

# SUBMISSION TO THE COMMERCE COMMISSION

## Application for Authorisation by the New Zealand Gynaecology Association

*Collective Negotiation of an Affiliated Provider Agreement with Southern Cross Health Insurance*

**Submitted by: Anglesea Gynaecology**

29 June 2026

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### 1. Introduction and Background

Anglesea Gynaecology is a leading specialist group practice in the Midland region of New Zealand, providing high-quality private gynaecological care across a broad spectrum of conditions including complex pelvic floor disorders, endometriosis, uterine fibroids, fertility-related surgery, and oncological gynaecology. Our clinicians hold Fellowship of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (FRANZCOG), with sub-specialist expertise across multiple domains. We are recognised in our region for clinical excellence, patient-centred care, and the management of complex surgical cases that require advanced operative skill and considered clinical judgement.

We submit in support of the New Zealand Gynaecology Association's (NZGA) application for authorisation to collectively negotiate the terms of an Affiliated Provider Agreement (APA) with Southern Cross Health Insurance (SCHI). We do so because we believe the current trajectory—in the absence of such authorisation—poses a serious and foreseeable risk to patient outcomes, clinical standards, specialist autonomy, and the long-term sustainability of private gynaecological services in New Zealand.

This submission addresses five key concerns: (1) the structurally distinct nature of gynaecological APAs compared to those in other specialties; (2) the strongly negative perception of existing APAs among gynaecological surgeons; (3) the material harm to patient choice and clinical outcomes arising from poorly designed APAs; (4) the downstream cost consequences of suboptimal surgical outcomes; and (5) our constructive proposals for a well-structured, clinically informed APA that serves patients, insurers, and providers equitably.

### 2. APAs in Gynaecology Are Structurally Distinct

The Commission should be aware that APAs operating in other medical and surgical specialties are partial and limited in scope. In ophthalmology, general surgery, and orthopaedic surgery, for example, the APA framework typically covers only between one and four specific, high-volume elective procedures within each specialty—such as cataract extraction, cholecystectomy, or knee arthroscopy—with the substantial majority of procedures in each specialty remaining outside the APA and subject to normal fee arrangements. These are procedures where case complexity is relatively

uniform and outcomes are more readily standardised, making a fixed or blended fee arrangement more defensible. What SCHI is proposing for gynaecology is categorically different: a comprehensive APA intended to cover the full breadth of private gynaecological surgical services. There is, to our knowledge, no comparable precedent in other surgical specialties in New Zealand, and the assumption that a model which operates on a narrow, selective basis elsewhere can be translated wholesale to an entire specialty is not supportable. Anglesea Gynaecology would also note that our private discussions with surgeons in other specialties who are subject to existing SCHI APAs have revealed significant and widespread dissatisfaction with those arrangements. Surgeons across ophthalmology, general surgery, and orthopaedics have expressed serious concerns about inadequate procedural funding, insufficient recognition of complexity, and the erosion of clinical autonomy—views that are consistent with those of our own members. Notably, those surgeons have expressed strong support for the approach that NZGA is now pursuing through this authorisation application. We respectfully recommend that the Commerce Commission conduct a structured, objective survey of surgeons in other specialties currently subject to SCHI APAs to obtain direct, independent evidence of the profession's experience with these arrangements. Such a survey would provide the Commission with empirical data to complement the submissions before it and would, we submit, corroborate the concerns raised in this document.

Private gynaecological surgery is fundamentally different from other specialties in the breadth and complexity of its scope. The specialty encompasses an extraordinarily wide range of conditions—from routine procedures such as diagnostic hysteroscopy, to highly complex reconstructive pelvic floor surgery, fertility-preserving myomectomy, and radical surgery for advanced endometriosis. The clinical complexity, operative duration, intraoperative risk, and postoperative care burden of these procedures vary enormously, and they are often performed on the same patient in a single operative episode.

Any APA applied to the full scope of gynaecological surgery must therefore be comprehensive, differentiated, and clinically nuanced. A blanket or partial approach—modelled on frameworks developed for other specialties—will inevitably fail to account for the procedural diversity and complexity that is intrinsic to this specialty. The Commission should not assume that an APA structure that functions adequately elsewhere will translate appropriately to gynaecology without significant modification.

### **3. The Proposed APA by SCHI Is Almost Universally Perceived Negatively by Gynaecological Surgeons**

Feedback gathered from NZGA members has made clear what is already well understood within the profession: the proposed APA framework from SCHI is regarded with significant scepticism, concern, and in many cases outright opposition. This is not an isolated or minority view—it reflects a near-universal response from practising gynaecological surgeons who have considered the proposal in detail.

The concerns are not primarily about remuneration—though that is a legitimate professional interest—but rather about the structural constraints that poorly designed APAs impose on clinical practice. Surgeons report that existing agreements do not adequately capture procedural complexity, do not reflect meaningful differences in training or expertise between providers, and do not allow for the flexibility required to

deliver individualised, evidence-based care. The result is a system that incentivises volume over value and standardisation over clinical appropriateness.

We respectfully urge the Commission to seek this feedback directly. The near-universal negative sentiment among gynaecological surgeons is itself a significant public interest indicator—it signals that existing and proposed arrangements are misaligned with the clinical realities of the specialty and with the expectations of the professionals upon whom quality service delivery depends.

## **4. The Proposed APA by SCHI Reduces Patient Choice and Compromises Clinical Outcomes**

### **4.1 The Hospital-Led Model Proposed by SCHI**

It is our understanding that SCHI's preferred approach to APA implementation involves designating private hospitals as lead providers, with individual surgeons then negotiating operative fees with those hospitals under hospital-controlled frameworks. Anglesea Gynaecology has serious reservations about this model.

Private hospitals operate as commercial entities with their own margin imperatives. When hospitals are placed in the position of sub-contracting surgical services from individual surgeons, institutional interests will inevitably influence surgeon selection. Hospitals will be incentivised to favour surgeons who accept lower procedural fees over those with greater expertise, sub-specialist training, or higher complexity caseloads. Over time, this creates a systematic drift towards lower-cost, lower-expertise provision—a race to the bottom that may not be visible in short-term cost metrics but will manifest in clinical outcomes, complication rates, and patient satisfaction.

The consequences for patients are material. Patients lose the ability to exercise informed choice of surgeon, often based on prior care relationships, sub-specialist expertise, or specific procedural skills. Referring general practitioners similarly lose the ability to direct patients to the most clinically appropriate specialist. This is a genuine and foreseeable harm to patient autonomy and clinical quality.

### **4.2 Procedural Compression and the Consequences of Suboptimal Surgery**

A further and closely related concern is that poorly funded APA frameworks will create incentives—whether explicit or implicit—to perform less technically demanding, less comprehensive, or less appropriate surgical procedures in place of gold-standard interventions. In gynaecological surgery, this risk is pronounced. The following clinical examples illustrate the point:

- A patient presenting with significant pelvic organ prolapse may require a comprehensive surgical repair including anterior colporrhaphy, posterior colporrhaphy, and sacrospinous fixation to achieve level 1 apical support and prevent vault prolapse. However, the APA framework proposed by SCHI does not permit sacrospinous fixation to be funded concurrently with anterior and posterior repair. The practical consequence is that the patient undergoes only the anterior and posterior repair at primary surgery. Without apical support, vault prolapse recurs—often within months to a few years—necessitating a further operative episode specifically for sacrospinous fixation. The patient endures a second anaesthetic, a second recovery, and the morbidity

associated with operating in a previously dissected field. The insurer funds two procedures where one comprehensive operation would have sufficed. This is a direct and foreseeable cost to both the patient and the health system arising from an APA structure that is clinically indefensible.

- Severe or deeply infiltrating endometriosis requires experienced laparoscopic or robotic excision, which is a highly technical and time-intensive procedure. Where APA funding does not adequately support this level of intervention, surgeons face pressure to perform less complete excision, treat symptomatically, or refer patients through a lengthier and more costly pathway. Incomplete treatment of endometriosis is associated with recurrence, repeat procedures, chronic pelvic pain, and fertility compromise.
- Complex pelvic floor reconstruction in patients with multi-compartment prolapse or pelvic organ prolapse following prior failed repair demands advanced reconstructive expertise. Undertreating such patients at first presentation increases the risk of recurrence, the need for mesh or complex secondary procedures, and significant quality-of-life impairment.
- Laparoscopic myomectomy for large or multiple uterine fibroids is technically demanding and time-intensive. Inadequately funded APAs may make this procedure economically unviable, leading to either referral for open surgery (with greater morbidity and longer recovery) or deferral of treatment until fibroids become larger and more symptomatic—increasing operative complexity and risk.
- Fertility-preserving surgery—including tubal surgery, adhesiolysis, and surgical treatment of uterine anomalies—requires subspecialty skill that cannot be assumed across all APA providers. Where hospitals or funders select surgeons based on cost rather than competence, the implications for patient fertility outcomes and associated psychological harm are significant.

These are not theoretical concerns. They reflect the predictable consequence of misaligning procedural funding with clinical complexity—a misalignment that NZGA's collective negotiation is expressly designed to prevent. The Commission should weigh these prospective harms carefully in its public benefit analysis.

## **5. A Well-Structured APA Will Deliver Better Outcomes and Reduce Downstream Costs**

Anglesea Gynaecology does not oppose an APA in principle. We recognise that SCHI faces genuine cost pressures, that the private health insurance market must remain financially sustainable, and that structured provider agreements can—when well-designed—create efficiencies that benefit patients, providers, and insurers alike. Our submission is in favour of the NZGA's authorisation precisely because we believe collective negotiation is the mechanism most likely to produce an APA that is genuinely fit for purpose.

We submit that a well-designed APA for gynaecological surgery must incorporate the following features:

- Clinically granular procedural codes that distinguish between procedures of substantially different complexity, duration, and technical demand. Generic or bundled codes that fail to differentiate, for example, a simple diagnostic

laparoscopy from laparoscopic excision of deeply infiltrating endometriosis, are not appropriate for this specialty.

- Appropriate fee structures that reflect the actual cost of delivering quality surgical care, including theatre time, assistant fees, and post-operative follow-up. Fee reductions should be evidence-based and proportionate—not blanket reductions applied uniformly regardless of case type.
- Recognition of sub-specialist expertise and training. Not all gynaecological surgeons have equivalent training or competence in advanced laparoscopic, pelvic floor reconstructive, or fertility surgery. An APA framework that ignores this variation will erode quality and patient safety.
- Explicit preservation of patient choice of surgeon. Any APA must include mechanisms that allow patients to be referred to and treated by the specialist most appropriate to their clinical needs, regardless of hospital-level commercial arrangements.
- Provision for complex case add-ons. Many gynaecological procedures involve intraoperative findings that necessitate additional interventions beyond the primary listed procedure. The APA must include a clear and reasonable mechanism for funding these additional components without penalising the surgeon for undertaking clinically necessary work.
- A collaborative review and update mechanism. Clinical practice evolves. An APA that cannot be updated to reflect new techniques, new evidence, or changes in procedural complexity will rapidly become outdated and misaligned with best practice. There should be a structured process for periodic joint review involving NZGA and SCHI.

We wish to be explicit on one further point: Anglesea Gynaecology is not seeking higher fees as a primary objective. We are cognisant of the cost pressures facing health insurers and the broader affordability challenges in the private health system. We are open to fee structures that involve appropriate, evidence-based reductions from current levels where this is clinically and economically justified. What we oppose is the imposition of arbitrary, undifferentiated fee reductions that take no account of clinical complexity, operative risk, or the downstream cost consequences of procedurally inadequate care.

## **6. Public Benefit of Authorising Collective Negotiation**

The Commission is required to assess whether the public benefits of authorisation outweigh the competitive detriments. Anglesea Gynaecology submits that the public benefits are substantial and identifiable:

- Patient outcomes: A well-designed APA will support, rather than undermine, the delivery of comprehensive, gold-standard surgical care, reducing complication rates and the need for repeat procedures.
- Cost efficiency: Investing appropriately in primary surgical care reduces the downstream costs of revision surgery, complications, emergency presentations, and prolonged morbidity. For an insurer, this is both a moral and a financial argument.

- Sustainability of specialist services: Without a viable APA framework, experienced sub-specialist gynaecologists may withdraw from SCHI-affiliated practice, reducing access for insured patients and exacerbating pressure on the public system.
- Information equity: Individual surgeons negotiating alone with a dominant insurer face a significant information and bargaining asymmetry. Collective negotiation corrects this imbalance without requiring price-fixing—it enables a more equitable process through which a clinically sound agreement can be reached.
- Preservation of clinical independence: The APA framework should not compromise the clinician-patient relationship or the surgeon's professional obligation to recommend the most clinically appropriate treatment. Collective negotiation provides a mechanism to enshrine these principles contractually.

## 7. Conclusion

Anglesea Gynaecology respectfully urges the Commerce Commission to grant authorisation to the New Zealand Gynaecology Association to collectively negotiate the terms of an Affiliated Provider Agreement with Southern Cross Health Insurance.

The specialist gynaecology sector serves patients at some of the most vulnerable and complex points in their reproductive and pelvic health journeys. It deserves an APA framework that is thoughtful, clinically grounded, and developed through genuine partnership between providers and insurers. Collective negotiation—under the oversight and authorisation of the Commerce Commission—is the appropriate mechanism for achieving this.

We are available to provide further information, attend any hearing, or assist the Commission in any way that would support a well-informed decision on this application.

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