

## Southern Cross Healthcare Response to Commerce Commission Statement of Preliminary Issues on NZGA Authorisation Application

- 1.1 Southern Cross Healthcare Limited (**SCHL**) is grateful for the opportunity to submit in response to the Statement of Preliminary Issues (**SOPI**) published by the New Zealand Commerce Commission (**Commission**) on 25 May 2026 regarding the application by the New Zealand Gynaecology Association Inc (**NZGA**) for an authorisation and interim authorisation to collectively negotiate with Southern Cross over the provision of gynaecology services (the **Application**).
- 1.2 As a for-purpose organisation under the Southern Cross Health Trust, SCHL seeks to advance the provision of quality healthcare in Aotearoa New Zealand, today and for generations to come. In 2025, we delivered care to more than 118,000 patients through our hospitals and endoscopy clinics; worked with over 82,000 allied health and rehabilitation clients; and delivered community-based health, mental health, and wellness services to over 52,000 clients. We employ 3,071 people (including 2,043 nurses) serving 1,221 credentialed surgeons and anaesthetists. Southern Cross Health Trust funded 104 charitable surgeries, 17 nursing scholarships, over 500 first-year nurse students received vouchers for nursing uniforms and footwear, over 1,100 nursing students received starter kits to support their nursing journey, and it funded nursing roles at three City Missions.

### Executive summary

- 1.3 SCHL and Southern Cross Health Insurance (**SCH Insurance**) are not associated entities. SCHL acknowledges that the historical position was different, and the shared brand can cause confusion, but the Application does not accurately reflect the relationship between SCHL and SCH Insurance. SCHL is a contracting party with SCH Insurance, as any other private hospital group is and it must negotiate, like any other group, Affiliated Provider (**AP**) contracts for the provision of services to SCH Insurance. These contracts are arm's length. SCHL is not an interconnected or associated person of SCH Insurance. To the extent previous decisions of the Commission made that finding, they are no longer correct.
- 1.4 SCHL supports the NZGA receiving interim authorisation to bargain collectively with SCH Insurance for the purposes of setting codes to support a contracting framework funded by SCH Insurance. Historically, funder contracts (including AP contracts) have been implemented with specialists' input into the scope of the clinical procedures (in the case of AP contracts, the codes) with the contract holder (usually the hospital) negotiating the pricing with the funder once the scope of the procedures has been agreed.
- 1.5 SCHL believes the clinical appropriateness of any proposed code set is best achieved through the involvement of the specialists (in this case the gynaecologists) who have in depth knowledge of the procedures being coded.
- 1.6 SCHL also supports NZGA entering into a standstill arrangement to allow this negotiation to occur.
- 1.7 SCHL considers that the hospitals, as the contract holder, should continue to negotiate the prices for the AP contract and any part of the contractual framework which imposes obligations on hospitals. Logically the codes would need to be agreed prior to applying a pricing value. The bundled funding needs to consider (in addition to the specialists fees) infrastructure costs, operating costs (including the medical consumables associated with each code), fit-out and equipment costs (including technology) and back office requirements (particularly in administering a bundled contract), all of which can only be

considered once the codes are set and require hospitals' input. Hospitals, as contract holder, will also need to be able to operationalise the complexity of providing surgical services, including complying with any obligations that are imposed on the contract holder under an AP contract.

**1.8** Bundled funding of hospital providers is the prevailing healthcare funding model - it is all about how it is implemented. SCHL acknowledges the objective of SCH Insurance to manage cost increases across its business, including by moving certain gynaecological services onto an AP model of bundled funding. In that regard, SCHL notes:

- (a) Bundled funding is the prevailing model of healthcare funding in New Zealand and internationally. It is supported by the OECD as a way of managing rising healthcare costs and the best way of incentivising the provision of efficient and effective end to end patient care. SCH Insurance's bundled funding through AP contracts has been in place with many other speciality groups since about 1997 and this type of model is consistent with all other major funders in New Zealand who have also adopted bundled funding arrangements - Health New Zealand/ Te Whatu Ora (**HNZ**) and the Accident Corporation Commission (**ACC**).
- (b) Historically, SCH Insurance has taken a staged approach to the implementation of AP contracts, managing a small number of the highest volume, most common procedures per speciality through AP Contracts and leaving the balance to be managed through fee for service (**FFS**) arrangements. SCHL has observed that this approach has enabled the impacted specialities to adjust over time as different procedure types have been brought under AP contracts and the hospitals, specialists and SCH Insurance have been able to build an understanding of how the bundled funding model optimally works.
- (c) The balance of negotiating power in bundled funding arrangements is complex, and influenced by a number of commercial drivers, only one of which is properly compensating gynaecologists for their skill and expertise. The funder usually has and exerts significant power in respect of terms and prices. However, private gynaecologists also control the volume and mix of work they do, and which hospital they choose to provide care at. Therefore, they control levers that affect the private hospitals' productivity and profitability.
- (d) Funding is only one part of the mix of the success of a gynaecologist's practice, with patient satisfaction and specialist reputation, referral pathways, and list efficiencies being other key levers for competition and opportunities for differentiation of specialists.
- (e) Private medical specialists in New Zealand are credentialled to perform procedures at private hospitals (they are not employees) and are often business owners, or paid self-employed individuals, and in some cases, direct or indirect investors in hospitals, with at least a reasonable degree of control over the profitability of their businesses, under either funding model. This is significantly different to other professions who are employees where collective bargaining with their employer is common, such as nurses, teachers, first responders, or hospitality.

**1.9** The Application does not provide enough information to comment on benefits and detriments. As the Commission will appreciate, private healthcare must not only deliver high quality healthcare outcomes for patients as its first priority, it must also be affordable for it to be sustainable which, with the cost of living, is becoming increasingly challenged. To achieve that, it is critical that no single part of the system has too much market power, as that will tend to shift risk and cost to another part of the system in a way that is expensive and inefficient. The levers in this market power dynamic are price, volume and mix of procedures and specialties. It is important that commercial tension is distributed, so no

market participant has control over all three, but collectively can ensure a high quality and efficient sector for our patients.

- 1.10** Key drivers of cost and risk for each of the main participants, which a benefits and detriments analysis might take into account, are that:
- (a) Funders, such as SCH Insurance, need to balance increasing claims costs driven by both price and volume increases, against premium affordability, which drives insurance participation rates and leads to greater, or lesser financial concentration risk.
  - (b) Hospitals face consumables and operating costs increasing faster than funding increases, facility development costs increasing significantly, and funders seeking to reduce volumes, which impacts the economics of hospital operations. It is important for hospitals to continue to be able to compete for volume and mix of procedures.
  - (c) Specialists must support both public and private services, carry increased workloads, and, depending on personal circumstances, may weigh those pressures against international opportunities.
- 1.11** Ultimately, the Application does not provide enough detail on the anticipated contractual arrangements, nor does it quantify the price effects or other cost increases or indicate where any cost effects are likely to fall. Particularly where authorisation is sought for arrangements or structures that would influence the next decade of provision of gynaecological services [ ], more information is required to properly understand and weigh the potential systemic impacts of the proposal, to both end-customers and to other parts of the healthcare system, including hospitals. Without this information, the benefits and detriments analysis is incomplete. SCHL has been unable to comment on the benefits and detriments analysis in the Application for this reason.
- 1.12** There is no hub and spoke cartel. The Application suggests that SCH Insurance and the private hospitals may be in a cartel arrangement. This is inappropriate and incorrect. [ ].
- 1.13** Summary: In any bundled funding model, alignment of incentives is difficult to achieve, and it is not a perfect science. The current approach that is applied to other specialties, where codes are set with deep involvement of the specialists, and bundled funding is focussed on a small number of high-volume, common procedures, with the hospitals holding those contracts and the balance of less frequent and more specialised procedures being undertaken on a FFS basis, strikes a reasonable balance of competing interests. As applied to the Application, SCHL therefore supports NZGA collectively negotiating codes with SCH Insurance, and any standstill arrangements necessary to give effect to that process. The standard approach to negotiating AP arrangements, applying to a small number of high volume procedures rather than the entire specialty, has the potential to drive more efficient outcomes and increased competition on quality, efficiency and service, without undermining the incentives on gynaecologists to develop their specialty practices for the benefit of the wider health system in Aotearoa New Zealand.

### **Support for submission**

- 1.14** Attached to this executive summary are the following confidential appendices providing more detail to assist the Commission in its consideration of the effects of interim and final authorisation of this Application:

- (a) [ ]

(b) [ ]

(c) [ ]

(d) [ ]

**1.15** SCHL requests that the Commission treat the information in this submission marked as confidential as strictly commercially sensitive and not for disclosure. SCHL requests that the Commission consult with it, as is its usual practice, if any information is requested under the Official Information Act 1982 that may be referenced in or derived from this information.

**1.16** SCHL looks forward to the opportunity to assist the Commission further as required in considering this Authorisation application.