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11 August 2026

The Registrar
Commerce Commission
Wellington

Kia ora,

My name is Professor Jaime King and I have been asked by the New Zealand Private Surgical Hospitals Association to provide an unbiased, academic assessment of the implications of the New Zealand Gynaecology Association Inc.'s Application seeking Authorisation and Interim Authorisation for Collective Bargaining for competition and healthcare. While I have been paid for the time needed to prepare this letter, the opinions and findings within are my own, and do not represent those of the New Zealand Private Surgical Hospital Association or the University of Auckland. I appreciate the opportunity to give you my thoughts on this matter and your time in reading this letter.

To give you a brief sense of my background, I am currently the Head of School and the John and Marylyn Mayo Chair in Health Law at the University of Auckland, Faculty of Law. Prior to joining the University of Auckland, I was the Associate Dean and Co-Director of the UCSF/UC Law SF Consortium on Health Law and Policy which is a joint initiative between the University of California San Francisco's Medical Sciences campus and the University of California College of the Law in San Francisco. I co-founded and directed The Source on Healthcare Price and Competition, a multidisciplinary web-based resource for information and analysis about healthcare markets, competition, and regulation. My research over the last thirteen years has focused extensively on the impact of healthcare provider market power on healthcare price, quality, and access. In 2015, I was called to testified before the U.S. House of Representatives Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law on issues surrounding proposed health insurance mergers. I have also testified before the California State Legislature, advised the California and Rhode Island Attorneys General, and several state health departments on matters of healthcare competition. In terms of my training, I hold a Ph.D. in Health Policy from Harvard University, a J.D. from Emory University, and B.A. from Dartmouth College. I held a two-year post-doctoral fellowship at Stanford University School of Law. I have attached a CV with my publications and additional details.

By way of disclosure, I hold private insurance from Southern Cross. As a result, I am interested in lower premiums for my health insurance, but as a woman, I am also interested in appropriate and comprehensive access to gynaecological services, especially related to surgery. As a health law and policy scholar, I care deeply about affordable access to healthcare for everyone and have dedicated the bulk of my professional career to the use of law and policy to promote health and improve healthcare. In my opinion, the matter before you is one that requires careful consideration and a delicate balance of interests, as I am sure you know.

As you also know, Section 58 of the Commerce Act 1986 permits you to authorise an arrangement that may restrict trade that "will in all the circumstances result, or be likely to result, in a benefit to the public which would outweigh the lessening of competition that

would result, or be likely to result therefrom."[1] Furthermore, the Act counsels that the Commission must not grant an authorisation relating to an application under section 58(6B) to (8) unless it is satisfied that granting the application "will in all the circumstances result, or be likely to result, in such a benefit to the public that the matter should be permitted."[2] As such, I will focus my comments on the potential lessening of competition that may result from the proposed arrangement as well as the implications for the public in terms of price, quality, and access to healthcare services for the public.

Potential Lessening of Competition

Private health insurance markets are difficult to discipline through competition due to market imperfections such as asymmetric information regarding the need for care and the cost of care, an inelastic demand curve for many services, insurance payments which shield patients from the true price, and the misaligned incentives for different market actors.[3] As such, healthcare markets require significant oversight and regulation to maintain market balance.

Impact on Prices

The United States, while an outlier in healthcare on many measures, provides a useful exemplar of the challenges facing private healthcare markets and the potential results. Within private healthcare markets in the United States, the research is compelling – hospitals and doctors that face less competition charge higher prices to insurers and consumers with little to no gains in efficiency or quality of care.[4] Scholars have found similar results in private markets in Australia[5] and the Netherlands.[6] The market power enjoyed by healthcare providers has contributed significantly to the dramatic rise in American healthcare prices and overall healthcare spending in the last several decades.[7] That said, research also demonstrates that dominant insurers or insurers in less competitive markets may use their market power to pay lower prices to providers.[8] Regardless of where the dysfunction lies, the burden of poorly functioning healthcare markets will be borne by individuals – either through increasingly high or out of reach health insurance premiums or through lack of access to services as providers move elsewhere or from reductions in the number of services covered.

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[1] Section 61(6) of the Act, applying to Sections 58 (1) to (6A).
[2] Section 61(8) of the Act, applying to Sections 58(6B) to (8).
[3] Michael Chernew "The Role of Market Forces in US Health Care" (2020) 383 N Engl J Med 1401.
[4] See for example Martin Gaynor, Farzad Mostashari and Paul B Ginsburg "Making Health Care Markets Work: Competition Policy for Health Care" (April 2017) Brookings Institution <www.brookings.edu> at 4–5; Zack Cooper, Stuart V Craig, Martin Gaynor and John Van Reenen "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured" (2019) 134 QJ Econ 51; Paul B Ginsburg "Wide Variation in Hospital and Physician Payment Rates: Evidence of Provider Market Power" (2010) Center for Studying Health System Change Research Brief No 16 <www.hschange.org>; and Martin Gaynor "Examining the Impact of Health Care Consolidation" (statement before the Committee on Energy and Commerce Oversight and Investigations Subcommittee, US House of Representatives, Washington DC, 14 February 2018) at 5.
[5] Hugh Gravelle, Anthony Scott, Peter Sivey and Jongsay Yong " Competition, Prices and Quality in the Market for Physician Consultations" (2016) 64 J Ind Econ 135.
[6] RS Halbersma, MC Mikkers, E Motchenkova and I Seinen "Market Structure and Hospital-Insurer Bargaining in the Netherlands" (2011) 12 Eur J Health Econ 589.
[7] Gaynor, Mostashari and Ginsburg, above n 4, at 4–5.
[8] Eric T Roberts, Michael E Chernew and J Michael McWilliams "Market Share Matters: Evidence of Insurer and Provider Bargaining over Prices" (2017) 36 Health Aff 141; Halbersma, Mikkers, Motchenkova and Seinen, above n 6; and Martin Gaynor "What to Do About Health Care Markets?" (2020) Hamilton Project <www.hamiltonproject.org> at 20–21.

For many decades, healthcare insurers and other payers around the world have sought to control spending by moving away from fee for service payments, which incentivise overutilisation of services and in some cases allow providers, especially specialists, to set their price. One method of controlling price through affiliated provider programmes, like the one initiated by Southern Cross Health Insurance (SCHI). The goal of affiliated provider programmes is to enable an insurer to negotiate sustainable/reduced payment rates with providers in exchange for preferred status in the health insurance plan, such that they should attract a higher volume of patients.

The proposed arrangement by NZGA would enable its members, approximately 90% of gynaecologists in New Zealand, to negotiate collectively with not only SCHI, but also other insurers and private hospitals. This arrangement significantly reduces the potential for the Affiliated Provider programme to promote competition over price and quality of gynaecological services. Negotiating as a group with insurers and hospitals will enable NZGA to demand higher prices for gynaecological services for all providers or threaten to not be a part of the Affiliated Provider network at all. SCHI would face the decision of whether to not cover gynaecological services, making their plans unattractive to members, or pay the demanded rates. In many cases, the insurers end up paying the demanded prices and passing the expense through to their customers via increased premiums in order to maintain broad coverage in their health plan. As detailed below, the ability of independent provider associations, like NZGA, to refuse to negotiate entirely if their demands are not met has proven a powerful tool to drive price increases and is often met with swift action from enforcers.

Examples from Other Nations

Collective negotiation by independent providers grants them the ability to make unified demands regarding price, terms, and whether to participate in negotiations with payers. Below I provide some examples of such behaviour in different countries and the competitive results.

In the United States, collective negotiation by independent physicians is generally treated as price fixing in the absence of genuine clinical integration. Between 2001-2026, the Federal Trade Commission brought approximately 40 complaints against associations of independent physicians for negotiating on behalf of their members.[9] These cases were summarised in an Overview of FTC Actions in June 2026.[10] In most instances, the collective negotiation resulted in allegations of significant price increases and refusal to deal if price demands were not met, resulting in harm to consumers and competition. Final orders in these cases frequently prohibit the association from entering into or facilitating agreements between physicians: 1) to negotiate with payers; 2) to deal, not deal, or threaten to not deal with payers; 3) regarding specific terms for dealing with payers; and 4) to not deal individually with a health plan.[11] In a similar matter to this one, an independent practice group made up of nearly every OB/Gyn in Napa County, California collectively agreed to prices and other contract terms in negotiations with payers, and then collectively refused to deal with them.[12] The Final Order from the FTC required dissolution of the independent practice group and

[9] Bradley S Albert, Kara Monahan and Lauren Peay "Overview of FTC Actions in Healthcare Services and Products" (June 2026) Healthcare Division, Bureau of Competition, Federal Trade Commission <www.ftc.gov/system/files/ftc_gov/pdf/Overview-Healthcare.pdf> at Part II.B.

[10] At Part II.B.

[11] At Part II.B.

[12] Obstetrics and Gynecology Medical Corporation of Napa Valley, Docket No. C-4048, Decision and Order, FTC (2002) <www.ftc.gov/enforcement/cases-proceedings/0110153/obstetrics-gynecology-medical-corporation-napa-valley>.

forbade respondents from negotiating on behalf of physicians, agreeing to refuse to deal with payers, or agreeing on any terms with payers.[13]

Physicians and other providers in broad health systems have also used market leverage to contract with insurers on "all-or-nothing" bases – take all of us at the demanded price or none of us will join your insurance network– essentially unifying network inclusion and prices throughout the system. This collective negotiation by physicians and health systems with market power has resulted in significant price increases.[14] In the United States, the price increases have been so detrimental that a handful of states have used legislation to prohibit the use of "all-or-nothing clauses" in contracts between health providers and insurers.[15]

A recent example from Chile is also directly on point.[16] Chile has parallel public and private health systems, with private provider rates negotiated independently with insurers. In 2011, 26 of the 29 gynaecologists (~90%) in Ñuble formed the Gynaecologists' Association of Ñuble to negotiate with insurers. The following year after six months of unsuccessful negotiations with insurers, association members simultaneously cancelled their contracts with insurers and established their own minimum fees for office visits and named a single representative for all future negotiations.[17] As a result, all Association members became out-of-network and "out-of-pocket visit prices rose almost 200% on average."[18] Nearly two and a half years later, the National Economic Prosecutor challenged the practice on antitrust grounds, which was ultimately abolished as collusive by the Supreme Court.[19] Economists estimated that the decision to leave the insurer jointly resulted in profits 2.5 times larger than if an individual gynaecologist had decided to leave the network independently.[20] This gap in price was large enough to eliminate any surplus created by agreement with the insurers.

In Canada, provincial governments negotiate with organisations of private physicians over the prices and payment for healthcare services. Following provincial government attempts to control costs through the use of global budgets in the 1990's, independent physician organisations began to strategically rotate regional office strikes, short-term withdrawals of certain services offered by certain specialities, and strengthening negotiating terms to increase physician wages and improve contracting terms.[21] These strategies and a desire by provincial governments to keep the peace with physicians has resulted in a steady increase of physician salaries from CA$187,134 in 2001 to CA$248,113 in 2010.[22] This increase is the fastest growth in physician salaries since the introduction of public insurance.[23]

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[13] Obstetrics and Gynecology Medical Corporation of Napa Valley, above n. 12.

[14] Katherine L Gudiksen, Alexandra D Montague, Amy Y Gu, Brent Fulton and Thomas L Greaney "Preventing Anticompetitive Contracting Practices in Healthcare Markets" (September 2020) The Source on Healthcare Price and Competition <www.sourceonhealthcare.org>; and Katherine L Gudiksen, Alexandra D Montague and Jaime S King "Mitigating the Price Impacts of Health Care Provider Consolidation" (23 September 2021) Milbank Memorial Fund <www.milbank.org>

[15] The Source on Healthcare Price and Competition "Provider Contracts: Restriction of All-or-Nothing Practices" <www.sourceonhealthcare.org>.

[16] Jorge Alé-Chilet and Juan Pablo Atal "Trade Associations and Collusion among Many Agents: Evidence from Physicians" (2020) 51 RAND J Econ 1197.

[17] At 1198.

[18] At 1198.

[19] At 1198.

[20] At 1198.

[21] Hugh M Grant and Jeremiah Hurley "Unhealthy Pressure: How Physician Pay Demands Put the Squeeze on Provincial Healthcare Budgets" (2013) University of Calgary School of Public Policy Research Papers vol 6 issue 12, Social Science Research Network <www.ssrn.com>.

[22] At 12.

[23] At 11.

Overall, the evidence from different nations is quite similar. Collective negotiations by physician organisations typically result in higher prices, which harm both consumers and competition. Antitrust enforcers overseas typically prohibit this behaviour and look to other ways to protect competition when insurers have sufficient monopsony power to depress prices. By granting NZGA the ability to collectively bargain with insurers and private hospitals, the proposed arrangement is likely to reduce competition for gynaecological services in New Zealand by which insurers and other payers have the ability to negotiate based on price, quality, and volume of services.

Impact on Other Physicians and Providers

Furthermore, the nature of the proposed arrangement does not align well with the proposed plan by SCHI to bundle payments for gynaecological services. Under this plan, SCHI would pay one price to private hospitals that provide care to Southern Cross members, and then the private hospitals will divide that payment between the gynaecologists, anaesthesiologists, any other providers that participate in the procedure, and itself. Bundled payments are a common form of payment for health care services, and have the potential to provide administrative simplicity for patients, improve or not harm quality of care, and reduce spending growth.[24] Bundling eases pressure on patients to contact and contract with multiple providers and eliminates the unrealistic expectation that patients know and understand the market forces in private health care and can meaningfully negotiate over price with individual specialists, especially when they are sick. Private insurers and hospitals are in a significantly better position to negotiate with specialists over price than patients. Yet, collective negotiation between all NZGA members and insurers or private hospitals over its share of the bundled payment is likely to either increase the overall size of the bundled payment or reduce the payments to other providers involved in services with NZGA members.

The likely flow on effect of approving NZGA's request is that other healthcare provider organisations will apply immediately for similar approvals to bargain collectively with insurers and other payers. I do not see a logical distinction that would enable the Commission to permit NZGA to collectively bargain, but deny similar requests from other healthcare provider organisations. If all healthcare provider organisations were granted the ability to collectively bargain with insurers and payers, this would significantly hinder competitive negotiation in private healthcare based on quality and price. The likely results would be increased private insurance premiums over time and reductions in incentives to improve quality or innovate.

Implications for the Public

The potential implications for the public of the proposed arrangement are quite significant, both in terms of increased prices and reduction in access to gynaecological services. Furthermore, the likelihood of other specialist and provider organisations submitting similar requests if NZGA's proposed arrangement is permitted increases the significance to the public.

In terms of price, the implications for the public are clear and in one direction. The cost of gynaecological services in New Zealand are likely to be higher and increase more quickly under the proposed arrangement than under SCHI's Affiliated Provider proposal. As a result, the price of private insurance and private gynaecological surgery is likely to increase

[24] Jeroen N Struijs, Eline F de Vries, Caroline A Baan, Paul F van Gils and Meredith B Rosenthal "Bundled-Payment Models around the World: How They Work and What Their Impact Has Been" (April 2020) Commonwealth Fund <www.commonwealthfund.org>.

throughout the country. If private hospitals must give a larger share of money from bundled gynaecological services to gynaecologists, they are likely to increase the price of other medical services provided in the hospital, a practice known as "cost shifting." From any perspective, the increase in prices paid to gynaecologists as a result of the proposed arrangement will end up being borne by consumers via higher insurance premiums or payments directly paid to providers. As other specialist and provider groups seek similar arrangements, the prices for their services are likely to increase as well. If premiums increase too much, some consumers will drop private health insurance and rely exclusively on the public system for healthcare services.

The implications for access to care are less straightforward. Increased prices and reductions in private insurance are likely to reduce affordable access to private gynaecological services. On the other hand, failure to adequately compensate gynaecologists and restricting coverage for services can also result in reductions in access to care. If conditions become unfavourable, gynaecologists may simply decide to leave New Zealand and find higher pay and better conditions in other countries, further reducing access in both the public and private system. This is very important to avoid and requires delicate balancing.

The availability of the public health system in New Zealand provides an important backdrop to these considerations. For the majority of individuals living in New Zealand, it reduces concerns about a complete lack of access to gynaecological services if private gynaecological services were not covered by insurance or if premiums became so high that patients did not purchase private insurance. That said, access to gynaecological services in the public system is under significant strain,[25] with reports of women waiting several months for a specialist appointment and then several more months for surgery.[26] There is a risk to the public healthcare system embedded in this issue – if gynaecologists work in both the public and private system, and they do not continue to make sufficient wages in the private system to meet their income needs, they may leave the country, creating access deficits in both the public and private systems. Unpublished data from the Medical Council of New Zealand's Medical Workforce Survey of 2024 indicates that over a quarter of gynaecological hours are spent in private practice.[27] Ensuring that gynaecologists earn a sufficient and comparable wage to other comparator nations will be essential to maintaining the right balance between insurer and provider market power.

The market power held by SCHI is quite dominant in New Zealand, and threatens to artificially depress prices paid to healthcare providers. In addition, the use of preexisting condition exclusions in New Zealand diminishes the ability of health insurance customers to switch easily between health insurers – hindering competition and entrenching market power in insurance companies with strong market share, like SCHI. One possibility would be to enable NZGA and other provider organisations to collectively negotiate with SCHI and other insurers about what services should be covered and the nature of the coding for billing to ensure that New Zealanders will have access to appropriate services and healthcare providers will have the complexity and nature of their services appropriately recognised, but then allow insurers or private hospitals to negotiate separately with physicians or physician practice groups over the prices paid and the volume of services. In addition, the Commerce

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[25] Association of Salaried Medical Specialists "A Spreading Problem: Changes in Distribution of Medical Specialists between Public and Private Work – 2022 to 2024" (2025) at 8 (citing unpublished Medical Council of New Zealand data gathered during its Workforce 2024 survey, showing that New Zealand would need 31 additional gynaecologists to be proportionate with Australia).

[26] Royal Australian and New Zealand College of Obstetricians and Gynaecologists "RANZCOG Raises Alarm over Crisis in Access to Gynaecological Care in Aotearoa New Zealand" (press release, 2 April 2025) <www.ranzcog.edu.au>.

[27] Association of Salaried Medical Specialists, note 25, above n 25, at Figure 3.

Commission could agree to review prices paid to private healthcare providers in New Zealand on a regular basis (every 3 years) to ensure that health insurers were not abusing their monopsony power. Such a review is essential to retaining specialist services in New Zealand and high-functioning public and private healthcare systems, as many providers work in both systems.

Conclusion

Given the risks of higher prices, refusals to deal, threats of refusals to deal, and potential harm to consumers and other providers, the benefits of the proposed arrangement do not appear to outweigh the impact on the public and the implications for competition. However, I would encourage the Commerce Commission to take the claims of NZGA regarding the market power of SCHI quite seriously and look for viable options to maintain appropriate pricing levels for all physicians and healthcare providers. This could be done through regular reviews of price and other negotiated terms between dominant health insurers and providers, as well as increased quality transparency. In addition, the Commerce Commission could consider imposing regulations on SCHI to promote competition in private health insurance markets, including removing or limiting preexisting condition exclusions and standardising some coverage plans.