Sustainable Elective Surgery over the next Two Decades

The demands on all health services around the world are at crisis, no more so than during the current COVID-19 pandemic. Whilst the pandemic has heightened the limitations in pandemic preparedness, and the fragility of the systems worldwide, the burgeoning crisis in healthcare is not new.

All health systems struggle, and there is no system that can provide high quality care, immediately when required without wait, at reasonable cost. No system is able to manage more that two of these qualities. Public health systems in the western world, including New Zealand provide high quality care, at a reasonable cost, but with delay in care particularly in elective surgery. Contrast this with private care where quality care is available at short notice, but costs are significant, and no country including the USA can sustain these costs across a population. Competing demands for healthcare dollars result in emotional pleas for service, surgery and pharmacology, which can be potentially limitless. No country or medical system has, or is likely to find a sustainable solution to these issues.

Here in New Zealand, costs are reduced via central control of pharmaceutical purchasing, and delayed elective surgery via the mechanism of waiting lists for non-urgent elective surgery, as two examples.

Elective orthopaedic surgery is the most common area where patients wait for operations such as hip and knee replacement. The surgery can be delayed on waiting lists, yet patients suffer pain and disability with hidden costs that grow at the patient waits for treatment. Disability increases costs for care in the home, reduces gainful employment and income, and results in greater complexity of the arthritic disease requiring more costly and time consuming surgery with inferior results. This is all as a result of delay – waiting lists.

The simplistic demands that emanate from those in need are for more surgeries, needing more hospitals, wards, beds, nurses, operating rooms, anaesthetists and surgeons. There is no doubt that the provision of these services has dramatically increased in recent years, however the needs of a growing, and ageing population that expect a greater quality of life is difficult to achieve.

New Zealand's workforce planning indicates that current training of surgeons will cause a continual reduction in service production if we don't increase training surgeon numbers significantly.

There is however a further complicating factor in orthopaedic surgery that is limiting the provision of elective surgery. Over the last three decades in particular the magnitude and complexity of urgent trauma surgery for accident related conditions has resulted in greater resource required to achieve optimum outcomes for victims. Specialised

reconstruction options provided by sub specialist surgeons and teams are performed in daylight hours and this need displaces planned waiting list surgery particularly in the major centres where Sub Specialty expertise is dominant. Elective surgery is delayed, but there is increasing evidence that the funder of care for accident related conditions – ACC – is not funding acute surgery to anywhere like the real costs of such care. Current ACC funding of accident related care in the acute stage in public hospitals is funded by PHAS – Public Hospital Acute Services. This is bulk funding that is feed through to the DHBs by the population based funding mechanism, and seems to be calculated on a relatively antiquated basis. Recent DHB calculations of the true costs of care differ from estimated provision by PHAS to the DHB by close to double the amount, and indicate that the underfunding of DHBs providing care for injury victims could amount to half a billion dollars per annum through the country.

A current focus of the New Zealand Orthopaedic Association is to highlight the low funding of trauma by ACC to the public system, and the deleterious effects upon elective surgery provision in the public hospital sector. Correction of the funding stream has the potential to improve funding for acute and then elective care. Whilst the demand for more elective surgery is yet another demand for funding from the public purse, at least this request is associated with the potential solution of having the provider of accident care contribute appropriately to its costs.

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