Removing systemic barriers to register overseas trained doctors in New Zealand while preventing their mental distress

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Dr Charles Mpofu and Dr Dianne Wepa discuss removing systemic barriers for overseas-trained doctors registering in New Zealand while also addressing mental health challenges

New Zealand (NZ) depends on internationally trained medical graduates (IMGs), yet too many remain blocked from practice by processes that are slower, costlier and less flexible than comparable jurisdictions.

This article distils evidence and international practice to outline balanced, pragmatic reforms that uphold patient safety while accelerating IMG integration. It highlights solutions for experienced practitioners and refugee doctors, ensuring their mental health distress is minimised and communities can access care when and where it is needed.

Key messages

- NZ faces persistent workforce gaps while hundreds of internationally trained medical graduates remain under employed or out of practice.
- Current pathways over weight risk and under weight access: safety matters, but so do equity and service coverage.
- Other OECD systems use policy levers (bridging programmes, supervised provisional licensure, bonded roles) to integrate IMGs quickly and safely.
- Targeted, time bound pathways and funded supports reduce delays without compromising standards.
- Recognising prior experience and widening ‘comparable system’ routes cuts cost and duplication.
- The IMGs mental health needs to be prioritised.

What’s the issue, and who is impacted?

Addressing these barriers is, therefore, not only a matter of workforce efficiency and equity but also one of health promotion. Enabling IMGs to enter practice more quickly reduces isolation, restores professional identity and enhances mental health resilience. System-level reforms, such as funded bridging, supervised placements, and recognition of prior experience, are protective not only for patient access but also for IMG well-being itself.

Mental health impacts are compounded for refugee and migrant doctors who may already carry mental health trauma from displacement and resettlement. A Canadian survey found that 45% of IMGs reported symptoms of depression linked to barriers in medical licensure, with women and refugee doctors disproportionately affected (Wong & Lohfeld, 2008).

Studies in Australia also confirm that prolonged exclusion from the medical workforce undermines confidence, social integration and financial stability, all of which worsen mental health outcomes (Eley et al., 2020).

Systemic barriers to registration not only block access to practice but also have significant impacts on the mental health and well-being of internationally trained doctors. Prolonged unemployment, underemployment in non clinical roles, and repeated exam failures contribute to stress, depression, anxiety and feelings of professional identity loss. Research in the UK and Canada has shown that internationally trained medical graduates facing delayed licensing pathways are at higher risk of experiencing psychological distress, burnout, and even suicidal ideation (Healey et al., 2025).

Systemic barriers and mental health impacts

Workforce shortfalls persist in primary and secondary care, including rural and hard-to-staff specialities. Estimates have pointed to hundreds of vacancies for senior doctors, alongside limited domestic graduate throughput and competition for intern and training places (McElvaney & McMahon, 2024).

At the same time, many IMGs in New Zealand remain unemployed or under employed – a loss to patients, services and the public purse (Thomas-Maude, 2023). For IMGs outside comparable system pathways, total out of pocket costs for tests and clinical assessment can reach five figures, with pass rates and placement availability adding uncertainty. The net effect is a system that protects the public, but too often at the cost of timely access and fair participation.

What other systems do

Internationally, regulators and governments balance patient protection with access by enabling supervised or time-limited pathways, funded bridging programmes, and targeted incentives. Australia's National Law emphasises rigorous yet responsive assessment and has used area-of-need routes with supervision to sustain services.

Several U.S. states, Canada, Sweden and Germany support IMGs through language and clinical bridging, paid observerships and provisional licences tied to rural or high need placements, often with living support and exam fee coverage (Tsugawa et al., 2017).

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EU rules allow mobility for EU trained doctors, while some jurisdictions relax language thresholds where appropriate supervision and audit are in place. Evidence from large cohorts shows quality and outcomes for IMG practitioners are comparable to locally trained peers when fair assessment and oversight are provided (Kureshi et al., 2019).

Policy options for New Zealand

Policy levers, not just regulatory discretion, are the difference between ad hoc, slow progress and scaled, consistent integration (Medical Council of NZ, 2023). A national, multi stakeholder approach can:

1. Fund bridging models that combine English for clinical communication, cultural safety and assessed workplace practice.
2. Expand supervised provisional licensure for experienced IMGs into bonded roles.
3. Recognise prior seniority to avoid blanket classification as interns.
4. Grow supervised placement capacity by incentivising specialists to precept.

Recommendations

- Create a live national register of unregistered IMGs (with consent) to quantify capacity, target outreach and match candidates to placements.
- Legislate a funded IMG Bridging Pathway that integrates language, cultural safety, exam preparation and paid clinical observerships, ending with an assessed workplace placement.
- Introduce supervised provisional licences for experienced IMGs tied to bonded service in priority settings (rural, after hours, aged care), with clear progression milestones.
- Recognise prior experience and speciality: replace one-size-fits-all 'intern' categorisation with tiered entry (e.g., senior IMG fellow; IMG registrar; IMG intern).
- Expand the 'comparable health system' list and accept a wider set of English language evidence where safety is ensured through supervision and audit.
- Subsidise exam, assessment and relocation costs for refugee and priority-speciality IMGs; offer living stipends during bridging/placement phases and mental health counselling.
- Grow placement capacity by funding specialist preceptors, protected teaching time and rural clinical educator hubs.

- Integrate IMG pathways with Health New Zealand workforce planning, so IMG onboarding aligns with service gaps and budgeted FTEs.
- Apply transparent data and equity metrics (time to practice, pass rates, complaints, patient outcomes) to continuously improve pathways.
- Include IMGs and community representatives (including migrant and mental health lived experience voices) in the governance and codesign of pathway refinements.

Conclusion

New Zealand can uphold public protection while unlocking a proven, diverse medical workforce. Time-bound, supervised routes; funded bridging; and recognition of prior expertise are pragmatic steps that many peer systems already use. With clear governance, fair assessment and targeted incentives, IMGs can contribute sooner and safely, improving access, equity and continuity of care across NZ.

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