4 August 2026

NZGA's responses to clinical assertions by SCHI

1. NZGA further responds to clinical assertions raised by SCHI (in red) in its submissions on the Statement of Preliminary Issues. We reiterate that NZGA does not in principle oppose the AP model. Its concerns are practical ones: that the proposed code set, and the absence of any transparent mechanism for recognising complexity identified during surgery, will affect the care women receive in the private sector. NZGA would have preferred to resolve these matters directly with SCHI, but the circumstances have required NZGA to apply for authorisation.

6.9 (e)(iv) ***Contrary to the assertions in the Application, the gynaecology surgery specialty is not unique compared to other specialties where SCHI's AP programme has been successfully implemented. Many of the factors mentioned in the Application (including differing surgical complexities, medical co-morbidities, high BMI, patient factors, post operative pain and nausea) are common to all specialties. It is SCHI's standard approach to AP contracting to take account of these factors in its proposed pricing, and in the current instance SCHI has included complexity factors in its pricing and benchmarked to surgeries with similar surgical complexity and medical co-morbidities.***

NZGA's response:

2. NZGA acknowledges that surgical complexity, and patients with significant medical co-morbidities, are managed across many specialties. The distinction in gynaecology is that the majority of laparoscopic and hysteroscopic surgery is diagnostic, and therefore unpredictable. What is required is guided by what is seen during the operation, which may be significantly different to what is found on pre-operative imaging. For many pelvic floor surgeries, the need for vaginal prolapse components of surgery depends on the examination findings once the patient is under anaesthetic.

3. NZGA's concern is that applying a uniform funding approach across virtually all gynaecological procedures fails to recognise the substantial variation in procedural complexity, the combinations of procedures required (often only known intra-operatively), operative time, technical difficulty, and resource requirements.

4. That has direct consequences for patient safety. Procedures with markedly different levels of complexity have been bundled into the same AP category. For example, hysterectomy has been grouped together with advanced endometriosis surgery, ureterolysis, and cystoscopy, despite these procedures often requiring significantly greater surgical expertise (sometimes a second gynaecologist as an expert assistant rather than a nurse surgical assist), longer operating times, multidisciplinary involvement, and carrying substantially higher operative risk. Where a surgeon faces barriers to involving a second gynaecologist, difficulty arranging a surgical assistant, or time pressure to complete a complex case, that bundling may put patients at increased surgical risk.

5. AP works well where there is minimal variability in the procedures needed to complete a patient's surgical care and surgical complexity is predictable. That is usually not the case for most gynaecological conditions. Gynaecological procedures are well recognised to be highly variable, requiring surgical flexibility at the time of surgery, and the combinations of procedures an individual patient may need resist standardisation of the kind proposed under SCHI's AP programme.

6. There are clinical reasons for that variability. The uterus undergoes cyclical hormonal changes, menstruation, pregnancy, and childbirth, each of which can significantly alter pelvic anatomy and increase surgical complexity. Advanced endometriosis is widely recognised by general surgeons, urologists, and other specialists involved in its management as technically more challenging than many cancer operations, because normal tissue planes are frequently altered or obliterated.

7. Other surgical specialties have only a small number of procedures (typically three or four) included under the Affiliated Provider (**AP**) Arrangement. The approach proposed for gynaecology includes almost the entire spectrum of possible gynaecological procedures. That does not represent equity across surgical specialties, and it constrains the surgical decision-making on which patients with the most complex clinical needs depend.

8. NZGA has sought to test its thinking with colleagues in other specialties, including general surgery. They confirm that AP does not work where disease complexity or patient factors alter the standardised time-based approach applied to the pricing structure, and that at times procedures cannot be combined which would otherwise be a recognised standard of care.

6.9 (f) ***It is not correct to assert that SCHI's proposed AP gynaecology surgery programme may result in insufficient support for other "wrap around services"[101] or that the proposed AP transition gives rise to concerns in relation to "pre and post-operation care by surgeons, nurses and administrative staff".[102] Demonstrating this:***

(i) ***The current AP negotiations are only in relation to gynaecology surgery procedures. Under SCHI's member policies, some of these other "services" are a separate benefit or not included in the individual member's policy. The proposed AP agreements would not stop members being offered additional services, however, they should not be billed within the surgical procedure currently being negotiated, and should be billed separately so that they can be assessed by the member and SCHI against the member's available policy benefits. For example, pre-operative consultations are already covered under a separate consultation AP agreement - they are not part of the surgical episode. In other words, the currently proposed AP transition for gynaecology surgical procedures would not prevent gynaecology surgeons from offering or charging for wrap around services – it is simply the case that they should be billed separately. That is how specialties and health insurance are supposed to operate.*** **[]**

NZGA's response:

9. SCHI's submission does not fully reflect how private gynaecology services are delivered in practice. NZGA accepts that the proposed AP agreements do not legally prohibit surgeons from providing pre-operative, post-operative, nursing, or administrative support services. NZGA's concern is a practical one: the proposed funding model puts at risk the continuity of care that surrounds the operation, and shifts that care, and the clinical and financial risk that comes with it, onto patients and the public system.

10. Private gynaecology is delivered as a comprehensive package of care, of which the procedure itself is only one component. Patients frequently require pre-operative assessment including investigations and imaging, counselling on complex treatment options, multidisciplinary coordination with the anaesthetist and other specialists, post-operative review in hospital and more than one review in the first six weeks after surgery, telephone advice on pain, medication changes and wound issues, nursing support, and administrative coordination. Where that support cannot be sustained in private, patients present instead to already overstretched emergency departments and public gynaecology services, transferring both cost and clinical risk from the insurer to the public system and to patients themselves.

11. These services carry real cost, and much of that cost sits outside the funded codes. Clinic-based reimbursement codes are limited to clinic visits, while the majority of this time-intensive work is done outside those visits by the surgeon and clinic staff. For example, there is only one funded post-operative clinic visit in the first six weeks after surgery, when most patients in practice need a further visit, telephone advice, and wound checks with input from clinic nursing and administrative staff. Assessing the adequacy of the proposed pricing by reference to the procedural fee in isolation therefore does not reflect what is in fact being funded, or what practices absorb.

12. While SCHI states that these services may be billed separately where policy benefits exist, that does not address the underlying concern. Separate billing does not guarantee that the services are

adequately funded, nor that patients have insurance cover available for all aspects of the wrap around care their surgery requires to be safe and to achieve a good surgical outcome.

13. If remuneration for surgical procedures is substantially reduced under the proposed AP arrangements, there will be fewer resources available to support these essential components of care. That is particularly significant in gynaecology, where patients with conditions such as severe endometriosis, large fibroids, chronic pelvic pain, bladder incontinence or bowel dysfunction, or significant medical co-morbidities require considerably more peri-operative support than procedural fees alone recognise, or than can be delivered within the confines of the funded pre and post-operative clinic visits.

14. NZGA's concern is therefore whether the proposed funding model allows this standard of individualised peri-operative care to continue to be delivered to patients, and where that care and its cost fall if it does not.

Appendix 2:

- ***NZGA's assertion in the Application "that currently SCHI already refuses to exercise 'risk corridor' discretion even when complex surgeries are performed"[184] is not correct. SCHI anticipates that this assertion may be in relation to robotic gynaecology surgical AP agreements, where top-ups have been requested but declined due to the claim being outside SCHI's policy terms and conditions (not because of complexity). For example, top-ups have been requested for robotic gynaecology procedures that are not covered by SCHI's insurance policies and, therefore, are also not contracted for in the relevant AP agreement.***

NZGA's response:

15. NZGA disagrees. In NZGA's experience, SCHI has on many occasions declined to exercise risk corridor discretion even where complex surgery has been performed.

16. SCHI's response does not undermine that evidence. Whether SCHI characterises the refusal as arising from "policy terms and conditions" or from another contractual basis does not alter the practical outcome for patients or surgeons: no additional payment is made despite significantly increased operative complexity and time.

17. NZGA's statement in the Application was directed at the absence of a meaningful mechanism to recognise and remunerate complex cases, rather than at any suggestion that SCHI refuses payment solely because a case is complex. In practice, there is currently no effective mechanism by which surgeons are remunerated appropriately when procedures become substantially more complex than anticipated. Equally significant is the absence of transparency about how and when the discretion is exercised. Clinicians are not told what criteria apply or why a request has been declined, and are asked to accept that SCHI's discretions will be applied fairly without being told how SCHI proposes to apply them. That is what reduces individual clinicians' confidence and trust that SCHI will do what is right by the patient.

18. The robotic surgery examples illustrate the issue. SCHI states that additional payments were declined because robotic procedures were not covered under its policy terms rather than because the cases were complex. There are currently very limited robotic AP codes through the country. Take a patient who requires a robotic hysterectomy. The code can only be applied for robotic hysterectomy plus stage one or two endometriosis. Quite often the stage of endometriosis cannot be ascertained clinically despite very good imaging. Imaging may be entirely normal with only a clinical suspicion of endometriosis, and on performing laparoscopy we find stage three, and sometimes stage four, endometriosis that imaging has not picked up. An application for top up where the disease proves more severe is not considered and is declined. Clinicians are duty bound to complete the surgery as required and receive no funding for these changes, which means a substantial number of cases are underfunded.

19. The robotic hysterectomy code also does not take into account the complexity of the hysterectomy itself, as is evident in the RANZCOG coding document, which recommends three

different codes for laparoscopic hysterectomy based on complexity. Where the uterus is much larger than normal size and there is stage three or four endometriosis, the surgery requires extra time and expertise to perform the additional procedures that allow the patient to have key hole surgery. That is not considered either prospectively or retrospectively.

20. The reason robotic surgery was requested was precisely because it represented a more complex procedure requiring specialised equipment, advanced training and, in many cases, substantially longer operating times to enable women having key hole surgery for complex disease processes that otherwise would require an open surgery with its associated risks and slower recovery.

21. More broadly, NZGA's concern is not confined to robotic surgery. Gynaecological surgery frequently presents unexpected intra-operative complexity, including severe endometriosis, dense adhesions, distorted pelvic anatomy, obesity, previous multiple abdominal surgeries, or unexpected pathology. These factors may significantly increase operative time, technical difficulty and surgical risk. Under the proposed arrangement, there is little or no practical ability for surgeons to obtain additional remuneration reflecting that increased complexity, regardless of the contractual explanation subsequently provided.

22. The inability of the current funding model to recognise or accommodate that complexity demonstrates the rigidity of the existing arrangements. SCHI has to date declined to review its terms and conditions for this surgery despite repeated requests from clinicians, and has not engaged on the clinical application of the existing codes. Clinicians are left with no choice but to continue performing procedures that are not appropriately funded.

23. If AP is applied widely across the specialty, there will be downstream impacts for patients. Private surgeons will be faced with referring complex surgical cases into the public system to avoid taking on additional surgical risk that the funding model does not recognise. Complex surgery does not only increase operating time. It carries an increased chance of complications and a longer hospital stay, and requires more post-operative care from the surgeon and clinic staff once the patient is discharged, all of which needs to be taken into account within funding models.

- ***It is very concerning to SCHI that NZGA would imply that gynaecologists would alter treatment ("increase output speed or quantity by doing 'easier' procedures" or subject "women to undergo multiple operations")[186] when there is an appropriate code-set for them to claim under one surgical setting.***

NZGA's response

24. NZGA rejects the suggestion that gynaecologists would alter clinical decision-making or subject women to unnecessary procedures in response to the proposed remuneration model. Treatment decisions are, and will continue to be, based solely on clinical need and established professional standards. The biggest reason for us to put up this resistance is to avoid this very thing happening.

25. The concern raised by NZGA is not that surgeons will change the operations they perform, but that the proposed remuneration model fails to adequately recognise the additional time, expertise, responsibility and resources required for complex gynaecological surgery. Where remuneration does not reflect this complexity, the unintended consequence is that these procedures become increasingly unsustainable to offer in the private sector.

26. NZGA has highlighted that under the current coding structure of SCHI, this would become a reality, as certain operations that are quite often combined together are not possible to combine under the code set of SCHI. We will therefore be left with no choice but to decline these surgeries for women in the private sector to avoid harm.

27. Complex gynaecological surgery frequently requires extensive pre-operative planning, multidisciplinary collaboration with other specialists (including general surgeons, urologists and colorectal surgeons), significantly longer operating times, increased post-operative care, management of complications, and greater availability to patients after discharge including after hours to avoid presentations to already overstretched emergency departments at public hospitals.

These activities are essential components of delivering high quality patient care following complex gynaecological surgery, but they are not being adequately recognised and reimbursed if complex procedures are reimbursed at similar rates to routine (non-complex) procedures.

28. If undertaking complex gynaecological surgery becomes financially unsustainable, the outcome will not be that gynaecologists alter their surgical treatment plan or perform unnecessary operations. Rather, fewer gynaecologists will be able or willing to undertake these highly complex cases in private practice, and other specialists may be less willing to participate where remuneration is inadequate.

29. Patients with advanced endometriosis, severe pelvic adhesive disease or other complex urogynaecological conditions (eg recurrent prolapse or incontinence after previous surgeries have failed) will increasingly require referral to the public health system, resulting in longer waiting times and reduced access to timely care for all women in Aotearoa New Zealand.

30. NZGA's concern is about maintaining access to complex gynaecological surgery in the private sector, not about clinical decisions being driven by financial incentives.

- ***It is not correct to assert that SCHI "had indicated that pelvic floor procedures would remain outside the Affiliated Provider (AP) scheme on a Fee-for-Service basis".[187] SCHI is seeking to implement several pelvic floor procedure codes at agreed prices as part of its AP transition, while also having open pelvic floor procedure codes, which SCHI would fund based on time and costs taken to perform the surgery.***

NZGA's response

31. SCHI's statement does not reflect the practical concerns that led NZGA to raise this issue. At the time SCHI was progressing the AP transition, the proposed pelvic floor procedure billing matrix contained only a limited number of procedure combinations. Under the proposed coding structure, several commonly performed reconstructive pelvic floor procedures could not be appropriately claimed together. For example, anterior compartment repair, posterior compartment repair, and apical suspension/fixation (procedures that are frequently performed during the same operation to provide a durable and comprehensive pelvic floor repair) were not adequately accommodated within the proposed matrix.

32. This created a significant concern to many NZGA members who perform pelvic floor surgery (urogynaecologists and general gynaecologists with a special interest in pelvic floor disorders) that women requiring multi-compartment pelvic floor reconstruction may be faced with having to undergo separate prolapse operations for a pelvic floor condition that would ordinarily, under usual surgical judgement, be performed in a single surgical setting with the one general anaesthetic and one recovery period. In addition, surgeons would face inadequate remuneration for the complexity of the pelvic floor surgery undertaken. NZGA considered this outcome contrary to the best interests of patients and inconsistent with accepted clinical practice.

33. It was in this context that NZGA understood, from the one meeting we were able to secure with SCHI, that pelvic floor procedures would be treated on a fee-for-service basis. We had raised the concern that certain pelvic floor procedures could not be combined with each other under the proposed codes, notwithstanding that in clinical practice this is a common scenario, and our understanding was confirmed on three occasions during that meeting. This is a matter that can be verified against the minutes, which SCHI agreed to share with us but has not yet provided.

34. To the extent SCHI is now implementing several pelvic floor procedure codes at agreed prices, alongside open codes funded on a time-and-cost basis, NZGA welcomes that development (to the extent that it addresses the very concerns NZGA has raised). This illustrates the value of the coding structure being revisited to reflect contemporary clinical practice.

35. These concerns about pelvic floor/urogynaecology procedures were a key reason NZGA sought authorisation from the Commission. Throughout this process, NZGA repeatedly attempted to engage constructively with SCHI to explain the clinical implications of the proposed coding

framework. NZGA wrote to SCHI outlining the deficiencies in the proposed procedure codes and requesting discussion, highlighting our major concerns about the pelvic floor/urogynaecological procedure codes. SCHI acknowledged receipt of the correspondence but did not respond to the substantive issues raised, nor did it invite NZGA to discuss potential solutions. We are also aware that individual gynaecologists wrote to and/or met with SCHI to discuss their concerns about the pelvic floor/urogynae procedural codes not being fit for purpose and were offered no solutions.

36. NZGA involved RANZCOG as the proposed AP scheme would have had major impacts on the delivery of private gynaecological care, and RANZCOG shared the same concerns and were willing to advocate for the gynaecological health of women in Aotearoa New Zealand by writing to SCHI. It was only after SCHI received correspondence from RANZCOG that SCHI engaged with RANZCOG and were willing to look at revising some of the procedural codes (but has not yet addressed all issues raised).

37. **Our objective has never been to oppose the AP model itself, but to ensure that the coding structure accurately reflects contemporary clinical practice, and enables women to receive appropriate treatment in a single operation in the private sector, as would be offered in our public hospitals, and commensurate with an accepted international standard.**

38. **NZGA remains willing to engage constructively with SCHI at any time to develop clinically appropriate procedure codes that maintain quality surgical outcomes for New Zealand women, while supporting the future sustainability of a high quality gynaecology workforce.**

- ***It is not correct to assert that:***
  - ***"if a patient has stage 3 or 4 endometriosis and also requires hysterectomy the patient may be disadvantaged as full excision of endometriosis would not be covered if carried out with a complex hysterectomy"; or***
  - ***"these codes suggest that when certain pelvic floor procedures are performed together the surgeon (and other providers) will not be able to claim payment if all the procedures that are clinically appropriate are carried out".***

Under code "AP 1208 Laparoscopic Hyserectomy Complex", a complex hysterectomy and a full excision of endometriosis stage 3 is included. If the procedure goes over the applicable risk corridor theatre time, then the extra payments under the risk corridors will apply. If the endometriosis was stage 4 then an additional code can also be claimed, either code "AP 1083 Lap Endometriosis ASRM Stg4" or "1084 Lap Endo Stg4 + Discoid Resection". When additional pelvic procedures are performed, providers can use the additional pelvic floor code "AP 1478 AP Open Code – Add-On Pelvic Floor Procedure".

NZGA's response:

39. NZGA's concerns were based on the information available at the relevant time.

40. The detailed explanation now provided by SCHI regarding the interaction between AP 1208, the Stage 4 endometriosis codes (AP 1083/AP 1084), the operation of the risk corridor provisions, and the AP 1478 pelvic floor add-on code was not provided to NZGA during our only face to face meeting in January 2026.

41. At the meeting held in late January 2026, SCHI did not explain that the complex hysterectomy code would encompass excision of Stage 3 endometriosis, that additional Stage 4 endometriosis codes could be claimed where clinically appropriate, or that further pelvic floor procedures could be claimed through an add-on code. Instead, SCHI declined further engagement with NZGA and indicated that substantive discussions about procedure codes would not continue until after implementation of the AP contract.

42. Consequently, NZGA was required to assess the proposed coding framework based solely on the limited information made available at that time.

43. Despite the absence of meaningful engagement, NZGA continued to raise its concerns in writing and sought clarification on numerous aspects of the proposed coding framework. Many of those requests remain unanswered. Under these circumstances, it is not appropriate for SCHI to criticise NZGA for identifying potential gaps and unintended consequences in a coding structure that had not been fully explained.

44. NZGA also understood, from what was communicated to private gynaecologists around the time a change to an AP contract was first presented in September 2025, that the proposed procedure code set had been endorsed by RANZCOG. RANZCOG has since confirmed to NZGA that it had not endorsed the code set. The absence of formal endorsement by our relevant professional college further contributed to NZGA's uncertainty regarding the adequacy, completeness, and clinical applicability of the proposed coding framework.

45. In addition, practical experience from gynaecologists demonstrates that the surgical coding process is not always straightforward. NZGA members, including surgeons in Dunedin who have participated in the SCHI pilot arrangement using similar defined surgical billing codes for approximately three years, reported that where intra-operative findings reveal more extensive disease than anticipated (for example, Stage 4 rather than Stage 3 endometriosis) it can be difficult and administratively burdensome to amend approved procedure codes or obtain approval for additional codes after surgery has commenced or been completed.

46. Surgeons are already working under significant clinical and time pressures and should not be required to engage in repeated post-operative negotiations to secure remuneration for procedures that were clinically necessary and only became apparent during surgery. Allowing surgeons to focus on providing the most appropriate surgery for each patient requires distancing them from financial distractions, as occurs in the public system, where (with appropriate resourcing) that approach has a proven track record as a successful model of care.

47. This illustrates the broader concern raised by NZGA throughout the consultation process: complex gynaecological surgery cannot always be accurately categorised before an operation. Surgical findings frequently determine the extent of disease and the procedures required. Any remuneration framework must therefore be sufficiently flexible, transparent, and contractually certain to accommodate these circumstances without creating unnecessary administrative barriers and/or financial uncertainty.

48. NZGA's position has consistently been that all applicable procedure codes, together with the use of risk corridor provisions, some built in complexity modifiers, add-on payments, and any mechanisms for managing unforeseen intra-operative complexity, should be clearly documented and contractually guaranteed before surgeons are asked to enter into AP agreements. Explanations offered after the event, or assurances that discretions will be applied sensibly, are not a substitute for that certainty.

49. Providing this certainty protects clinicians, ensures appropriate remuneration for complex surgery, reduces administrative disputes, and above all, safeguards patients' access to high-quality specialist gynaecological care in the private sector.

Concluding remarks

50. In summary, NZGA did not seek, and would have preferred to avoid, regulatory proceedings. From the outset, NZGA's clear preference has been to resolve these matters through constructive, transparent, and good-faith engagement with SCHI. Our multiple attempts to do so were unsuccessful.

51. As one of New Zealand's largest New Zealand-owned health insurers, SCHI plays a significant role in supporting access to private healthcare, and NZGA recognises the importance of maintaining a strong and sustainable insurer for the long-term benefit of New Zealand patients and the wider health system.

52. Throughout this process, NZGA has consistently acted in good faith with the objective of achieving a fair, clinically appropriate, and sustainable funding model that supports the delivery of high-quality gynaecological care while appropriately recognising the complexity, diversity, and evolving nature of specialist gynaecological practice. At every stage, NZGA sought meaningful dialogue and collaborative engagement before resorting to regulatory processes, but those efforts did not result in a satisfactory opportunity to address the substantive concerns raised by its members.

53. NZGA remains firmly committed to the principles and conditions set out in its application, as these are fundamental to protecting patient safety, preserving clinical autonomy, ensuring appropriate remuneration for complex specialist care, and maintaining the long-term sustainability of specialist gynaecological services in New Zealand. These principles are not put forward for commercial advantage, but to ensure that any future funding arrangements continue to support high-quality care and positive patient outcomes.

54. Notwithstanding the present regulatory proceedings, NZGA remains willing to engage with SCHI in genuine, constructive, and good-faith negotiations at any time. NZGA remains open to reaching a mutually acceptable resolution, provided that any agreement adequately addresses the legitimate clinical and operational concerns identified by NZGA and preserves the core principles necessary to protect patients' access to gynaecology services and ensure the continued viability of high-quality specialist gynaecological services. NZGA considers that a negotiated outcome, reached through meaningful engagement and mutual respect, would be in the best interests of all stakeholders; patients, healthcare providers, SCHI, and the New Zealand private and public gynaecological healthcare system.