source: Johanna Thomas-Maude).



**Table 1:** Comparison of general registration pathways in 1905 and 2024.

Pathway	1905 <sup>16</sup>	2024 <sup>10,11,12,13,14</sup>
New Zealand medical graduates (NZMG)	NZMGs were automatically eligible for registration	NZMGs are automatically eligible for registration
Australian medical graduates/registrants	Australian medical graduates were eligible for registration (because they were eligible for British registration)	Australian medical graduates are eligible for registration IMGs with general registration in Australia are eligible for general registration
British and Irish graduates/registrants	All practitioners registered or eligible to register in the UK or Ireland were entitled to registration	Doctors with a primary medical degree from the UK or Ireland, and 1 year of general medical experience in that country, are eligible for registration under the competent authority pathway IMGs with general registration in the UK are eligible for general registration
Comparable health systems	Governor in council (now known as the governor-general) prepared a list of foreign qualifications he considered to be “ <i>equal in status to that of New Zealand</i> ”, and such IMGs were eligible for registration	IMGs are eligible for registration if they have worked 20 hours per week for a minimum of 33 months within the past 48 months, in a country the MCNZ designates as a “comparable health system”
New Zealand Registration Examination (NZREX)	IMGs whose qualifications were not deemed “equal in status” could apply for registration after completing the final examination at the University of Otago medical school	To be eligible for registration via PGY1, IMGs must pass an approved medical knowledge examination and complete the NZREX or the UK’s PLAB 2 clinical skills examination

IMG = international medical graduates; UK = United Kingdom; MCNZ = Medical Council of New Zealand; PGY1 = Postgraduate Year 1; PLAB 2 = Professional and Linguistic Assessments Board.

workforce shortages were prevalent in rural and under-privileged areas.<sup>20</sup> In 1982, Aotearoa New Zealand was reported to have a lower ratio of medical practitioners (130 per 100,000) than Canada, Denmark, Finland, France, Germany, Netherlands, Norway, Sweden, Switzerland, the UK, the USA and Australia.<sup>23</sup> Aotearoa New Zealand continues to have fewer doctors per capita than most of these countries,<sup>24</sup> which are all classified as CHS.<sup>12</sup>

In addition, policies introduced in the 1980s began to distinguish more specifically between IMGs based on their country of origin, echoing earlier colonial policies. Graduates from the “old white Commonwealth”<sup>20</sup>—the UK, Ireland, Australia, Canada and South Africa—were auto-

matically eligible for general medical registration. In contrast, IMGs from other countries received a 2-year temporary registration and had three opportunities to pass a registration examination to continue practicing in Aotearoa New Zealand. The first of these examinations was the Probationary Registration Examination in New Zealand (PRENZ), encompassing an English language competence assessment, a written medical knowledge examination and a clinical skills examination.<sup>25</sup>

### The origins of NZREX

After its establishment in 1983, the PRENZ examination was phased out by 1989 and replaced by the NZREX. This change required IMGs who trained outside of the “old white Commonwealth”<sup>20</sup>

or the USA to take a screening examination of medical knowledge and English language abilities before being granted a 2-year temporary registration. The key difference was that temporary registration was only granted *after* passing the first two components, marking a shift towards more stringent policies. By 1997, however, the NZREX screening examinations were phased out and replaced by international medical knowledge examinations from the USA and, later, Australia, the UK and Canada.<sup>14</sup> The purpose of these examinations was to ensure doctors required to sit them had the necessary skills and knowledge to integrate successfully into the health system of Aotearoa New Zealand.

However, challenges were identified early on with both the PRENZ and NZREX. Candidates faced difficulties accessing the necessary exposure to the local medical system, resulting in low pass rates. While opportunities have been explored over the past three decades for clinical attachments, observerships and bridging programmes, only 52% of candidates (2,045 of 3,907) passed the clinical component of the PRENZ and NZREX between 1984 and 2023.<sup>26</sup>

A noticeable increase in total attempts and successful passes can be seen in the MCNZ's annual reporting when NZREX became briefly compulsory for all IMGs seeking general registration (except for Australian medical graduates) in 1996.<sup>26</sup> At this time, hospitals became concerned that this would result in staffing shortages, particularly in rural areas. As a result, MCNZ announced a new exemption for doctors from the "old white Commonwealth"<sup>20</sup> and the USA, making them eligible for temporary registration of up to 3 years.<sup>27</sup> During this time, registration data show that most IMGs from the UK, Canada, Ireland, South Africa and the USA took advantage of this exemption from the NZREX. For example, in 1999, there were 254 temporary registrants from the UK, compared to just six taking the NZREX.<sup>28</sup>

Nevertheless, even with these doctors able to obtain temporary registration without sitting the NZREX, the total number of IMG registrations still decreased in the late 1990s.<sup>26</sup> While other factors may have contributed to this decline, it is possible that the examination requirement for registration beyond 3 years acted as a deterrent for doctors from countries now considered as CHS. Furthermore, the examination was held four to five times per year until 2012, for up to 28 candidates at a time.<sup>26</sup> However, offerings were since reduced to three per year, and reduced even further since

2020 and the COVID-19 pandemic. At the time of writing, in 2024, NZREX sessions are only being held twice annually,<sup>14</sup> although these doctors may now take the UK's PLAB 2 clinical skills examination in lieu of the NZREX.<sup>13</sup> The impacts of these changes are as yet unmeasured.

## Conclusion

The historical evolution of medical licensing policies reflects a responsiveness to shifting workforce demands in Aotearoa New Zealand, while maintaining certain characterisations and distinctions between IMGs from different backgrounds. Stringency increased in the 1970s and 1980s amid concerns about an excessive influx of IMGs, with exceptions made for doctors who trained in the "old white Commonwealth".<sup>20</sup> Subsequently, in response to predicted workforce shortages, exceptions to government requirements for all IMGs to take the NZREX in the late 1990s privileged IMGs from the UK, Ireland, Australia, Canada and South Africa. There is a historical precedent for more flexible medical licensing processes in response to workforce shortages, which suggests there may be room for movement in response to the current workforce crisis that has been exacerbated by COVID-19.<sup>5</sup>

Rather than a linear progression of change, medical registration policies for IMGs have appeared to oscillate between stringency and more relaxed regulations over the decades. This oscillation reflects the tensions and complexities in ensuring rigorous standards of medical practice are upheld, while also ensuring processes are viable for qualified IMGs hoping to contribute to the understaffed health workforce. The stated aim of the MCNZ, as seen in their annual reports, is to "*protect the public, and promote good practice.*"<sup>26</sup> However, it is unclear at times how aspects of current processes directly reflect this aim of public protection. For example, the significant delays NZREX doctors face in obtaining the PGY1 positions required for registration, even after passing the examination and being considered by the MCNZ as equivalent to an NZMG,<sup>4</sup> are incongruent with staffing shortages<sup>1</sup> that negatively impact the public when seeking healthcare. This is an example where policy does not appear to translate well to practice.

Furthermore, this historical overview also raises questions about the relationship between some policies and this aim of upholding medical practice standards. It is unclear, for instance,

whether there are data to support how the socio-economic development indicators specified as determining the “comparability” of a health system<sup>12</sup> directly translate into IMGs most able to integrate safely into Aotearoa New Zealand’s health workforce. Additional points of consideration, such as a propensity for culturally safe practice, are not publicly mentioned as points of criteria in shaping the list of countries considered to be “comparable”, despite cultural safety being a priority in national healthcare provision.<sup>29</sup> In fact, it is pertinent to note that the NZREX clinical skills examination, designed specifically to assess competency within the Aotearoa New Zealand health context, includes elements of cultural safety that are not assessed for IMGs on other licensing pathways prior to becoming registered to practice. In addition, countries such as Japan, which perform very highly on the stated comparability indicators,<sup>24</sup> were not included in the 2024 list of CHS countries.<sup>12</sup> It would be helpful, therefore, if further information was publicly available around how such medical licensing policies for IMGs uphold the MCNZ’s stated aim of protecting the public, and what other criteria are considered in this decision-making process.

Despite this oscillation between stringency and leniency, some key consistencies have remained. Categories originating in the colonial era continue to differentiate between doctors from the UK and Ireland,<sup>11</sup> countries deemed “equal in status” or “comparable”,<sup>12</sup> and the rest of the world. Given these contemporary links to policies

that were implemented under British imperialism, the recent decision to recognise the UK’s PLAB 2 clinical skills examination raises questions around why a British examination that does not account for the specific cultural context and challenges associated with equitable healthcare provision in Aotearoa New Zealand would be considered a viable alternative to the NZREX. Efforts to improve recognition of IMG medical qualifications and streamline processes thus need to take into account potential colonial legacies, with policymakers making data available to demonstrate how current criteria and categorisations directly contribute to public protection through medical regulation.

More systematic monitoring of IMG licensing policies, and the rationale behind these, could also be beneficial in understanding why some IMGs are included and others are excluded. It may also be useful to explore other models, such as that of the USA (a CHS), where all local graduates and IMGs are required to take the same examinations and meet the same standards to become registered.<sup>30</sup> Moreover, criteria relating to cultural safety could be brought to the forefront when determining which IMGs are considered competent to practice in Aotearoa New Zealand. Further consideration and research into alternative options for rigorous yet equitable registration processes are thus recommended, in order to explore ways to better serve the needs of Aotearoa New Zealand’s understaffed medical workforce and, by extension, the public.

**COMPETING INTERESTS**

Nil.

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## Appendix

### Detailed timeline of medical licensing history in Aotearoa New Zealand since 1849

The following timeline (refer to Appendix Table 1) provides a more detailed historical overview of the policies relating to medical licensing since Aotearoa New Zealand became a British colony. The table describes who was eligible for registration in Aotearoa New Zealand, organised according to how they most correspond with the categorisations of medical doctors in place in 2024:

- **NZMGs:** New Zealand medical graduates.
- **Specialists:** The distinction between graduate (primary medical qualification) and postgraduate specialist qualifications was not clearly established in policy until 1971. Members of a recognised British college of surgeons, for example, would likely be considered specialists now, although no such distinction was made in

nineteenth and early twentieth century policy. Those who would now be classified as *specialists* registered through whichever available pathway applied to them at the time.

- **Australian:** This category refers to Australian medical graduates, or general registrants applying on the basis of having obtained full medical licensing in Australia.
- **United Kingdom (UK)/Ireland:** Doctors with primary medical qualifications and/or training in the UK and Ireland, or general registrants applying on the basis of having obtained full medical licensing in the UK.
- **Comparable:** Doctors from other countries whose qualifications and/or experience were considered acceptable and/or equivalent to NZMGs.
- **NZREX:** Doctors required to retrain or take a licensing examination to work in Aotearoa New Zealand.

Pathways shaded in grey were not applicable at that time.

**Appendix Table 1:** Historical overview of key policies indicating who was eligible for medical registration in Aotearoa New Zealand since 1849.

NZMGs	Specialists	Australian	UK/Ireland	Comparable	NZREX
<b>1849<sup>1</sup></b>					
			Recognised by a college of physicians or surgeons in the <u>UK or Ireland</u> ; and/or  Served and trained in the British armed forces as a medical officer		
<b>1869<sup>2</sup></b>					
		Australian medical graduates were entitled to registration <sup>3</sup>	All practitioners registered or eligible to register in the <u>UK or Ireland</u>	All other applicants with medical qualifications requiring at least <u>3 years of training assessed for acceptability by the registrar-general</u>	
<b>1905<sup>4</sup></b>					
<u>NZMGs automatically eligible</u> for registration		Same as above	Same as above	Governor in council (governor-general) prepared a list of qualifications from foreign institutions (which provided at least 5 years of training) that he considered to be " <u>equal in status to that of New Zealand</u> "	IMGs whose qualifications were not deemed "equal in status" could apply for registration on completion of the <u>final examination at the University of Otago</u> medical school

**Appendix Table 1 (continued):** Historical overview of key policies indicating who was eligible for medical registration in Aotearoa New Zealand since 1849.

NZMGs	Specialists	Australian	UK/Ireland	Comparable	NZREX
<b>1914<sup>5</sup></b>					
Same as above		Same as above	Same as above	A “ <u>medical board</u> ” was <u>responsible</u> for assessing individual applications from IMGs with at least 5 years of training and could refuse a candidate at their discretion	No mention of the option to register after examination
<b>1924<sup>6</sup></b>					
Same as above			Same as above, but British and Irish were <u>no longer automatically entitled</u> to registration and <u>could be refused at the MCNZ’s discretion</u>	Same as above, but the Medical Board was renamed as the Medical Council of New Zealand	<u>Examination option re-established</u> for those whose degrees were not recognised by the MCNZ  The MCNZ also made provisions for <u>some IMGs to complete a 3-year retraining programme</u> in Otago <sup>7</sup>
<b>1950<sup>8</sup></b>					
NZMGs entitled to <u>conditional registration</u>		Australian medical graduates <u>eligible for conditional registration at the MCNZ’s discretion</u>	Medical practitioners licensed or eligible to be licensed in the UK and/or Ireland were <u>eligible for conditional registration at the MCNZ’s discretion</u>	There was no clear distinction between IMGs with acceptable qualifications and those required to take further examination  Instead, conditional registration was available to IMGs from foreign approved universities requiring a minimum <u>6 years of study</u> who, <u>at the discretion of the MCNZ, could have been asked to take further courses or examinations</u> , or simply be refused  A 1964 amendment first gave the MCNZ the authority to assess IMG <u>English language competency</u> , <sup>9</sup> which has been included in all licensing policies since	

**Appendix Table 1 (continued):** Historical overview of key policies indicating who was eligible for medical registration in Aotearoa New Zealand since 1849.

NZMGs	Specialists	Australian	UK/Ireland	Comparable	NZREX
<b>1968<sup>10,a</sup></b>					
Same as above	The <u>first list of approved specialist qualifications</u> was published in 1971, including those from <u>Australia, the UK, Ireland, Canada, South Africa<sup>11</sup> and the USA<sup>12</sup></u>	Australian graduates now specifically mentioned on the list of qualifications <u>recognised for conditional registration at both the general and specialist levels</u>	Same as above	In 1970, other qualifications (beyond those accepted in Australia or the UK/Ireland) recognised for conditional registration were from <u>Canada, South Africa, Hong Kong, Singapore, Sri Lanka (Ceylon) and Malta<sup>13</sup></u>  By 1979, this only included <u>Canada and South Africa<sup>14</sup></u>	Other IMGs were eligible for <u>probationary registration upon recognition by the USA ECFMG<sup>7</sup></u>  <u>Temporary registration of up to 2 years was introduced in the 1980s while candidates prepared for probationary status on completion of New Zealand licensing examinations: the PRENZ (1984–1989) and then the NZREX (1989–1997)</u>  <u>From 1990, a screening examination (first part of the NZREX) was also required before temporary registration was available<sup>15</sup></u>
<b>1995<sup>16,b</sup></b>					
NZMGs <u>eligible for probationary registration</u> (which required the completion of an internship as a house officer to progress to general registration, i.e., PGY1)	Shift to accepting specialist qualifications on a <u>case-by-case basis<sup>17</sup></u>  However, <u>general registration was a prerequisite for vocational registration,</u>	Graduates from Australian institutions were eligible to apply for temporary, probationary or general <u>registration without examination</u> , depending on	Officially, <u>all IMGs (except for Australian IMGs) were required to take the NZREX</u> , as doctors from the <u>UK, Ireland, Canada and South Africa</u> were no longer automatically eligible for registration  However, the MCNZ “ <u>ruled that for a limited period these</u>	<u>Temporary licensing option phased out</u> for candidates preparing for the NZREX, who now <u>had to pass the examination before they could work as</u>	

**Appendix Table 1 (continued):** Historical overview of key policies indicating who was eligible for medical registration in Aotearoa New Zealand since 1849.

NZMGs	Specialists	Australian	UK/Ireland	Comparable	NZREX
	meaning specialists without recognised primary qualifications were diverted to the NZREX <sup>18</sup>	their experience <sup>19</sup> From 2000, NZMGs and Australian graduates with completed <u>internships could apply for immediate general registration</u> on a case-by-case basis <sup>20</sup>	<u>doctors could still apply for temporary registration under the new Act</u> <sup>21</sup> for up to <u>3 years</u> From 1998, this also applied to doctors from <u>the USA</u> <sup>22</sup> This “limited period” of exemption from the NZREX lasted for the entire length of time before the new <u>Health Practitioners Competence Assurance Act 2003</u> <sup>23-25</sup> <u>Temporary registration thus changed in meaning</u> from previously applying to those on the NZREX pathway preparing for probationary registration to those from countries previously accepted for conditional or general registration, <u>in order to avoid severe workforce shortages</u> <sup>26</sup>		<u>doctors</u> in any capacity <sup>27</sup> The majority of doctors who took the NZREX during this time continued to be from countries outside of the UK, Ireland, Canada, South Africa and the USA <sup>20, 26-31</sup>
<b>2003<sup>32, 33, c</sup></b>					
NZMGs <u>eligible for provisional registration</u> until internship requirements (PGY1 and PGY2) are complete	IMGs assessed and granted <u>full vocational registration</u> or <u>provisional vocational registration</u> (pending supervision for at least 12 months and completion of any other MCNZ requirements), or <u>referred to a general licensing pathway</u>  Special purpose registration available for <u>locum tenens</u> specialists from <u>Australasia, the UK, Ireland, South Africa, Canada and the USA</u> to work for	Requirements for Australian medical graduates were now <u>identical to those of NZMGs</u>	Medical degree from a list of <u>UK or Irish universities</u> only, plus <u>1 year minimum experience</u> (this could include an internship year, and the country where this experience should be completed was not specified)	Must have <u>worked for 36 months continuously, at least 30 hours per week</u> , in a listed comparable health system to obtain provisional registration  Must then work at least 1 year full-time with satisfactory supervisory reports to be eligible for full general registration  In 2004, comparable health system countries included <u>Australia, the UK, Ireland,</u>	Hold a <u>medical degree</u> from the WHO World Directory of Medical Schools or the ECFMG FAIMER Directory, and have <u>passed USMLE steps 1 and 2</u> , and <u>NZREX</u>  The Australian Medical Council multiple-choice examination was accepted from 2006 as an alternative to USMLE steps 1 and 2, <sup>35</sup> with the first mention of acceptance of the UK PLAB 1 examination from 2009 <sup>36</sup>

**Appendix Table 1 (continued):** Historical overview of key policies indicating who was eligible for medical registration in Aotearoa New Zealand since 1849.

NZMGs	Specialists	Australian	UK/Ireland	Comparable	NZREX
	up to 6 months, if they worked <u>at least 30 hours per week for 24 of the past 36 months</u>			<u>Canada, the USA, the Netherlands and Germany</u> <sup>33</sup>  By 2005, <u>Austria, Belgium, Denmark, Finland, France, Italy, Norway, Sweden and Switzerland</u> had been added <sup>34</sup>	After NZREX, candidates must work under supervision for at least 1 year (PGY1) in a <u>hospital OR general practice</u> in Aotearoa New Zealand, with satisfactory supervision reports  All IMGs (including those on other licensing pathways) must pass (or be exempt from) the MCNZ's English testing policy (in 2004 this was <u>7.5 overall in the IELTS Academic Module, with at least 7.0 in all individual components</u> )
<b>2010</b> <sup>37</sup>					
Same as above	Same as above for vocational registration ( <u>case-by-case basis</u> )  From 2010, specialists applying for <u>locum tenens</u> positions were only required to have worked <u>20 hours per week over 24 months of the last 36 months</u>	Same as above	Primary medical degree from approved competent authority (UK or Irish medical councils) and 1 year of general medical experience  Unlike earlier, it is clearly specified that the <u>1 year of prior work experience required must be in a competent authority country</u>	Have worked for 36 months (minimum 30 hours per week) during the 48 hours prior to application in a comparable health system (listed on website) and have full or general registration in a comparable health system;  <u>OR be satisfactorily participating in a training programme recognised by the</u>	Primary medical degree from an approved medical school listed on the website, an approved medical knowledge examination as listed on website, and completion of the NZREX within 5 years of this  NZREX candidates must then either complete the four rotations of PGY1 <u>OR apply for an exemption</u>

**Appendix Table 1 (continued):** Historical overview of key policies indicating who was eligible for medical registration in Aotearoa New Zealand since 1849.

NZMGs	Specialists	Australian	UK/Ireland	Comparable	NZREX
				<p><u>American specialty boards or Canadian colleges</u></p>	<p><u>on a case-by-case basis to work directly in primary care</u> if they worked at least 5 years in general practice previously</p> <p>In 2009, <u>English language policy</u> changed to require <u>7.5 in Speaking and Listening</u> in IELTS, and 7.0 in Reading and Writing for IMGs<sup>36</sup></p>
<b>2012 onwards</b>					
<p>Same as above</p>	<p><u>Locum tenens</u> was extended to allow special purpose registration for <u>up to 12 months</u>, instead of just 6 months in 2012<sup>38</sup></p> <p>From 2013, <u>locum tenens</u> applicants now only required 22 months (minimum 20 hours per week) of active clinical practice prior to application (1,760 hours worked)<sup>39</sup></p> <p>Current listed approved qualifications from <u>Australasia, Canada, Ireland, South Africa, the UK and the USA</u><sup>40</sup></p>	<p>Same as above</p> <p>From 2018, the <u>Australian general registrants pathway</u> was introduced, where <u>doctors who completed Australian medical licensing examinations</u> and 12 months supervised practice in Australia could apply for provisional registration<sup>41</sup></p>	<p>Same as above</p> <p>A 2022 update states clearly for the first time that competent authority refers only to UK and Irish graduates<sup>42</sup></p> <p>From June 2023, the <u>UK general registrants pathway</u> was introduced for IMGs who have completed <u>UK medical licensing examinations and PGY1 in the UK, making them eligible to bypass the NZREX</u> and receive provisional registration<sup>43</sup></p>	<p>From November 2013, comparable health system doctors were now only required to have <u>33 months recent clinical practice (minimum 30 hours per week)</u> during the past 48 months, equating to 3,950 hours (but only a maximum of 40 hours per week count)<sup>39</sup></p> <p>From 2023, working <u>20 hours per week is now considered sufficient</u> (for a minimum of 33 months within the past 48 months), and a wider range of experience is accepted for doctors</p>	<p>Same as above</p> <p>In 2014, the <u>option to complete the PGY1 year in primary care for NZREX graduates was removed</u>, so requirements for registration were identical for NZREX candidates and recent NZMGs and Australian graduates<sup>46</sup></p> <p>From June 2023, IMGs who have completed the <u>UK medical knowledge and clinical examinations (PLAB 1 and 2)</u> do not also need to take the NZREX to apply for PGY1 positions<sup>43</sup></p>

**Appendix Table 1 (continued):** Historical overview of key policies indicating who was eligible for medical registration in Aotearoa New Zealand since 1849.

NZMGs	Specialists	Australian	UK/Ireland	Comparable	NZREX
				<p>applying to work in rural settings<sup>42</sup></p> <p>Comparable health system countries increased to 22 by 2012 with the inclusion of the <u>Czech Republic, Greece, Iceland, Israel, Singapore and Spain</u>,<sup>3</sup> and 23 in 2018 with the addition of <u>Portugal</u><sup>44</sup></p> <p>In 2024, 24 countries are recognised, with <u>Hong Kong</u> being the most recent addition<sup>45</sup></p> <p>From 2022, comparable health system applicants need to have worked in the “<u>same area</u>” of medicine as the role they are applying for, OR a “<u>similar area</u>”<sup>42</sup></p>	<p>A <u>pilot programme</u> for 10 NZREX graduates to complete PGY1 in a <u>primary care</u> setting is currently underway, alongside a pilot bridging programme<sup>47</sup></p> <p>From December 2022, English language policy requires <u>7.0 in all four individual components of IELTS</u> or a minimum score of <u>350 in the Occupational English Test Medical Module</u><sup>48</sup>—the Occupational English Test was also added to the policy between 2009 and 2022, but it is unclear when that change was made</p>

NZMG = New Zealand medical graduate; UK = United Kingdom; NZREX = New Zealand Registration Examination; IMG = international medical graduate; MCNZ = Medical Council of New Zealand; USA = United States of America; ECFMG = Educational Commission for Foreign Medical Graduates; PRENZ = Probationary Registration Examination in New Zealand; PGY1/PGY2 = Postgraduate Year 1/Postgraduate Year 2; WHO = World Health Organization; FAIMER = Foundation for Advancement of International Medical Education and Research; USMLE = United States Medical Licensing Examination; IELTS = International English Language Testing System; PLAB 1/2 = Professional and Linguistic Assessments Board clinical examination.

<sup>a</sup> In addition to “conditional registration” for those with recognised qualifications, “probationary registration” was introduced for IMGs with non-approved qualifications to register without having to go through formal retraining upon consideration of their medical knowledge and English competency by the MCNZ. “Temporary registration” was introduced for those preparing to take examinations and apply for “probationary registration”. IMGs could apply for “conditional registration” after completing their probationary period and passing required examinations and/or completing supervised work to an acceptable standard. “Temporary” and “probationary” registration were therefore only for IMGs with qualifications that were not automatically recognised for “conditional registration”.

<sup>b</sup> With the new Act in 1995, “conditional registration” was renamed as “probationary registration” for all doctors (not just IMGs) who were not yet eligible for full registration (usually less experienced practitioners).

<sup>c</sup> “Probationary registration” is now referred to as “provisional registration”.

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