Submission to the Commerce Commission

NZGA authorisation application and Southern Cross Health Insurance contracting conduct

PUBLIC VERSION - FOR PUBLICATION

Submitter	Intus Limited
Matter	New Zealand Gynaecology Association Inc application for authorisation and interim authorisation to collectively negotiate with Southern Cross Health Insurance and/or hospitals
Commission case	PRJ0049061
Version	Public version – confidential and commercially sensitive material removed
Date	16 June 2026

NOTE: This document deliberately omits Intus-specific pricing, revenue exposure, cost modelling, negotiation correspondence, patient examples, direct contact details, and confidential contract extracts. These matters are provided, where appropriate, in the confidential version and confidential annexures.

1. Executive summary

Intus Limited supports, in principle, the grant of interim and final authorisation for the applicant specialist society to collectively negotiate with Southern Cross Health Insurance, subject to clear safeguards. Intus also submits that the application should be understood as a response to a broader market concern: the effect of Southern Cross's dominant purchasing position in private specialist healthcare.

Southern Cross has legitimate objectives, including premium affordability, no-surprise billing, administrative efficiency and consistent claims decision-making. The concern is that, where a funder has very substantial buyer power, standardised contracts, fixed prices and unilateral eligibility rules may transfer clinical, cost, access and innovation risk to fragmented providers in ways that affect patients and the wider health system.

In Intus's view, the NZGA application is a symptom of monopsony-style buyer power. Collective bargaining may mitigate the imbalance for one specialty, but it does not resolve the underlying structural concern. If the issue is dealt with only specialty-by-specialty, authorisation may leave intact a patchwork system in which each provider group must seek permission to respond collectively to the same centrally imposed contracting model.

2. Intus's interest and evidence base

Intus provides private specialist healthcare services and has direct experience of Southern Cross Affiliated Provider contracting. Intus is not seeking to prevent Southern Cross from managing claims costs. Rather,

Intus seeks to assist the Commission by describing how the current contracting model can affect quality, equity, access, service sustainability and innovation.

This public version summarises the evidence at a high level. The confidential version provides provider-specific evidence, including contract material, correspondence, cost modelling and de-identified patient examples.

3. Market context: dominant buyer power

The 2025 Southern Cross Annual Report records that Southern Cross pays over 68% of the value of all health insurance claims paid in New Zealand and makes up 60% of the health insurance market. [2] This position gives Southern Cross substantial influence not only over members' insurance benefits, but also over the revenue, investment and service-design incentives of private healthcare providers.

In this setting, individual bilateral negotiation is not necessarily a meaningful counterfactual. A provider may be legally free not to accept Southern Cross terms, but may be commercially unable to absorb exclusion from access to such a large proportion of insured patient demand. That is the core monopsony-style concern.

4. Contracting architecture

At a high level, the agreement illustrates a contracting framework in which the funder sets or controls key parameters of reimbursed services, including service descriptions, service locations, eligibility, annual price movement, member charging restrictions, approval processes and unilateral changes linked to member policy changes.

Intus's concern is not that every such provision is illegitimate in isolation. The concern is the cumulative effect of these mechanisms when used by a funder with dominant purchasing power. The practical effect is that commercial and reimbursement settings are largely determined by the funder, while clinical responsibility remains with the provider.

5. Provider notices support the concern about eligibility control

Southern Cross provider notices supplied with the confidential submission support the concern that policy and eligibility settings can be changed by notice rather than through genuine negotiated clinical agreement with affected providers.

One notice acknowledged provider feedback and wording changes. Intus does not suggest that Southern Cross never receives feedback. The point is narrower: the substantive intent and implementation timetable remained determined by Southern Cross, and providers were instructed to apply the changed criteria when requesting approval or claiming under Affiliated Provider agreements.

Notice timing	Subject	Public relevance
Oct-Nov 2025	Skin lesion removal/minor skin surgery and Mohs surgery	Illustrates notified policy and eligibility changes, including

Notice timing	Subject	Public relevance
		changes affecting benign lesions and skin tags.
Dec 2025	Endoscopy under general anaesthesia or deep sedation	Illustrates new eligibility settings that affect whether certain forms of endoscopy will be reimbursed.
Dec 2025	Skin lesion removal or closure under GA/IV sedation; lipoma removal; hernia repair	Illustrates funder-defined criteria affecting access to cover for a range of specialist services.
Feb 2026	Anal/perianal skin lesions	Illustrates movement of some services into an Affiliated Provider-only pathway and the practical importance of provider contracting terms.

6. Specific conduct Intus asks the Commission to examine

The following matters are addressed in more detail in the confidential version and annexures. This public version states them cautiously as matters warranting examination, not as concluded legal findings.

Issue	Intus concern	Public detriment to examine
Eligibility and policy changes	Southern Cross can make policy and eligibility changes that determine whether clinician-recommended services are reimbursed.	Potential effects on patient access, clinical pathways, provider administration and public/private system balance.
Technology and innovation	Intus has confidential examples concerning funding treatment of robotic-assisted procedures compared with non-robotic approaches.	Potential slowing of innovation, reduced patient and clinician choice, and reduced incentive for hospitals and specialists to invest in new capability.
Regional pricing	Intus has confidential evidence concerning higher costs of delivering services in locations such as Queenstown and Wanaka.	Potential reduced regional access, increased patient travel, and inequity between metropolitan and regional communities.
Indexation and healthcare input costs	General CPI is not necessarily a good proxy for specialist healthcare delivery costs.	Potential progressive erosion of provider capacity to fund staffing, compliance, equipment,

Issue	Intus concern	Public detriment to examine
		support services and safe service delivery.
Pricing methodology	Intus provided Southern Cross with a structured pricing methodology based on resource use, complexity, risk and follow-up. Southern Cross considered the material but continued to rely significantly on market pricing.	Potential self-referential pricing where the dominant purchaser materially shapes the market it then benchmarks against.

7. Consequences for quality, equity and access

Tight, commoditised fee constraints affect more than provider margins. They change the service model that providers can sustainably offer, and therefore affect the quality, equity and accessibility of private healthcare.

This submission does not ask the Commission to determine whether standardised pricing is inherently inappropriate. It asks the Commission to examine the effects when such pricing is imposed by a dominant purchaser with monopsony-style buyer power. In that setting, Southern Cross's pricing and eligibility decisions may operate as de facto market settings that limit providers' ability to innovate, differentiate services, respond to regional cost differences, or maintain higher levels of patient support.

7.1 Service quality - pressure towards a minimum viable service model

Where bundled prices do not recognise education, emotional support, patient navigation and follow-up, providers may be unable to sustain the level of wrap-around care that patients value. The public detriment is not merely lower provider income; it is the risk that the funded service model shifts toward the minimum viable model rather than the model that best supports patient understanding, compliance and continuity.

For example, Intus considers that some patient-convenience and compliance supports, such as directly supplying preparation materials for procedures, are difficult to sustain where the cost cannot be recovered through either the funder or a transparent patient-funded option. The confidential evidence provides examples.

Similarly, modern procedural quality may involve additional equipment, time, technology, staffing, audit and compliance requirements. A pricing model that treats a procedure as static over time may fail to recognise how clinical practice and patient expectations develop.

7.2 Equity - complex patients and patients with co-morbidity

Flat procedural pricing can disadvantage patients whose care requires more time, monitoring, preparation or aftercare. Patients are not homogeneous. They differ in co-morbidity, medication risk, anaesthetic risk, frailty, disability, anxiety, language needs, social support and travel burden.

Where pricing does not recognise those differences, providers are disincentivised from investing in the additional resources required to support complex patients. The practical effect may be that fitter, lower-risk patients have better practical access to private care than patients with chronic health conditions or higher support needs.

7.3 Regional equity

Regional access is threatened where the cost of providing services outside metropolitan areas cannot be recovered. The confidential evidence describes additional regional delivery costs, including travel, accommodation, premises, staffing and freight. If those costs are not recognised, regional services may become less sustainable and patients may need to travel to major centres.

That outcome would reduce the practical value of private health insurance for regional communities and may shift cost and pressure back to patients and the public system.

7.4 Access and continuity

Practices incur real costs in maintaining after-hours accessibility, answer services, clinical triage arrangements and weekend capacity. If those costs are not recognised in the funding model, practices are economically encouraged to restrict availability to standard business hours.

That may fragment private care and shift out-of-hours problems arising from private care into public acute services. It may also reduce patient choice where weekend or extended-hours services would otherwise be valuable.

7.5 Innovation and clinical autonomy

Innovation may be slowed where a dominant funder does not recognise new modes of delivering the same clinically indicated procedure. The public issue is not whether every new technology should automatically be funded, or whether every technology is superior in every case. The public issue is whether the reimbursement policy of a dominant purchaser can materially influence technology adoption, hospital investment, clinician recruitment and patient choice.

The confidential evidence includes examples concerning robotic-assisted surgery. Intus asks the Commission to examine whether funding policies of this kind suppress innovation or interfere with clinically appropriate development of specialist services.

7.6 Prior approval and eligibility

Eligibility criteria and prior approval processes operate as gateways to care. Where a dominant funder changes those criteria by notice, or applies them in ways that providers consider difficult to reconcile with clinician advice, patients may experience delay, confusion or reduced access.

The confidential evidence includes de-identified patient examples. Intus asks the Commission to examine whether unilateral eligibility control by a dominant purchaser has system-wide consequences for access to private specialist healthcare.

The relevant public detriment is therefore not merely lower provider revenue. It is the potential reduction in quality, service differentiation, innovation, regional availability and capacity to treat complex patients. In a market where Southern Cross's purchasing decisions may operate as de facto market settings, these are not isolated contractual consequences; they are system-wide effects that warrant closer examination by the Commission.

8. Collective bargaining helps, but does not solve the underlying problem

Intus supports the NZGA application because collective bargaining may create public benefits: better information flow, more efficient negotiation, a clinically informed reference framework, and some countervailing constraint on Southern Cross buyer power.

However, collective bargaining by one specialty does not cure the underlying monopsony-style concern. It may leave the structural issue unresolved if the system evolves into repeated specialty-by-specialty applications to respond to the same unilateral funder model. The Commission should treat the application as evidence that the existing market may not be functioning as a normal competitive negotiation.

9. Requested Commission action

Intus respectfully asks the Commission to consider the NZGA application as evidence of a broader structural problem rather than as an isolated specialist group seeking collective bargaining permission.

1. Grant interim authorisation only to the extent necessary to enable good-faith discussions, necessary information exchange, and a short standstill that preserves patient access.
2. Examine Southern Cross's underlying conduct as a dominant purchaser of private specialist services, including eligibility changes, innovation funding, regional cost recognition, pricing methodology, and the cumulative effects of commoditised fee schedules.
3. Assess the impact of that conduct on non-price competition, including quality, service differentiation, regional access, innovation, workforce sustainability and provider entry or exit.
4. Consider whether further inquiry, information requests, monitoring or investigation is required under the Commerce Act 1986, including the substantial market power provisions applying to firms that acquire goods or services.

10. Suggested safeguards if authorisation is granted

- Limit the authorisation to the services, parties and contractual terms directly relevant to the application.
- Limit information exchange to what is reasonably necessary, with aggregation or independent adviser controls where appropriate.
- Preserve individual providers' ability to enter bilateral agreements and to compete on service quality, availability and innovation.
- Prohibit coordination on unrelated services, self-pay patients, ACC work, public work or other funders.
- Require monitoring of patient access, regional availability, waiting times, provider participation, innovation impacts and complaints.
- Require review during the authorisation period rather than allowing an unexamined 10-year framework.

11. Conclusion

The Commission should view this application as more than a question of whether one specialist group may bargain collectively. It is evidence of a deeper imbalance in private healthcare. Southern Cross's scale, combined with eligibility control, fixed and commoditised pricing, regional cost issues, innovation funding

issues and limited uptake of objective pricing methodologies, may affect quality, equity and access for patients across New Zealand.

Intus therefore supports authorisation subject to safeguards, but respectfully asks the Commission to look more deeply into Southern Cross's monopsony-style purchasing conduct and its impact on specialist healthcare sustainability.

Sources reviewed

[1] Commerce Commission case register, New Zealand Gynaecology Association Inc, PRJ0049061, opened 25 May 2026.

[2] Southern Cross Medical Care Society Group, 2025 Annual Report - Summary.

[3] Commerce Commission, Information for businesses with market power; Authorisation Guidelines, June 2023.

[4] Southern Cross provider notices to Intus dated 16 October 2025, 18 November 2025, 17 December 2025 and 26 February 2026 concerning policy changes and eligibility criteria.

[5] Southern Cross Medical Care Society and Intus Limited Affiliated Provider Agreement IGE030203, 1 April 2026 to 31 March 2029, reviewed in confidential version only.