The Health Consumer Advocacy Alliance NZ

Written by Co-founder Charlotte Korte

Insufficient Surgical Expertise Highlights Risk in Lifting Mesh Suspension in NZ

Surgical mesh procedures for stress urinary incontinence (SUI) were suspended in New Zealand due to safety concerns in August 2023. New Zealand followed the Scottish Government who implemented a suspension of mesh procedures in 2014, and the United Kingdom whom suspended these same procedures in 2018, their suspensions are still in place. After a successful parliamentary petition by Sally Walker in 2022, requesting that a mesh suspension for SUI procedures be established in Aotearoa, the former Director-General of Health, Dr Diana Sarfati announced that due to safety concerns, all SUI mesh procedures must be stopped, Four key criteria were identified as needing to be met before the mesh suspension is lifted. These are credentialing of surgeons, establishment of patient decision aides, patient case discussion at a multi-disciplinary meeting and a national registry to track relevant procedures. Critical concerns about New Zealand's ability to safely deliver the full range of treatment options for women suffering from urinary incontinence remain. Without a workforce capable of offering all evidence-based options, the system risks defaulting to mesh as the first treatment option for patients, not because it is clinically superior, but because it remains the most readily available and accessible.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and Royal Australasian College of Surgeons (RACS) training pathways have not consistently produced surgeons credentialed in non-mesh procedures. Limited surgical expertise restricts women's access to care, and these gaps highlight lack of system preparedness for the provision of safe SUI treatment options. This disparity contributes to limited access to non-mesh options across different regions and clinical settings, undermining patient choice and equity in care.

The Ministry of Health published a National Credentialling Framework for surgeons to be assessed against and the credentialing process began in 2022. Credentialing ensures that surgeons have been formally assessed and verified as meeting the necessary standards and experience to safely perform procedures. The credentialing process is ongoing, but as of July 2025, only 12 surgeons (8 urologists and 4 gynaecologists) have been credentialed to perform fascial sling surgery, and only 4 (2 urologists and 2 gynaecologists) for Burch Colposuspension. Notably, only one surgeon (a urologist) has achieved credentialing across all four SUI procedure types, and no gynaecologists are credentialed for mesh removal. Additionally, a number of surgeons applied for credentialing in procedures they did not ultimately achieve, suggesting a misalignment between perceived and actual surgical competence. This imbalance raises serious questions about the readiness and distribution of the surgical workforce, the adequacy of existing training pathways, and the capacity of the health system to deliver safe, equitable, mesh-free treatment options for women.

The ability of the health system to provide safe, mesh-free treatment options for women, and clearly evidenced regional disparities, particularly those seeking help after mesh complications,

underscores the need for transparent workforce planning, targeted training and clear treatment pathways. A strengthened and continued credentialing framework (as endorsed by the Credentialing Committee), and oversight mechanisms that prioritise patient safety and informed choice are crucial.

Premature Lifting of the Mesh Suspension Would Recreate Harm Under the Guise of Progress

Lifting the suspension on mid-urethral mesh slings before our surgical workforce is 'ready' and before appropriate safeguards are in place would risk compounding the very harm that led to the suspension in the first place. The justification that we do not have enough surgeons to provide non-mesh alternative surgical options as a reason for lifting the pause is not an ethical argument, essentially, with the decline in women wanting mesh, and lack of monitoring of non-mesh procedures we could end up with double the harm.

1. The workforce is not yet equipped to offer true informed choice to women

The foundation of safe care is the ability to provide women with access to ***all*** clinically appropriate treatment options. That is not the case in Aotearoa today.

- Only 14 surgeons nationwide are currently credentialed to perform non-mesh alternatives (Burch Colposuspension or autologous fascial sling).
- Fewer than 30% of gynaecologists and 50% of urologists who applied were able to meet credentialing requirements for non-mesh procedures.
- Only one surgeon has been credentialed across all four SUI procedure types.
- In contrast, 25 surgeons have been credentialed to perform mesh sling procedures, nearly identical to the 29 surgeons who were performing mesh implants *prior to credentialing* This indicates that the credentialing process has not been "too harsh"; rather, it has confirmed longstanding gaps in education, capability, technical expertise particularly in non-mesh techniques. These gaps matter!

In overseas health systems, surgeons routinely perform higher volumes of native tissue procedures and maintain recent, relevant experience. This enables full and balanced informed consent. In contrast, as seen by the current credentialling outcome to date, too few women have access to such procedures or receive balanced surgical counselling. Clinicians need to participate in ongoing training, both in the diagnosis and treatment of complications of mesh and non-mesh surgery, this should include demonstration of all aspects of credentialing expectations, such as training in complete mesh removal. It is two years since the pause was first put in place. If the suspension is lifted now, the documented bias toward mesh procedures will resume by default, not design.

2. High vigilance must remain in place for **all** SUI procedures

The MoH has indicated that they will remove the high-vigilance status for non-mesh surgeries while reintroducing mesh, this would dangerously reduce scrutiny at a time when workforce readiness is still incomplete. These procedures also carry significant risks and must remain subject to the same level of robust, independent oversight to ensure patient safety is not compromised. The current high vigilance processes must remain unchanged to prevent further harm and ensure all procedures mesh and non-mesh are subject to appropriate oversight.

3. Patient safety must drive decision-making

Any suggestion that the credentialing process has been excessive or obstructive ignores its core purpose: to prioritise patient safety, ensure competence, and rebuild trust. Claims that the process is too strict also undermine the role of the international experts, who were chosen for their specialised knowledge and impartiality. Their involvement was critical to aligning with global health standards, ensuring the highest levels of safety, clinical competency, and credibility throughout the process. The most important factor, which is being forgotten in all of this, is the harm. This is why these mesh procedures were suspended in the first place. And why these procedures remain suspended overseas. That 25 mesh-credentialed surgeons have emerged from the process, strikingly similar to the 29 practising prior to the suspension raises serious concerns. It suggests that despite years of scrutiny, little has changed. This outcome reinforces the need for greater, not lesser, caution. True system preparedness must be measured by demonstrated competence across all treatment options, not just mesh. Lifting the mesh suspension prematurely would:

- Deny many women access to viable non-mesh alternatives.
- Erode informed consent by defaulting to what is available, not what is appropriate.
- Reinforce mesh-first clinical behaviour the very bias that caused harm previously.

Until those conditions change, the suspension must remain firmly in place, alongside ongoing high vigilance for *all* surgical options. This is not about denying care it is about making sure the care we provide is truly safe, informed, and equitable. Furthermore, the wider mesh issue cannot be addressed solely through surgeon credentialing. The absence of integrated wraparound support services, inadequate education programs (focused solely on technical expertise), and a lack of trauma-informed approaches remain serious gaps. Importantly, mesh removal regardless of surgical expertise, partial or complete does not guarantee recovery, and this must be recognised when assessing any return to suspended procedures.

The Health Consumer Advocacy Alliance (HCAA) is also deeply concerned by the latest update to the mesh tracker published on the Ministry of Health website. The update reflects a tick-box approach to serious issues arising from the Restorative Justice (RJ) process and the broader mesh harm response. While the narrative presented appears polished on paper, it is inaccurate and, at times, disingenuous. This undermines the intent of the RJ process and fails to reflect the lived reality of many harmed New Zealanders. A process of this significance requires independent review and input from those outside the Surgical Mesh Roundtable (SMRT). Without that, there is no meaningful way to assess whether the outcomes have delivered real change. The claim that 17 of the 19 recommendations have been completed is inconsistent with what many women and men continue to experience. Suggesting the process is largely resolved risks dismissing ongoing harm, eroding trust, making a mockery of the process.

The HCAA strongly urges the Ministry to **NOT** remove the surgical mesh suspension.

Any move to reinstate mesh procedures before the system is ready will reinforce outdated clinical biases, and undermine the very reforms that patients fought so hard to achieve. We strongly recommend an independent review of the RJ process outcomes, that a robust national credentialing framework is maintained, and independent oversight of the SMRT is provided. Without accountability and transparency, patient safety will remain compromised.

The Government must hold the line on safety. Anything less would be a betrayal of the thousands of New Zealanders whose lives have already been affected by surgical mesh harm.