2017 NEW ZEALAND GENERAL ELECTION

Election Issues

July 2017
**INTRODUCTION**

The Royal Australasian College of Surgeons (RACS) was established in 1927 and is the leading advocate for surgical standards, professionalism and surgical education in New Zealand and Australia. RACS is a not-for-profit organisation representing more than 7,000 surgeons and 1,300 surgical trainees across nine surgical specialties. Approximately 95 per cent of all surgeons practising in New Zealand and Australia are Fellows of the College (FRACS).

RACS is committed to ensuring the highest standard of safe and comprehensive surgical care for the communities it serves and, as part of this commitment, strives to take informed and principled positions on issues of public health.

Government decisions on health have an impact on the surgical care available in New Zealand. There are number of key issues RACS considers to be of particular importance to the provision of this care:

- Elective prioritisation and unmet need
- Māori health equity
- Alcohol-related harm
- Obesity
- Health workforce

Background information on these follows, and RACS would like to have your party’s responses to the questions posed.

**ELECTIVE PRIORITISATION AND UNMET NEED**

Access to elective surgery is a key area of concern for the public and for surgeons. It is accepted that public funds cannot provide for all elective surgery; however, the proportion of patients currently missing out on elective surgery is a significant concern. Clinical Priority Access Criteria (CPAC) have evolved considerably and are proving useful to prioritise patients. While it is essential that these tools continue to be refined and developed, these on their own cannot identify or address the unmet need.

At present, there are too many New Zealanders who are unable to access the only treatment that will resolve conditions that are affecting the quality of their personal and work lives.

The number of publicly funded elective procedures has increased in recent years but this has not kept up with the country’s growing and aging population. Considerable investment is required from government in personnel, infrastructure and facilities to ensure that the surgical needs of the population can be adequately met.

The current data on the levels of unmet surgical need in New Zealand is inadequate. The Ministry of Health’s collection of First Specialist Assessment (FSA) data is beginning to provide part of this picture, but the current system fails to capture deserving patients who are either not referred by their GP for an FSA, or who do not visit a general practitioner. Accurate data is essential if we are to respond effectively and reduce this unmet need.

**Question 1:** How does your party plan to identify and meet the increasing surgical needs of New Zealand’s growing and aging population?

**Question 2:** In what way does your party plan to improve data collection on unmet need in New Zealand?
MĀORI HEALTH EQUITY

There remain significant discrepancies in health outcomes between Māori and non-Māori despite multiple initiatives. Māori continue to have a greater incidence of, and mortality from, conditions amenable to health care such as diabetes, cardiovascular disease and cancer. Māori also have higher rates of acute admissions for surgery and have significantly higher perioperative mortality rates, even when after adjusting for sociodemographic and clinical factors. Health inequity is further compounded by differential access to health services and treatment options. The purported equality in healthcare delivery has clearly not resulted in equal outcomes.

Despite composing 15.5% of the population, approximately 2.7% of New Zealand’s active medical workforce are Māori; the proportion of Māori practicing surgery is even lower. The lack of a visible Māori presence and the very limited contribution of Māori in the delivery of surgical care may be one of the reasons that the workforce is not optimally responsive to, or understanding of, Māori healthcare needs and aspirations. While tremendous work has ensured that undergraduate medical training now includes and supports our Māori population, low representation within postgraduate, hospital specialist training will continue without on-going access to educational resources and support.

RACS has a Māori Health Action Plan with a vision of achieving health equity for Māori. Under this plan, RACS is committed to fulfilling its obligations under Te Tiriti o Waitangi by addressing health inequity and improving Māori representation in the surgical workforce.

Evidence based research is required to investigate options to improve equitable surgical outcomes for Māori; however, there are limited funds available for such research.

**Question 3**: How will your party address the significant inequitable health outcomes for Māori?

**Question 4**: Does your party support additional funding for research into improving Māori health outcomes?
ALCOHOL RELATED HARM

Alcohol misuse is a causal factor in more than 200 diseases and injury conditions, including cirrhosis of the liver, inflammation of the gut and pancreas, heart and circulatory problems, sleep disorders, male impotency, and eye disease. Excessive alcohol consumption increases an individual’s overall risk of cancer, including cancers of the mouth, throat and oesophagus, liver, breast and bowel. Surgeons are also frequently confronted with the effects of alcohol when treating patients with injuries from road traffic trauma, interpersonal violence and personal accidents.

Alcohol is the most commonly used recreational drug in New Zealand; 80% of the adult population report at least occasional use, with one quarter of these exhibiting binge drinking behaviour. As a result of its high proliferation, alcohol is a considerable burden on New Zealand society, having an adverse effect both on individual drinkers and those around them. It is estimated that between 600 to 800 New Zealanders die each year from alcohol-related causes at an annual cost of $5.3 billion. Māori, youth under 25, and those with higher socioeconomic deprivation are disproportionately affected. Despite this knowledge, alcohol continues to maintain a strong presence in the New Zealand psyche due to its in-grained cultural status, availability, and high visibility.

RACS has advocated against the harmful use of alcohol for many years, not only because of adverse effects that it has on our patients, but also for the broader ramifications that alcohol-related harm has on our health system and society as a whole. RACS endorses preventative measures as the best way to reduce alcohol-related harm by restricting the physical and economical availability of alcohol. This can be achieved by reducing the trading hours of both on and off licences, restricting liquor outlet density, and imposing a volumetric tax on alcohol. While local councils are permitted to impose tighter restrictions on density and closing times than the minimums set by our laws, they seldom do.

Question 5: What are your party’s policies to address alcohol-related harm?

Question 6: Does your party support tighter national restrictions on outlet density and an earlier national closing time?
OBESITY

Nearly one third of New Zealand’s adult population (30.7%) is now estimated to be obese with a further third overweight, making us the third most obese country in the OECD. The rate of obesity is even higher in Māori (47%) and Pacific (67%) adults, with prevalence strongly linked to deprivation. Furthermore, one in nine children in New Zealand under 14 is obese, with another one in five overweight.

Obesity presents a significant problem for healthcare and is associated with a broad range of chronic medical conditions and premature mortality. Those who are obese are more likely to develop high blood pressure, insulin resistance, and high blood levels of cholesterol and triglycerides and insulin resistance. The risks of ischaemic heart disease, stroke, Type 2 diabetes and many cancers are intimately linked to increased BMI. Mental health issues and eating disorders are also associated with being overweight or obese.

Obesity has significant implications for patients under-going surgery. Anaesthesia can be problematic because of the increased risks associated with high blood pressure, heart disease, decreased oxygen delivery, hiatus hernia, and regurgitation and aspiration. Patients with a BMI over 40 also suffer disproportionately greater complications and morbidity following surgery, including an increased risk of coma, stroke or acute kidney injury.

RACS believes a combination of preventative measures and an increase in the availability of treatment options for those already obese is the most effective way to address obesity. Bariatric surgery is a proven treatment option for the morbidly obese. While the number of publicly funded bariatric procedures has slowly increased, the growth in obesity and the demand for this intervention far exceeds the available public resources. It is also important to consider that following therapeutic weight loss many individuals will be troubled by excess skin, which itself affects health and lifestyle. At present, there is only a small amount of surgery publicly funded to address this.

**Question 7:** How does your party propose to address both childhood and adult obesity?

**Question 8:** What is your party’s plan to improve access to bariatric surgery?

**Question 9:** Does your party support the provision of publicly funded body contouring surgery for removing excess skin following therapeutic weight loss?
HEALTH WORKFORCE

The provision of quality healthcare in New Zealand is reliant on quality training of the health workforce. This training needs to meet the growth and changing requirements of New Zealand’s population. Health Workforce New Zealand (HWNZ) funding supports post-graduate training, allocating $180 million to District Health Boards, tertiary education providers, and other health organisations every year. The largest portion of this supports postgraduate medical specialty training, including general practice, surgery, anaesthesia and internal medicine.

HWNZ has proposed a new approach for the funding support it gives for post-entry training of our health workforce. While its current arrangements provided longer-term funding certainty, this new approach proposes to introduce a sliding scale model whereby a proportion of its current funds are disinvested from current training and is open to contestable bidding every year, with all $180 million of its funds becoming contestable over a relatively short period. It also wishes to extend funding support within its current budget to all health professions and to community support workers.

Training for the wider health workforce is undoubtedly important. However, removing funding support for existing training programmes is likely to result in reduced vocational graduate numbers in some specialty areas where there is an ongoing or increasing need. With our growing and aging population, these numbers need to be increasing. The proposed contestable process will also be resource intensive, costly and have no surety of outcome. For training organisations that are not the trainees’ employer, and particularly for those who have national programmes encompassing many DHBs, this process will be prohibitively complex.

Medical vocational training takes many years and the impact of disinvestment on the specialist workforce will not be immediately apparent. This is especially true in small specialties where a small decrease in training numbers will show a marked impact some years later. As many training schemes rely on complex infrastructure to function, reinstating these some years later following disinvestment will be very difficult.

**Question 10:** Does your party support the contestable funding model for medical specialty training as proposed by Health Workforce New Zealand?

**Question 11:** How will you work with medical specialty training programmes to ensure that the future specialist workforce requirements are met?