3 July 2026

Commerce Commission Te Komihana Tauhokohoko
Ritchie Hutton
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CC: [redacted]
Senior Investigator Commerce Commission Te Komihana Tauhokohoko

Re: NZGA Authorisation – NZSA submission to the Commerce Commission regarding NZGA application for authorisation. ISBN 978-1-997321-24-8.

Tēna Koe,

1. On behalf of the New Zealand Society of Anaesthetists – Ngā Ringa Tauwhiro o Aotearoa (NZSA). The NZSA appreciates the opportunity and extension to submit a response to the application made by the New Zealand Gynaecology Association Inc (NZGA) seeking authorisation to collectively bargain, on behalf of its members, with Southern Cross Health Insurance (SCHI) and/or hospitals for the provision of private gynaecology services.
2. The NZSA is happy to meet with the Commerce Commission to assist with any further questions if helpful.

Overview

3. The NZSA does not oppose the NZGA application for authorisation to bargain collectively with Southern Cross. Based on the experience of the Society's members, we agree with a number of the points made by the NZGA.
4. Many anaesthetists providing private anaesthesia services are exposed to the Southern Cross Affiliated Provider (AP) Scheme used in other specialties and some private anaesthesia services will come under the proposed AP agreement for private gynaecological surgeries.
5. Without genuine negotiation and clinical input, these arrangements continue to produce detrimental outcomes for the public, particularly patients. Of greatest concern is that the current imbalance in market power between individual clinicians and Southern Cross is increasingly controlling the relationship between the clinician (healthcare provider) and patient, and the work is becoming financially unsustainable and unappealing.
6. More efficient and effective communication and negotiation between healthcare providers and funders will improve understanding of the practical implications of the proposed contractual arrangements. The benefits to the public will include:
    - 6.1. Patient-centred care: maintain quality, safety, autonomy, and clinically informed decisions.
    - 6.2. Efficient management of resources: maintain the quantity of procedures performed across the health sector, both public and private, and accessibility to procedures and specialists. Notably for high-risk and already disadvantaged groups.
    - 6.3. Specialist workforce recruitment and retention in Aotearoa New Zealand.
7. There are also likely to be significant efficiencies in collective arrangements. There are considerable demands on the time of medical practitioners, and shortages of practitioners are common. Every hour a medical practitioner spends on negotiation with a provider or funder is an hour that cannot be spent on patient care.

Who we are

8. The NZSA is a professional medical society representing 787 specialist anaesthetists and specialist pain medicine physicians (SPMP)[1] in Aotearoa New Zealand. Our members include specialist, trainee and retired Anaesthetists and SPMPs working in public and private practice. The Society's key roles are advocacy, facilitating and promoting education, and strengthening networks of anaesthetists nationwide.

9. NZSA membership as of June 2026 is:
   - 9.1. Specialist anaesthetists: 433
   - 9.2. Trainee anaesthetists: 245
   - 9.3. Associate & SPMP (not practising anaesthesia): 17
   - 9.4. Retired: 43
   - 9.5. Life: 14
   - 9.6. Honorary: 6
   - 9.7. Pasifika: 29

10. NZSA membership is spread across Aotearoa.[2] This is similar in population spread across the North and South Islands.[3] NZSA membership as of June 30 2026:
    - 10.1. 70% North Island
    - 10.2. 24% South Island
    - 10.3. 6% Outside of New Zealand, primarily Australia and the Pacific Islands.

Specialist Anaesthetists

11. Anaesthetists are specialist doctors who have completed a minimum of five years of anaesthesia specialist training. The Australian and New Zealand College of Anaesthetists anaesthesia training programme is the only accredited anaesthesia vocational training programme in Australia and New Zealand.

12. Anaesthetists are essential at every stage - before, during, and after surgery. Their role is much broader than the administration of anaesthesia during a medical procedure. Their expertise in perioperative care[4], from pre-operative assessment, to monitoring during surgery, to post-operative pain management, is vital for minimising complications and delivering the best possible outcomes.[5]

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[1] Specialist Pain Medicine Physicians (SPMP) are dual-qualified specialists who have completed two specialist vocational training programmes, including the Faculty of Pain Medicine Training Programme. Most SPMPs in New Zealand practice across both their SPMP and primary vocational specialty. A number of SPMP are also practising anaesthetists. SPMP from other specialties who are members of the NZSA fall within the 9.3 membership category.

[2] This is based on the member contact address provided to the NZSA.

[3] As of June 30 2024. Stats NZ article: *North Island population passes 4 million while South Island population grows faster* (16 April 2025). www.stats.govt.nz/news/north-island-population-passes-4-million-while-south-island-population-grows-faster/

[4] Australian and New Zealand College of Anaesthetists (ANZCA). The Australian and New Zealand Perioperative pathway – where extra care is provided before and after surgery to reduce the risks of postoperative complications and improve recovery. Complications arising after surgery are the third leading cause of death in the developed world. www.anzca.edu.au/patient-information/about-perioperative-medicine/the-perioperative-care-model-1

[5] Australian and New Zealand College of Anaesthetists (ANZCA). *PS59 (A) Position statement on roles in anaesthesia and perioperative care 2015* – the roles and responsibilities of professionals in anaesthesia and perioperative care teams in New Zealand and Australia. https://www.anzca.edu.au/getContentAsset/0d502397-75d0-44b9-a1da-3d946699f4ee/80feb437-d24d-46b8-a858-4a2a28b9b970/PS59(A)-Anaesthetist-roles-2015.pdf?language=en

13. An anaesthetist is required for all procedures and surgeries requiring a general anaesthetic, deep sedation[6], and moderate sedation[7] for specific procedures and patients of certain risk levels.[8] As well as regional anaesthesia, for example, epidurals and spinals.

14. Anaesthetists work across all surgical specialties, including gynaecology. Some anaesthetists become more involved in a specific sub-specialty for example, paediatrics, cardiology and perioperative medicine, of which they will have undertaken additional training after gaining their anaesthesia fellowship. Sub-specialties are more common in main centres with larger hospitals and resourcing.

15. It is common for specialists in New Zealand to work a hybrid between the public and private health sectors.[9] Previous surveys of NZSA members indicate that at least 75% of our members work some time in private practice,[10] and of those, their time working in private practice is a minority of their public/private work mix (up to 25%).[11]

16. Anaesthetists are a highly mobile workforce with easily transferable skills. Like most other specialist doctors in New Zealand, anaesthetists belong to an Australasian College. Whilst we can only speak to anaesthesia, it can be assumed it is similar across the other specialties with a combined Australian and New Zealand College:
    - 16.1. Gaining registration to work in Australia is a reasonably straightforward process for New Zealand registered and trained specialists.
    - 16.2. Second to Australia, the process to gain registration in the UK and Canada is also reasonably straightforward for New Zealand trained and registered specialists.
    - 16.3. It is not uncommon for new fellows (who have just completed their anaesthesia training - FANZCA) to do a post-FANZCA fellowship in Australia.
    - 16.4. There is collegiality across the two countries, with specialists attending and speaking at conferences and workshops in both countries.

17. As a consequence, anaesthetists, and likely other specialists, can and do move relatively easily across the Tasman. Our experience is that there are push and pull factors that lead practitioners to leave New Zealand, but decreased work conditions or remuneration in Aotearoa will cause an increase in practitioners leaving for Australia.

18. Additionally, anaesthetists, and likely other specialists, leave patient-facing positions for non-clinical roles such as managerial positions within the health sector, or research and academic positions for similar reasons.

Private anaesthesia services

19. Private anaesthesia services differ across the country. As do motivators to work in the private sector, contract providers, funders, and arrangements between the anaesthetist, surgeon, and

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[6] A drug-induced state of depressed consciousness during which patients are not easily roused and may respond only to noxious stimulation.

[7] A drug-induced state of depressed consciousness during which patients retain the ability to respond purposefully to verbal commands and tactile stimulation.

[8] Australian and New Zealand College of Anaesthetists (ANZCA): *PG09(G) Guideline on procedural sedation 2023.* https://www.anzca.edu.au/getContentAsset/3faa17f6-a6e0-4719-9992-9d67acef952b/80feb437-d24d-46b8-a858-4a2a28b9b970/PG09(G)-Sedation-2023.pdf?language=en

[9] Association of Salaried Medical Specialists (ASMS): *A less public place, A survey of ASMS members on reasons for working part-time outside of the public health system*. (August 2023).

[10] NZSA member feedback survey 2024. To note, the number working a mixture of private and public is likely higher, with 17% of respondents not being qualified to work in private care (trainee, retired).

[11] NZSA member private practice survey 2022.

hospital. Anaesthetists provide anaesthesia services for a surgeon's 'list' – a list of patients or procedures planned by a surgeon to cover a full or half day. The anaesthetist may be contracted to the surgeon or the hospital.

20. 'Lists' often consist of a mixture of procedures within the surgeon's specialty, and usually cover a range of different 'funders' (i.e ACC, private insurance, user paid). The anaesthetist may be recruited directly by the surgeon or through anaesthesia groups established in some larger centres.

21. In addition to providing a general anaesthetic or sedation during the procedure for the 'list', generally the anaesthetist will also:

    21.1. Complete a preassessment for each patient: review the patient's clinical notes to identify anaesthetic risks and develop a care plan. This may include a patient consultation over the phone or in person and working with the patient to manage their medications and health conditions.[12]

    21.2. Meet the patient on the day of their procedure to complete an airway assessment, sign an anaesthetic consent with the patient, and answer any questions.

    21.3. Monitor the patient for the full duration of the procedure.

    21.4. Post surgery: move the patient to the Post Anaesthesia Care Unit (PACU) to settle the patient and hand over to nursing staff.[13]

    21.5. The anaesthetist will often visit the patient after surgery to review and manage their pain relief and vitals. They may also complete the discharge prescription for pain relief.

    21.6. On-call: the anaesthetist is responsible for the care of the patient for the entirety of their stay in hospital and is responsible for the patient's pain management. If the patient has remained in the hospital, the anaesthetist may return to check on the patient. If the patient has returned home, in some cases, they may contact the patient to check on recovery.

    21.7. Private hospitals do not have after-hours doctors on site. If there is an emergency with the patient, the anaesthetist is the doctor commonly called in because these are often anaesthetic factors such as pain, blood pressure, and heart rate issues. If complications result in a patient returning to theatre, the anaesthetist who anaesthetised them is expected to return or arrange cover if they are unavailable.

22. Anaesthetists and surgeons have different risk and complexity considerations for each patient and procedure, resulting in different risk corridors for each case. While the surgical and anaesthetic risk or complexity can be correlated, they are not always. For example, a knee joint replacement procedure on a patient who is obese, has complex medical issues such as diabetes, is on long-term steroids, or has a cardiac condition, or may require special positioning, which significantly affects how the anaesthetist ventilates the patient. The surgeon in this example would be less affected by these complexities during the procedure; however, it would be higher

[12] Australia and New Zealand College of Anaesthetists (ANZCA). *PG07 Guideline on pre-anaesthesia consultation and patient preparation* – Established guidelines of care for anaesthetists registered in New Zealand relating to pre-anaesthesia consultation and preparation in all settings: https://www.anzca.edu.au/getContentAsset/d4eb4cab-69e6-4228-8568-bbc911c6c505/80feb437-d24d-46b8-a858-4a2a28b9b970/PG07-Guideline-on-pre-anaesthesia-consultation-and-patient-preparation-2024.PDF

[13] Australia and New Zealand College of Anaesthetists (ANZCA). *PS04(A) Position Statement on the post-anaesthesia care unit 2020* – Expectations on clinicians for PACU and provision in healthcare facilities: https://www.anzca.edu.au/getContentAsset/55ed8ce6-db5c-41f7-89ed-172c4b62803d/80feb437-d24d-46b8-a858-4a2a28b9b970/PS04(A)-PACU%C2%A02020.pdf?language=en

risk and more complex for the anaesthetist and would likely require significant pre- and post-operative care. This differential needs to be managed in any compensation structure.[14]

23. Anaesthetists use different company and billing structures for their private work. These differ depending on the region they work in, the hospital, funder, and the contract provider.
    23.1. In smaller centres, anaesthetists generally work as solo entities.
    23.2. Some larger centres have billing groups. Billing groups are groups of anaesthetists providing private anaesthesia services in the same region who have chosen to combine administrative tasks. The group may manage tasks such as providing patient information and questionnaires, chasing debt, engaging debt collectors, and arranging locum cover when the anaesthetist is not available.

24. It is uncommon for anaesthetists to travel inter-regionally for private work. Whilst some may travel to regions where anaesthesia workforce numbers are lower[15], this is more of an exception. The majority will be constrained by the location of their public health sector work.

The Affiliated Provider Scheme

25. The NZSA supports the NZGA's position on what is likely to happen without the Proposed Arrangements (the Counterfactual).

26. Some anaesthetists providing private anaesthesia services are working under Southern Cross' Affiliated Provider agreements and this gives some insight into the likely experience when applied to private gynaecology services. This 'bundled' model of payment for services varies across surgical specialties, locations, and procedures.

27. NZSA member feedback for some time has indicated the AP model is no longer fit for purpose. In general, the AP model is becoming increasingly problematic due to:
    27.1. No informed clinical input into contracting arrangements. Anaesthesia for these procedures is complex and multifactorial; a one-size-fits-all approach to calculating anaesthetic fees doesn't reasonably or appropriately reflect the clinical expertise involved to keep the patient safe, or the pre- and post-operative work required. Neither do they reflect the realities of an increasingly complex population.[16,17]
    27.2. The largely 'take it or leave it' offers with limited-to-no ability for individual clinicians to negotiate terms or risk or complexity modifiers for variations in surgical or anaesthetic complexities, or patient factors[18].
    27.3. A lack of transparency of the fee allocation within the bundle.

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[14] Anaesthetists have been aware of the need for 'modifiers' to reflect these complexities and recognition for the anaesthetists' perioperative role for some time. The NZSA's Relative Value Guide (RVG) is an optional guide available to NZSA members that relates anaesthesia services, one to the other, on the basis of the complexity of the service and the time to undertake that service. Anaesthetists set their own unit rate if they choose to use the RVG.

[15] For example, Auckland to Whangarei.

[16] Ministry of Health Manatū Hauora. *Health and Independence Report 2024* – Population growth, ageing, living longer, and diversification, alongside the increasing prevalence of non-communicable diseases (i.e. diabetes, cardiovascular disease) are contributing to a more medically complex population. Chapter: People of New Zealand. (September 2025): https://www.health.govt.nz/publications/health-and-independence-report-2024-online-version#people-of-new-zealand-nga-tangata-o-aotearoa

[17] Healthier Lives He Oranga Hauora, National Science Challenge 2015-2024 – Rise in non-communicable diseases in New Zealand. Four of the major non-communicable diseases account for over a third of total death and disability in New Zealand. This costs the country significantly, both financially and socially and contributes to health inequities experienced by Māori and Pacific peoples, those living in rural and isolated areas and people living with deprivation. https://healthierlives.co.nz/about-us/

[18] For example, the patient's American Society of Anesthesiologists' physical status classification score (ASA), age, Body Mass Index (BMI), and frailty.

27.4. No clarity on the scope of work, i.e when the anaesthetist-patient interaction begins and ends.

28. Southern Cross' dominant position in the insurance market causes an imbalance between them as the funder and the individual clinicians delivering the care. Whilst authorisation of NZGA's application may negatively impact the anaesthesia market and compress anaesthetists' share of the AP 'bundle', it will encourage quality negotiation and integration of clinical expertise, which is of benefit for the public.

    28.1. Southern Cross Health Society has made increasing inroads in influencing clinical care for their policyholders by proceeding with policies despite clinicians raising significant concerns about adherence to established clinical standards and patient outcomes.[19]

29. Without quality negotiation and clinical input, the resulting outcomes include:

    29.1. Financial incentives that may not align with optimal clinical decision-making.[19]

    29.2. Further downward pressure on services that will become financially unsustainable and unappealing. Resulting in reduced workforce participation and difficulty in obtaining specialist services.[20]

30. The Commission's SOPI has sought information on the flow-on effects to anaesthetists and other health professionals from the application.[21]

31. The NZSA's view is that:

    31.1. Southern Cross' AP approach, and its use of its dominant position, is currently compressing anaesthetists' share of the AP 'bundle' in relation to other private medical procedures. That will occur with or without the application.

    31.2. It is possible that authorisation of NZGA's application may further compress anaesthetists' share of the AP 'bundle' and negatively impact the relevant anaesthetists in relation to private gynaecology services.

    31.3. It is also possible that greater clinical input as a consequence of the authorisation of NZGA's application may result in changes to the AP 'bundle', mitigating this compression.

    31.4. Affected anaesthetists may well seek to collectively bargain with Southern Cross in the future if their concerns are not addressed.

Benefits / Avoided Detriments to the public

32. The NZSA sees significant benefit likely to arise from the application in the form of avoided detriments. There are significant detriments to the public as a flow-on effect of the market power referred to above at 27, namely:

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[19] Most recently demonstrated in policy changes made by Southern Cross Health Society (SCHS) that have restricted eligibility criteria for general anaesthesia and sedation options for tooth extractions, skin lesions, and endoscopic procedures for policyholders. SCHS has not adjusted the policy changes despite clinicians and professional bodies raising significant concerns that the new criteria will impact clinical judgement, patient autonomy and outcomes, and adherence to regulatory standards and guidelines. Southern Cross will not cover patients who may choose to pay the difference for general anaesthesia or deep sedation for these procedures.

[20] As demonstrated in the United Kingdom, where anaesthetists and doctors have resigned from contracts over perceived low fee levels or are no longer working with private health insurers:
BUPA: www.ft.com/content/0c15b7d8-fd19-4180-aea4-8d571e43969a?syn-25a6b1a6=1
AVIDA: https://healthcareandprotection.com/bupa-denies-consultants-and-anaesthetists-are-ditching-it-over-fees-as-aviva-acknowledges-practitioner-challenges/

[21] Statement of Preliminary Issues at 71.5

32.1. Reduced quality of care: clinical judgement and patient autonomy are impacted and influenced by financial decisions.

32.2. Inefficiencies such as unnecessarily repeated surgeries to meet policy criteria.

32.3. Reduced output of surgical procedures across the healthcare sector, both public and private, as a result of:

32.3.1. Specialists declining work under the AP model.[20]

32.3.2. Specialists leaving New Zealand for Australia.[22, 23, 24]

32.3.3. Reduced public sector specialist capacity: Most specialists work across both sectors, supplementing their public income with private work. A contraction in private work availability therefore reduces the number of specialists available for public services.

32.3.4. Future specialist workforce reduction due to undesirable income in comparison to other medical specialties. Alongside medical students or vocational trainees choosing to remain in Australia.

32.3.5. A reduction in specialists' desire to undertake innovative new surgeries due to time and output pressure.

32.4. Reduced accessibility due to the inter-dependency of our public and private healthcare sectors:

32.4.1. Increased pressure on the public sector with finite capacity (beds, staff, facilities).

32.4.2. Complex cases shifting to the public system despite suitability for private care.

32.4.3. Increased post-operative private-to-public patient transfers.

33. These detriments unevenly affect the public, with the greatest burden falling on those already experiencing health disparities. As such, the value of the benefits and detriments to the public cannot be considered homogeneous, and the NZSA encourages the Commerce Commission to consider these groups separately.

33.1. In particular, procedures for more complex patients (for example, those classified as ASA 3 or 4[25]) are more likely to be declined by specialists working in the private setting due to insufficient recognition of time and expertise. This, alongside the additional pressure placed on the public system, is highly likely to be more detrimental

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[22] Australian Society of Anaesthetists. *Anaesthetist Workforce Modelling Report* – Australia is also experiencing a shortage of specialist doctors. A 4% in 2027 and 5.7% in 2032 anaesthesia workforce shortfall is expected in Australia. May 2025. https://asa.org.au/publications/anaesthetist-workforce-modelling

[23] Australian healthcare providers regularly advertise vacant positions in New Zealand. The NZSA received 30 Australian vacancy advertisement requests between 14/08/2023 and 26/06/2026, mostly from the Queensland region.

[24] Insufficient data is available on the exact number of New Zealand trained doctors moving to Australia. What is available does demonstrate a likely increase in recent years. However, this data does not account for some variables such as SIMG entering and leaving New Zealand or New Zealand trained doctors providing locum cover.

- NZ Doctor: https://www.nzdoctor.co.nz/article/news/number-kiwi-trained-doctors-registered-oz-reaches-new-high.
- Medical Deans Australia and New Zealand website data dashboard. *Doctors Registered in Australia.* https://app.powerbi.com/view?r=eyJrIjoiMjdiNTU2NWMtMmJjYy00MTBiLTg5NTgtNzg1OTE4ZjU4NGJhIiwidCI6IjljY2Y4YjAxLWJhZTQtNDQ2ZC1hZWNhLTdkYTljMDFlZDBmOSJ9

[25] Hendrix JM, Garmon EH. *American Society of Anesthesiologists Physical Status Classification System* – ASA classification: The American Society of Anesthesiologists' physical status classification system is a tool commonly used in New Zealand and many other countries. It provides healthcare professionals with a standardised method to assess and categorise patients' physical status before surgery. National Library of Medicine. (February 2025) www.ncbi.nlm.nih.gov/books/NBK441940/

for those already experiencing inequities in our health system - Māori and Pacific peoples, those living in rural and remote locations and people experiencing deprivation.[17, 26, 27]

33.2. Gender inequity: With this application relating to gynaecological services, women will be further disadvantaged.[28]

Other benefits – efficiencies

34. The NZSA agrees, based on our members' experience, that the benefits identified by the NZGA and referred to in paragraph 68 of the SOPI will likely occur if the application is approved.

35. At a macro level, there are likely to be significant efficiencies in collective arrangements, compared with a counterfactual where individual practitioners must negotiate with a party like Southern Cross or an Affiliated Provider, in order to obtain changes such as higher rates and further time allowances. That is particularly so compared with requirements that this negotiation occur on a patient-by-patient basis.

36. These efficiencies are likely to be greater than in some other collective arrangements the Commission has considered in the past. A chicken farm continues to run even when the manager is tied up negotiating with a chicken supplier[29]. But every hour a medical practitioner spends on negotiation with a funder is an hour that cannot be spent on patient care.

37. It is well known that there are significant demands on the time of medical practitioners, and shortages of practitioners are common. It is inherently likely that negotiating a single, sustainable arrangement will create significant benefits by freeing up practitioners.

Potential outcomes with approval

38. A potential outcome of collective negotiation may be a framework of modifiers with set unit rates. This is an efficient method of determining fees that better addresses the identified detriments than the counterfactual.[30]

39. Opens pathways for a better balance in market power between Southern Cross and specialist groups, enabling more clinically informed, patient-centred arrangements.

40. Reduced administrative burden, allowing specialists to direct their time toward higher-value clinical activity.

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[26] Wheeler A, Rahiri JL, Ellison-Lupena R, Hanchard S, Brewer KM, Paynter J, Winter-Smith J, Selak V, Ameratunga S, Grey C, Harwood M. *Assessing the gaps in cardiovascular disease risk assessment and management in primary care for Māori and Pacific peoples in Aotearoa New Zealand- a systematic review.* Lancet Reg Health West Pac. (March 2025) 17;56:101511. doi: 10.1016/j.lanwpc.2025.101511. PMID: 40171473; PMCID: PMC11960672.

[27] Gurney J, Stanley J, Sarfati D. *The inequity of morbidity: Disparities in the prevalence of morbidity between ethnic groups in New Zealand.* Sage Journals. (November 2020). doi.org/10.1177/2235042X20971168.

[28] New Zealand Government Te Kāwatanga o Aotearoa: *New Zealand Women's Health Strategy 2023* – "Gender bias, racism and determinants of health shape women's health needs and experiences": www.health.govt.nz/system/files/2023-07/womens-health-strategy-oct23.pdf

[29] Commerce Commission. Case Number [2017] NZCC 37 – Waikato-Bay of Plenty Chicken Growers Association Incorporated.

[30] A similar structure to the NZSA's RVG and method of determining ACC anaesthesia fees. Where units are attributed to procedures and complications. The RVG allows individuals to set their own unit price, and ACC usually holds a fixed unit price.

Conclusion

41. The New Zealand Society of Anaesthetists – Ngā Ringa Tauwhiro o Aotearoa believes the benefits to the public outweigh the detriments if the New Zealand Gynaecology Association's application is approved.

42. Genuine negotiation and clinical input on framework and contract terms will better uphold quality patient-centred care. Whilst also maintaining surgical output and accessibility to treatment with efficient management of procedures and resources across both the private and public sectors.

43. Thank you for the opportunity to submit a response to this application. The NZSA remains happy to answer additional questions from the Commerce Commission if needed.

Submitted on behalf of the NZSA,

Ngā mihi,
Dr Jonathan Panckhurst,
President, New Zealand Society of Anaesthetists – Ngā Ringa Tauwhiro o Aotearoa