Aide-Mémoire

Health New Zealand
Te Whatu Ora

Private Sector Relationships

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To:	Hon Simeon Brown, Minister of Health		
From:	Martin Keogh, Regional Deputy CE – South Island		
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Contact for further discussion (if required)

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Purpose

1. This Aide Memoire responds to your request for a strategic approach to partnering with the private sector. This response will be delivered in two parts:

a) Paper One (this paper): provides an overview of the opportunities and challenges in outsourcing.

b) Paper Two (week of 13 February, following decision of Commissioner and confirmation of funding): provides you with the volumes to be procured by region for additional delivery of treatment from private hospitals over the next 6 months and assumptions for 25/26. This will include an assessment of potential impact on wait times and the National Health Targets.

Summary

2. Health NZ sees outsourcing to private hospitals as an important part of the delivery of planned care to help us achieve National Health Targets and shorten wait times to treatment. There are opportunities to accelerate how we create an environment where private hospitals are a central part of our planning in the production of treatment services rather than an adjunct to delivery that results in short-termism and uncertainty of signals. This uncertainty makes it difficult for private providers to plan.

Background

3. Historically District Health Boards provided most of its planned care through insourcing or provided by publicly owned hospitals, with individual districts entering annual outsourcing (contracted from private or other hospitals) agreements with local private providers, based on district demand and capacity constraints. There is opportunity for regions to take a wider view, particularly with private hospitals that provide in multiple districts.

4. Outsourcing volumes varied across the country ranging from 0-17% of the total 200,000 planned care interventions delivered by each district.

5. Experience over the years has shown that short-term “waiting list initiatives” take time to stand up, are not efficient and put pressure on workforce availability for both Health NZ and private providers who are competing for the same limited workforce. Longer term arrangements and partnerships are expected to be more cost-effective in delivering sustained reductions in waiting lists for planned care. This will be a focus of the second paper in this series.

Private Hospitals are a critical part of our delivery

6. There are three major players who make up 70% of the private market:

   a) Evolution Healthcare (12 facilities) mainly Wellington and Auckland

   b) Southern Cross (23 facilities) across NZ

   c) Healthcare Holdings (8 facilities) mostly Northern and South Island

7. S9(2)(b)(ii)

8. There is variation in access by district and region where some private providers only deliver locally or regionally. Some private providers may also specialise in a narrower range of treatments or diagnostics. There has been limited transfer of patients across a region or nationally but this offers an opportunity in the future again to provide certainty to patients by taking a whole of region or national approach depending on the need.

9. Since its formation, Health NZ has increased the spend on clinical outsourcing from $163M in 2021 to $350M in 2024 in response to increasing demand and limitations in internal capacity. In the 2024/25-year Health NZ planned to outsource is 22,175 cases. Historically, the centre held budgets to purchase additional volumes from districts. This funding does not exist anymore and Health NZ has had to absorb this cost within our baseline.

10. Health NZ currently outsources planned surgical procedures, endoscopy (colonoscopy and gastroscopy), diagnostic procedures and radiology. There is also a small amount of cancer treatment. This includes tonsillectomies, hernias, hip joint replacements, dental surgery, skin lesions and cataracts.

11. The types of surgical procedures outsourced is based on the clinical assessment by the anaesthetist (ASA[2]) and private hospital post operative care capability.

12. In addition, an estimated 140,000 radiology events are outsourced per annum. This includes plain x-ray, ultrasound and CT scanning. These patients are usually selected on the waiting time and managing clinical risk.

13. Panel agreements that establish contract terms and price are set nationally and relationships with hospitals are held at a Regional Deputy CEO level. This relationship is important because, private hospitals need close relationships with referrers to ensure that they have clinical capability to safely manage patients.

14. These relationships are best led regionally because patient referrals can be negotiated at the level where transparency on capacity, capability and cost impact for private hospitals matters most. This is to ensure private hospitals receive referrals that are appropriate for them to treat, and escalation pathways are in place.

More elective surgery is required to keep up with demand and achieve wait times

15. The 2024/25 insourcing & outsourcing activity plan will not keep up with the 7% growth currently occurring in waiting list, which is only partially met by a 5% increase in insourcing delivery through the first 2 quarters of 2024/25. While acute pressures continue to grow crowding out some insourcing capacity, expanding outsourcing to

[1] Private Market Assessments commissioned by Health NZ and completed by Deloitte 2024.
[2] American Society of Anaesthesiology Score

align with rate of growth of capacity in public system (e.g. commissioning of new hospital builds and refurbishments).is a necessary part of our strategy to reduce waiting times. While work continues on internal efficiencies, an estimated additional 10-15% of activity in planned care is required to keep up with estimated growth and to progressively treat more patients who have already waited greater than 120 days.

16. There are too many people waiting for treatment, and they need certainty on when they will get care. The table below shows the people on the treatment waiting list and the type of procedure they are expected to receive. It gives both the total waitlist and those waiting greater than four months. The table also gives the top 15 procedures that accounts for 56% of the total waiting list and 58% waiting greater than four months.

17. Of the current waitlist 40% are waiting over four months and 36,045 procedures are required to clear the long waiters if completed today.

Table one: People on the waiting list, by the intended procedure and the specialty

Procedure	Specialty	Total Waitlist*	Waiting > 4 months	% Waiting > 4 mths
Cataract surgery	Ophthalmology	10,840	4,227	39%
Knee replacement & other knee procedures	Orthopaedics	4,648	2,926	63%
Removal of teeth & other dental procedures	Dental Surgery	4,405	2,460	56%
Hip replacement & other hip procedures	Orthopaedics	3,266	1,864	57%
Tonsillectomy and/or adenoidectomy	Otorhinolaryngology (ENT)	3,477	1,698	49%
Excision of skin lesion (+/- graft)	Dermatology/General Surgery	4,750	1,536	32%
Repair of hernia	General Surgery	3,083	1,334	43%
Myringotomy/ myringoplasty	Otorhinolaryngology (ENT)	2,239	1,012	45%
Hysterectomy	Gynaecology	1,415	721	51%
Release of carpal tunnel	General Surgery	1,303	533	41%
Laparoscopic or open cholecystectomy	General Surgery	1,356	506	37%
Laparoscopy NOS	General Surgery	958	493	51%
Comprehensive oral examination	Dental Surgery	912	492	54%
Septoplasty	Otorhinolaryngology (ENT)	732	448	61%
Diagnostic hysteroscopy	Gynaecology	1,072	317	30%
Other		35,360	15,118	43%
Approximate missing Auckland waitlists		*10,041*	*360*	4%
Total waiting (early Jan 2025)		**89,857**	**36,045**	**40%**

18. Paper two will provide the additional surgical capacity/volumes required to reduce those waiting greater than four months and improve health target performance by 30 June and 31 December 2025. The work is to align bottom-up regional demand (including clinical advice on complexity) against available private hospital capacity and available funding.

19. This plan will account for the increasing number of people being placed on waiting lists, the complexity of the care provided and the internal and outsourced capacity. This assessment will include internal delivery opportunities and efficiencies.

20 S9(2)(b)(ii)

S9(2)(b)(ii)

21. Importantly, the cost of procedures is normally distributed. In other words, the costs to private hospitals are sensitive to patient complexity. At a regional and local level, working together to ensure appropriate patient selection is important so that private hospitals do not take on patients they may not be equipped to support and, consequently take on costs that may not be reflected in price. Analysis to determine the cost-efficient points for different procedures is a critical part of the decision-making process, hence, why longer-term relationships are important.

22. Longer term agreements with private providers will provide greater ability for Health New Zealand to negotiate on price and private providers can plan their activity (including investments) with greater confidence.

23. We need to work together on growing workforce. Longer term agreements and increased activity in the private sector means we can work together more closely on workforce issues that have a broader system impact. For example, as part of outsourcing arrangements we aim to negotiate that private hospitals also provide training opportunities to grow workforce. We also need to work together to enable transparency in employment arrangements where health professionals work in both public and private hospitals sometimes providing the same range of services.

Next steps

24. Health NZ will provide you with advice in the week of 13 February following consideration by the Commissioner when we can confirm funding, on our approach to securing additional delivery of treatment from private hospitals over the next 3-6 months. These opportunities to improve waiting times for elective care via longer term partnerships with private providers in conjunction with improved insourcing delivery.