**Dr Jason Gurney talks about the  
perioperative mortality explorer**

**Accessible transcript**

**Visual**

**Blue text on a white background reads: Dr Jason Gurney talks about the perioperative mortality explorer. The Perioperative Mortality Review Committee logo appears at the bottom of the screen, which is made up of three interlocking circles in shades of blue and purple. The logo disappears and is replaced by half circles in varying shades of blue and purple, which reflect POMRC’s logo. The onscreen text changes to read: Jason is an epidemiologist and brings a strong equity focus to the Committee.**

**Visual**

**Dr Jason Gurney appears on screen. He is sitting in a room with artwork on the wall behind him. He is wearing white headphones in his ears, and a black shirt. He has short black hair and a black moustache.**

Kia ora koutou. I'm associate professor Jason Gurney. I'm an epidemiologist and the director of the cancer and chronic conditions or C3 research group at the University of Otago, Wellington. I’m also a very proud member of the Perioperative Mortality Review Committee. I think my role on the Committee is to help communicate the latest evidence in the area of inequities in post-operative mortality, particularly for our Māori population. Our research group is quite active in this area. We've just finished quite a large Health Research Council grant, just looking specifically at that area. So it's really my pleasure to be able to bring that experience to the Committee and plug those findings straight into the Committee.

**Visual**

**Blue text on a white background reads: Jason talks about how these new tools can help the public.**

Audio

In epidemiology, I think that we can kind of overcomplicate things unnecessarily. We sometimes forget that the information we're creating needs to actually be digestible by those who might use it in the end. Of course, there's kind of a balance that you need to hit. You don't want to oversimplify things to a point where the information actually becomes pretty useless because it doesn't represent anything in the real world. An example of that in our own infographic that we've created here, is how we split the rates of postoperative mortality between acute settings and the elective or waiting list settings. So acute procedures are mostly undertaken because someone might die if they don't have the procedure. So it's kind of natural to know that the risk of postoperative mortality is much higher among those who have an acute procedure, relative to an elective or waiting list procedure. So if we were to just combine those two together in sort of one result, it wouldn't really represent anything or anyone in the real world. So that's why we’ve split them. It's about keeping it simple, but not stupidly simple.

**Visual**

**Blue text on a white background reads: How clinicians can use the perioperative mortality explorer.**

I think the clinicians around the motu are going to find the explorer quite useful. It's designed for those people, those clinicians who have been approved, quality and risk managers, academics, researchers, etc, who will be able to kind of quickly examine the data with their own lens rather than wading through those POMRC annual reports, for example, which might not have the information that they're looking for. The tool is divided into three key areas. Equity, district and procedure. So, in the equity tab, for example, users can explore by ethnicity, gender, deprivation, etc to see patterns in mortality rates and admissions and trends over time, which is quite useful. It also allows comparisons between districts over time. So, it will be useful for organisations like Te Whatu Ora and the districts within Te Whatu Ora to see how they're tracking in terms of surgical mortality relative to other areas. The data does remain non-identifiable and population-based, so privacy remains intact too.

**Visual**

**Blue text on a white background reads: Jason talks about the inequity shown in the perioperative mortality explorer.**

Unfortunately, the answer to why there is inequity in post-operative outcomes for our Māori and Pacific peoples relative to other populations really isn't that straightforward to answer. It's quite complex. But essentially it does boil down to our Māori and Pacific populations having poorer access to the determinants of good health. And this is particularly evident for our Māori populations, so this starts right at the top with our social determinants which stem all the way back to colonisation and the embedding of institutionalised racism within our society. And it manifests sort of further down the chain to things like poorer access to primary care, poorer access to secondary care, poorer access to resources in the first place. Now we really need to think about how our system is organised and how well it suits our majority European population relative to our minority, Māori and Pacific populations. Now essentially, we have a system that's designed to work well for the majority. So, it's relatively unsurprising that it isn't working too well for the minority.

**Visual**

**The POMRC logo reappears on a white background. Beneath it is the URL** [**www.hqsc.govt.nz**](http://www.hqsc.govt.nz)**. Beneath that is the black Health Quality & Safety Commission logo (the Commission logo is made up of the words HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND in capital letters with the words Kupu Taurangi Hauora o Aotearoa in smaller italic text underneath alongside three wedges of Swiss cheese). Alongside it is the New Zealand Government logo (the NZ Government logo is made up of the coat of arms of New Zealand with the words Te Kāwanatanga o Aotearoa in bold letters with New Zealand Government written beneath).**