



Assessment of economic issues in the draft determination on the NZGA Authorisation

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Executive Summary

1. In our review of the draft determination, we find that the Commission's preliminary views understate SCHI's monopsony power and, as a result, do not appropriately assess the likely benefits and detriments of the authorisation of arrangements proposed by the New Zealand Gynaecology Association (NZGA).
2. SCHI holds an approximate 60% share of private health-insurance customers and 68% share of claims. That size, in combination with the fact that alternative sources of demand are not sufficiently large, timely, and commercially equivalent to discipline SCHI's purchasing terms, make SCHI an unavoidable trading partner for many gynaecologists. SCHI's ability to impose standardised APS terms and reduce average fees by at least 30%, and potentially closer to 50%, particularly for complex bundled procedures, is consistent with the exercise of substantial buyer power.
3. SCHI's not-for-profit status does not exempt it from holding or using monopsony power. While there is some truth to the hypothesis that SCHI as a member-owned society has an incentive to ensure that gynaecologists' fees are set at levels that enable a sufficient supply of high-quality gynaecological services for members, in practice, management's incentives plus the fact that they are neither all-knowing nor unbiased materially weaken the link between SCHI's mission and mission implementation.
4. It appears that the Commission's preliminary view is that SCHI would not be an active player when gynaecologists negotiate with hospitals, but instead would sit out such negotiations accepting whatever was negotiated. However, SCHI implicitly is a party to the negotiations through its exclusive agents and is always their final backstop. It is exactly that exclusivity, granted at SCHI's prerogative, that would enable it to cut rates on average by 30% to 50%. It is therefore not credible that SCHI would not exercise its influence, most especially if not doing so would, as the Commission suggests, defeat the whole purpose of its affiliated provider undertaking.
5. Authorisation would not confer equivalent market power on gynaecologists: they would retain individual contracting autonomy and only gain access to NZGA-negotiated benchmarks and improved information. Those arrangements should modestly strengthen bargaining and support better-designed contracts without enabling coordinated withdrawal or binding minimum pricing. Moderately higher fees in the factual are therefore likely to improve efficiency by sustaining complex procedures, private-sector capacity and workforce entry and retention, while reducing negative spillovers to the public system and avoiding the increase of long-term funding pressure on the public system.
6. Even if it were true that the authorisation would enable gynaecologists to gain substantial market power with the implication that gynaecologists with SCHI, through its exclusive agents, would be bilateral monopolists, then standard theory suggests that would imply a relatively efficient market outcome.
7. We were also asked to review the empirical analysis contained in the report that was prepared by NERA as a cross-submission to the SOPI. That analysis is irrelevant to the question of whether the authorisation will result in a net public benefit. This is because, rather than considering public benefits and detriments of the authorisation relative to the counterfactual - SCHI's affiliate program (AP) with no authorisation - NERA has focused on outcomes under

FFS. It is not clear whether the Commission has relied on that analysis. However, as the results described in the NERA report could influence the Commission's view on various aspects of the benefits and detriments analysis, we have provided some detailed comments on data and methodology. As there were significant parts of that NERA's report that were redacted in the, we have not been able to able to fully test the methodology and conclusions, but have identified questions and issues that we would recommend the Commission scrutinise if it intends to rely on that analysis, either directly or as background context.

8. While the empirical analysis of price changes presented by NERA report is essentially irrelevant at one level - it does not compare the world with and without the authorisation - it also epitomizes the problem SCHI has. To the degree that the data it has relied on is misleading, as we suspect it must be, then, beyond invalidating NERA's analysis, it demonstrates how difficult it will be for SCHI to set efficient prices for procedures, which is exactly the problem the authorisation seeks to address.
9. We find that overall, the available evidence supports authorisation as likely to produce a net public benefit by constraining monopsony-driven underpayment and protecting the quantity, quality, range and continuity of gynaecological services.

1 Introduction

10. Link Economics has been engaged by Matthews Law, on behalf of the New Zealand Gynaecology Association (NZGA), to review and comment on the Commerce Commission's preliminary views set out in its draft determination on the NZGA's application for the authorisation (Draft Determination). We focus on the treatment of monopsony power, the implications of that power for outcomes and for key types of benefits and detriments.
11. We note that in submissions on the Statement of Preliminary Issues (SOPI), NERA has prepared a report for SCHI which included analysis of historic pricing of gynaecological services. We have provided comments on that analysis in section 4.
12. For convenience, when referring to paragraphs of the Draft Determination, we simply use the notation ¶.

2 Treatment of monopsony

13. Our review of the Draft Determination finds that the Commission does not appropriately weigh SCHI's exercise of monopsony power in reaching its preliminary views on the authorisation. We find that: SCHI's importance as the largest funder of private health services places it in a position of monopsony power; that its actions are consistent with holding and exercising that power; that SCHI's not-for-profit status does not exempt it from holding or using monopsony power; that Authorisation would not grant substantial market power to gynaecologists; and that SCHI is implicitly a party to the negotiations, and always the final backstop, which means that its monopsony power will drive outcomes. The welfare implications of these findings are discussed in Section 3.
14. We agree with the Commission that it seems likely that SCHI will continue with the deployment of the APS framework in the factual and proceed with our analysis on that assumption.

2.1 *SCHI's size gives it monopsony power*

15. SCHI has approximately 60% of private health insurance customers and accounts for 68% of claims (¶59; see also ¶177). Its scale makes it an unavoidable trading partner for gynaecologists seeking to provide privately funded services. Losing access to SCHI-funded patients would remove a substantial share of the demand available to most practices. That loss could not readily be replaced by patients funded by smaller insurers, self-funded patients, or public-sector work, particularly given the fixed costs of maintaining a private practice and the limits on how quickly a specialist can change workload, location, or practice model. The relevant constraint is therefore not whether some alternative demand exists, but whether those alternatives are sufficiently large, timely, and commercially equivalent to discipline SCHI's purchasing terms. They are not.
16. By contrast, SCHI can spread its purchases across many individual gynaecologists and hospitals, each of whom represents only a small share of its overall claims expenditure. And there are many gynaecologists, each of whom, in both the factual and the counterfactual, must bargain with private hospitals individually. This asymmetry makes the cost to an individual gynaecologist of rejecting SCHI's terms materially greater than the cost to SCHI of failing to reach agreement with that gynaecologist. It also gives SCHI the ability to set standard

rates, channel negotiations through affiliated hospitals, and credibly make take-it-or-leave-it offers. These are all characteristics of a buyer with substantial market power, independent of SCHI's market share. That market power, together with gynaecologists' dependence on SCHI-funded demand, the lack of sufficiently close alternative purchasers, and fragmented supply, gives SCHI the ability to depress prices or impose non-price terms below the level that would prevail under effective competition.¹

2.2 *SCHI's actions are consistent with monopsony power*

17. It is clear that SCHI has monopsony power and is exercising it. SCHI expects its actions to reduce prices by about 30% as compared with their expectation of FFS prices in each and every year over the next five years period (¶193 and Figure 2).² Further, that the reduction will be significant is an undisputed minimal expectation of the impact of the counterfactual. NZGA estimates that reduction to be 50%.³ Our review of current FFS pricing and the AP prices that have been provided to gynaecologists so far by hospitals is consistent with the NZGA estimate (see Appendix A for details of our price comparison).
18. No competitive firm can unilaterally force one of its suppliers to reduce their prices by such amounts by simply changing how it deals with those suppliers, let alone manage to do that through third parties. Further, SCHI's tool for achieving this goal is essentially a take-it-or-leave-it offer, a hallmark of substantial market power. In fact, SCHI is so powerful it has become the rate setter in at least some cases: some unaffiliated private hospitals are already using SCHI's rates in negotiations with gynaecologists: "NZGA found that pricing lists from different hospitals were near-identical for each procedure" (¶1384). Our review of prices, described in Appendix A, also shows identical pricing across unaffiliated hospitals for many procedures.
19. To put the market power inherent in SCHI's ability to reduce prices by 30% to 50% into context, we turn to the empirical analysis of pay transparency. Pay transparency—the making of all wage rates public—is often legally imposed to prevent unfair wage practices—but has an important drawback. It grants firms a degree of market power by putting them in the position of being able to make all-or-nothing offers to their own employees. This in turn harms labour and economic efficiency. What the literature shows, is that this grant of market power is small relative to the power SCHI obtains when it makes an all-or-nothing offer: pay transparency lowers prices by 2-4%, SCHI by 30% on its own admission, and in actuality potentially closer to 50%.
20. Pay transparency has a "spine stiffening effect": the employer knows that if they raise one person's wage, they will either have to raise the wage of every comparable worker, or face discontent and lower productivity from those other workers (see, e.g., Cullen, 2024, pp. 154, 159-164; see also Cullen and Pakzad-Hurson, 2023, especially 766). That grants the employer

¹ That shares matter as between insurers and medical providers is supported by Roberts et al., 2017, who using US data "estimated that—within the same [medical] provider groups—insurers with market shares of 15 percent or more (average: 24.5 percent)... negotiated prices for office visits that were 21 percent lower than prices negotiated by insurers with shares of less than 5 percent. Analyses stratified by [medical] provider market share suggested that insurers require greater market shares to negotiate lower prices from large provider groups than they do when negotiating with smaller provider groups."

² The APS gynaecology surgeon cost in Figure 2 of the Draft Determination is, in FY27, ~27% (= (66 – 48)/66) lower than the FFS cost and by 2031 the difference increases to ~34% (= (105 – 69)/105).

³ NZGA Authorisation Application, para 2.14(c)

market power in negotiations with many individuals doing similar jobs. They can credibly refuse a pay rise to one individual on the basis that it would amount to a pay rise for all. Yet, empirically, pay transparency only lowers wages by about 2% in the presence of collective bargaining (Cullen and Pakzad-Hurson, 2023, 768)⁴ and about nearly 4% otherwise (with economic efficiency declining with wages).⁵

21. The key difference between the two cases is firms in most environments only hire a small fraction of the people capable of doing any job type. In that situation, pay transparency across providers leads to greater competition between employers and broader employment searches by employees. The results are better matches, lower wage dispersion with labour being more efficiently priced, and higher average wages (Cullen, 2024, 154, 167-169). In contrast, SCHI faces little competition, being by far the largest ultimate hirer of gynaecologists for private hospitals.⁶ That allows SCHI, by making all-or-nothing offers, the capacity to cut wages an order of magnitude more than pay transparency would.
22. The ability to set rates that are least 30% lower than under FFS pricing for each year in a 5-year period, make all-or-nothing offers, and be a price setter on face demonstrates market power. Moreover, this is not avoided by observing that “it is unclear that there is a bargaining imbalance between individual gynaecologists and hospitals” (¶382).⁷ The price reduction is engineered by SCHI through its exclusive agents. It is that exclusivity which grants its agents monopsony power. To say, the bargaining balance between private hospitals and gynaecologists involves no monopsony power is to ignore a central fact of the case. Similarly, in the light of SCHI’s ability to dictate such terms the observation, whether true or not, that “[s]urgeons can move frictionlessly between hospitals” (¶382.1) does not allow the conclusion that “regardless of the funding model, hospitals compete vigorously to attract surgeons to their facilities” (¶382.1). Nor, as against SCHI’s 60-68% share of the insurance market (¶59), is it compelling to claim gynaecologists have market power because “[a]cross NZPSHA members, gynaecology represents approximately 6-7% per year of their total... discharges... more specialised hospitals... [share] of gynaecology surgeries and... total revenue can be much higher.” (¶63)
23. These simple but stark facts not only make it clear that SCHI is monopsonist, but also that individual gynaecologists have no market power when facing SCHI or its affiliates.

2.3 SCHI’s not-for-profit status does not exempt it from holding or using monopsony power

24. While a member-owned not-for-profit insurer is not a conventional profit maximiser, it still prefers lower costs because doing so reduces the premiums that it charges its members or

⁴ Collective bargaining offsets this source of market power with the bargaining parties, operating as bilateral monopolists, seeking an efficient outcome and sharing the gains between them (Cullen, 2024, 161-162; Cullen and Pakzad-Hurson, 2023, 766).

⁵ While Cullen and Pakzad-Hurson, 2023, represent the current empirical state of the art, Cullen, 2024, Table 1, shows other study estimates of the impact of wage transparency range from no effect to less than 4%. Cullen, 2024, 164, explains that it is largely the cases with collective bargaining that generate the no effect outcome.

⁶ Pay transparency has another effect which is efficiency enhancing: pay transparency over junior and senior positions tends to mildly increase wages and importantly productivity, largely because employees learn what promotion delivers thereby encouraging better performance (see, e.g., Cullen, 2024, 154, 166-167). Empirically this and the cross-firm competition effect are swamped by the first, lowering wages and economic efficiency.

⁷ The argument is developed across ¶¶380-389.

allows it to add extra benefits for members. That, in turn, allows it to grow its member base, providing additional scale and potentially improving its risk position by increasing the pool of insured persons. The not-for-profit constraint governs the destination of residual earnings but does not remove the incentive to obtain them.

25. It may be hypothesized, as the Commission does, that SCHI as a member-owned society has an incentive to ensure that gynaecologists fees are set at levels that enable a sufficient supply of high-quality gynaecological services for members.⁸ While there is truth to this proposition, there are two critical difficulties, which materially weaken the link between SCHI's mission and mission implementation. In both cases, the requested authorisation would reduce the resultant problems.
26. It is important to recognise that SCHI's managers are humans, and thus are neither all-knowing nor unbiased, and the Commission has not considered this. First, as evidenced by the losses SCHI has incurred in recent years (though not presently) and the extensive remedial actions it is now undertaking, SCHI managers cannot well-predict the effects of their actions. And this is not surprising: as all parties to this proceeding recognise, ensuring the efficient provision of medical care and insurance is extremely complex. Second, managers' interests are not typically the same as those of their employer/shareholders, and this too must be accounted for.
27. To develop these ideas, begin by assuming SCHI's management are able and willing to do their utmost to advance SCHI's goals, but are, like all of us, not all-knowing. Under the AP scheme, the easiest thing SCHI's managers can set and monitor is price, whereas they have much greater difficulty in identifying elements of quality, such as surgeon skill, optimal procedure lengths, the need for out-of-the ordinary procedures, patient-doctor interaction, etc. These non-price concerns are complicated and not readily measured, creating two reinforcing problems for SCHI. First, it is common for managers to focus on what they can control, even when more energy should be placed where management is the most difficult.⁹ Second, a well-known principle in economics is that as the number of goals of a principal increases, it becomes increasingly difficult to provide good incentives to its agent. In this case, to ensure the provision of appropriate quality services at reasonable prices—is increasingly weakened.¹⁰

⁸ The Commission expresses the view that that "SCHI has a structural incentive to ensure that fees are set at levels that maintain an adequate supply of high-quality gynaecological services for its members" (¶278.1, footnote omitted) and "to ensure that fees are at levels that maintain an adequate supply of high-quality healthcare services for its members" (¶290, footnote omitted). The Commission draws this conclusion essentially because "SCHI has submitted that as a members-focused friendly society, SCHI has a structural incentive to ensure that fees, including anaesthetists fees, are at levels that maintain an adequate supply of high-quality healthcare services for its members" (¶403, footnote omitted).

⁹ See, e.g., Heifetz, 1994 (on managers' preference for attacking "technical problems" which have clear and straightforward solutions, rather than complex problems that require adaptive change) and Michael, 1973 (on how managers over-invest in things they can measure and control, where instead they should focused on where they can learn).

¹⁰ A simple well-known example of this problem is the price cap. Setting a price cap provides good incentives to reduce costs as the price-capped firm claims the difference between its costs and prices. This could lead the price-capped firm to produce the same output at lower costs—a gain in economic efficiency. But it could also lead the firm to inefficiently cut quality, since this also reduces costs. More generally, this problem has spawned a wide literature and Nobel prize <https://www.nobelprize.org/prizes/economic-sciences/2016/summary/>). The seminal articles are Holmström & Milgrom, 1991, and Hart, *et al.*, 1997.

28. These difficulties, given SCHI's monopsony capacity to impose its will in the counterfactual, will lead to inefficiently low-quality gynaecology service. Yet quality is exactly where gynaecologists' incentives work to the benefit of patients. This is not to say that gynaecologists' incentives are exactly aligned with those of patients.¹¹ The point is that gynaecologists have better incentives to focus on service quality over all aspects of the patient-gynaecologist interaction, and are better informed on these matters, than SCHI's managers. For example, a patient receiving a high-quality experience is more likely to return or recommend the service to others, providing the gynaecologist with good incentives to provide excellent service. And the practicing gynaecologist is better placed than any other observer, except possibly the patient, to monitor the delivered experience and to understand what works better or worse.
29. While gynaecologists' interests in patient well-being do not change as between the factual and the counterfactual, two important things do. First, in the factual, despite continuing to negotiate as individuals, the bargaining position of individual gynaecologists is mildly enhanced, which will lead to more account being taken of their preferences for quality. Second, SCHI (directly or as acting through its exclusive agents), would be better informed, and hence would make better decisions than it would when it was essentially dictating terms. That is, even if the gynaecologists' raw bargaining positions were not strengthened, SCHI's preferences will likely change in their favor.
30. The second matter the Commission has not considered is that the factual would improve outcomes because SCHI's managers have their own goals, which in general do not align with those of SCHI, and no incentive structure can align their incentives with those of SCHI: SCHI's managers can and will behave in ways that might not be optimal from the perspective of SCHI.¹²
31. To illustrate, the present circumstance places managers in a position where quickly reducing costs, despite the impact of such actions on long-term service availability and both short- and long-term quality, would be attractive. After facing two years of deficits, SCHI's managers face substantial pressure to ensure SCHI's operations are made more sustainable. At the same time, SCHI's managers are understandably highly customer-focused, and well-aware that higher premiums will generate considerable member angst. Moreover, as the Commission recognised, higher premiums would also reduce subscriptions, which even if optimal—subscribers must be willing to cover the efficient costs of insurance—will lower the prestige and position of current managers. Thus, even when higher premiums are called for, this can be a difficult decision for managers to make. This makes alternatives that allow relatively easy cost cutting, e.g., through the exercise of monopsony power, attractive. Further, given we all can easily mistake an easy option for the right option, this may happen entirely without ill-intent.
32. In sum, in the factual, gynaecologists, in their individual negotiations with SCHI and/or its exclusive agents will be better placed to push back against the raw exercise of monopsony power. In addition, NZGA's negotiations likely will have two further beneficial effects. First, they would allow SCHI managers to better understand the impacts of their actions, which in of itself may lead them to take more careful consideration of harms to supply and quality or,

¹¹ A gynaecologist, even one that is not solely interested in maximizing its profits, would in general prefer a higher price for a given quality, while a fully informed patient and/or her agent would prefer the opposite.

¹² Again, following the literature encapsulated by the cited Nobel.

second, by throwing sunlight on the same, they may force managers to take actions that will more fully account for the well-being of their subscribers.

2.4 Authorisation will not grant significant market power to gynaecologists

33. As a preliminary, SCHI incorrectly considers that gynaecologists historically have had market power, because, “one would not expect... providers [to be] able to command materially different pricing outcomes. The evidence... demonstrates that providers may themselves possess bargaining power in particular regions and specialties.”¹³ Of course, it is perfectly normal in a workably competitive market for different providers to face different rates, whether because of the region in which they operate or their skillsets, including specialties.
34. In the factual, gynaecologists will not engage in collective bargaining, beyond NZGA’s benchmark negotiations. Instead, when it comes to contract negotiations they will negotiate individually with SCHI or its exclusive agents as they would in the counterfactual. No gynaecologist’s agreement will apply to another gynaecologist, and nor would one gynaecologist’s agreement be known to another (no pay transparency). And most obviously, gynaecologists will not be able to collectively refuse to treat SCHI-funded patients.
35. The difference between the factual and the counterfactual is merely that each individual gynaecologist will be armed with the knowledge of a benchmark. The Commission expects that having access to a benchmark rate would “raise... [gynaecologists’] fee expectations” (¶188), but it does not follow that this would allow the gynaecologists to effectively act as a collective. Access to the reference rates and agreements hammered out by NZGA will merely make the negotiating gynaecologists mildly better informed. Cheap information does not create substantial market power. Gynaecologists will continue to negotiate as individuals with a near or effective monopsonist. They will not know what other gynaecologists are bidding or earning. Each still faces a decision identical to the one they face in the counterfactual: turn down the SCHI offer for a large fraction of their business or accept it. Acceptance likely will be particularly tempting in the numerous cases where the SCHI offer exceeds negotiating gynaecologists’ current rates (¶187 and Figure 1).¹⁴ Gynaecologists currently obtaining more than the SCHI offer would also be tempted to accept the offer, recognising that if they do not take it, then they may be priced out by their rivals. Merely going into the negotiations with a benchmark—the difference between the factual and the counterfactual—does little to change this dynamic.¹⁵
36. SCHI’s additional fear that with “collective bargaining with pricing information disclosed... there is a significant risk that no higher-charging surgeons are willing to reduce their prices and that the highest prices become the ‘price floor’” is without basis.¹⁶ As discussed above, Cullen and Pakzad-Hurson, 2023, develop an empirically verified theoretical model that implies that if gynaecologist rates were transparent, then that would weaken their bargaining position against any employer (let alone one with the power of SCHI). Their model and empirical results further imply that if the gynaecologists were able to engage in collective

¹³ SCHI cross-submission, ¶3.10.

¹⁴ We cannot see the redacted Figure 1 from the Draft Determination, but the context in ¶187 makes it clear that there are gynaecologists that have prices below SCHI’s proposed APS pricing.

¹⁵ The dynamic will be changed for other, positive, reasons. For example, SCHI together with its exclusive agents will be better informed, and will thereby make better offers better accounting for service differences and the long-term viability of the profession. Price rises resulting from that would be efficiency enhancing.

¹⁶ Footnote 6 of the SCHI Cross-submission to the SOPI.

bargaining, which they are not, the loss in gynaecologist bargaining power due to price transparency would be somewhat offset, with bilateral monopoly negotiations leading to more efficient outcomes.

Modelling assumptions and evidence on price expectations

37. SCHI's claims the average rate in the counterfactual will rise in the factual by about 135% to levels well above SCHI's expected FFS trend.¹⁷ In making their predictions, SCHI assume "full surgeon participation in collective bargaining,"¹⁸ but in the factual there is no collective bargaining, so these estimates are not relevant.
38. Even putting the assumption of collective bargaining aside, such a large price rise seems implausible, yet SCHI provide little explanation as to how they arrived at their estimates. An example from Prof. King (at p. 4) of collective action by private physicians in Canada allows a direct calculation of price effects and illustrates the problem. The private physicians' action, coupled with "a desire by provincial governments to keep the peace with physicians" resulted in average annual salaries rising by nearly a third over nine years. This is a small change compared with SCHI's predicted jump of 135% in a single year. In fact, this is a small change on any measure, since some amount of this rise would be attributable to rises in medical costs generally and the compound annual change needed for that growth is 3.2% per annum.¹⁹
39. The NZGA conducted a survey of its members, asking what reduction in rates they would be willing to accept on FFS rates.²⁰ As can be seen from the following table, which contains the results of that survey, more than [] of respondents indicated that they would be willing to accept a reduction of some degree. These survey results are consistent with prices in the factual lying below the FFS trend.

Response	Count	Share
0-10% reduction		
11-20% reduction		
21-30% reduction		
I will not sign unless there is an increase		
No reduction (0%)		

40. While we would not necessarily expect all survey respondents to act in the way that they have indicated, we believe the survey provides some insight into gynaecologists' expectations.

¹⁷ Calculated from SCHI's 2027 cost estimates in Figure 2 of the Draft Determination. For example, in 2027, SCHI estimates rates in the counterfactual to be \$48 versus \$135 in the counterfactual, representing a change of ~135% (= (113 - 48)/48). In 2031, the change is ~130% (= (159 - 69)/69). SCHI also claims "NZGA-led price collective bargaining results in average prices increasing to the [] percentile... assum[ing]... all surgeons' fees (on average) move to the [] percentile, with lower-charging surgeons increasing their fees and higher-charging surgeons reducing their fees." Footnote 6 of the SCHI Cross-submission to the SOPI.

¹⁸ *Id.*

¹⁹ $1.032^9 = 1.33$. Prof. King provides other examples, e.g., of large increases in profit rates due to collective action, that are not readily comparable to SCHI's forecasts. Other aspects of Prof. King's evidence are discussed in an appendix. A key point in which we are in agreement with the Commission is that Prof. King's "examples [are] of limited assistance as those cases involved instances where medical professionals withdrew or threatened to withdraw services from more than one insurer") ¶196.

²⁰ The results of the survey were only visible to Link Economics and Matthews Law.

41. SCHI's claims in the counterfactual also rely on dubious assumptions. SCHI assume "no change in member behaviour or surgery mix... [or]... volume growth",²¹ which, after a 30% to 50% price cut is not only implausible but essentially assumes away any harms in the counterfactual. We discuss in section 3 below some of the allocative and dynamic efficiency impacts of such a price cut as well as the incurrence of significant renegotiation costs. It is perhaps not irrelevant that the Canadian case Prof. King describes occurred "[f]ollowing provincial government attempts to control costs through the use of global budgets" which resulted in "independent physician organisations... strategically rotat[ing] 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."

2.5 SCHI remains a key participant in the APS

42. It appears that the Commission has concluded that SCHI would not be an active player when gynaecologists negotiate with hospitals,²² but would sit out such negotiations accepting whatever was negotiated.²³ Yet, SCHI has gone to great lengths to set up its affiliated provider scheme, which its submissions make clear is very important to it. In any case, SCHI implicitly is a party to the negotiations through its exclusive agents, and always their final backstop. It is exactly that exclusivity, granted at SCHI's prerogative, that allowed it to cut rates by 30% to 50%. It is therefore incredible that SCHI would not exercise its influence, most especially if not doing so would, as the Commission suggests, defeat the whole purpose of its affiliated provider undertaking.²⁴
43. It is also not credible that if the gynaecologists were able to act as a unified collective (which does not describe the factual), SCHI would be rendered powerless. The Commission highlights that SCHI funds such a large share of gynaecological services in the private gynaecological market that it would be very vulnerable to concerted action by the gynaecologists (¶177, ¶186). If that is true, it is also true that the gynaecologists, who, in both the factual and counterfactual, must negotiate rates as individuals, are even more vulnerable to concerted action by one purchaser, SCHI. That is supported by the facts that SCHI can impose its affiliated provider program with its associated rate cuts and that historically gynaecologists, who no doubt have known their rates are substantially below some of their rivals, were still willing to accept those rates.
44. The alternative explanation that is more consistent with the facts, and which is the foundation of NZGA's application, is that SCHI has monopsony power, exercised through its exclusive affiliates, and it would use that power to obtain its desired ends in the factual.

²¹ Footnote 6 of the SCHI Cross-submission to the SOPI.

²² The Commission "expect[s] SCHI would continue to resist direct discussions with NZGA" (¶166) and "will resist attempts by NZGA to engage with it directly on price" (¶179).

²³ E.g., the Commission writes, "Negotiations on price between SCHI and NZGA will instead likely occur via hospitals... it is likely that the cost will be more directly felt by SCHI. For example, if all hospitals experience higher fee expectations from gynaecologists, and are unable to reach an agreement within their funding envelope, SCHI may be more inclined to meet these expectations and offer larger bundles that would allow hospitals to continue to feasibly offer services for gynaecology. Hospitals bear no material additional costs if FFS-based charging continues and gynaecologists decline to sign up to the APS." ¶180.

²⁴ *Id.*

3 Implications for benefits and detriments

45. The Commission examines numerous types of benefits and detriments. We focus on the implications for the supply of gynaecologists between the factual and counterfactual. The Commission appears to have concluded that the substantially lower prices of the counterfactual are an efficient outcome because SCHI has no monopsony power, or to the extent it has such power, it would not harmfully use it. It thus implicitly finds prices in the counterfactual must be efficient, so higher prices in the factual (whatever they are, and all parties agree prices will be higher in the factual) are inefficient. But we find above that SCHI is a near-monopsonist, which implies that at least moderately higher prices in the factual would be efficient. That leaves open the question of whether a sustained reduction of ~30% or more in average gynaecologist rates across five years would not be more harmful than prices in factual.
46. This section first shows that the price rise in the factual over the counterfactual is likely to be moderate. For argument's sake, it then considers the unreal case where authorisation would grant gynaecologists enough market power to make them bilateral monopolists against SCHI and/or its exclusive agents. The Commission's preliminary view about insurance prices is also touched on. The meat of the section then follows, providing concrete examples of how prices in the factual will substantially improve the efficient supply of gynaecological services with a focus on allocative efficiency. We also discuss the implications for the public health system, provide comments on transactions costs and point out that the dynamic efficiency gains of authorisation likely exceed all of these.
47. Having shown in Section 2 that SCHI is a monopsony position and having demonstrated substantial harm from SCHI's prices in the counterfactual, the section concludes that the factual's moderately higher prices will improve economic efficiency as compared with the counterfactual.

3.1 Prices in the factual and counterfactual

48. The material difference between the factual and the counterfactual is that individual gynaecologists, in their negotiations with SCHI or its exclusive agents, will have access to the NZGA benchmarks. This will have two impacts. First, given SCHI's monopsony power and the weak bargaining position of gynaecologists, our view is that access to the NZGA benchmarks (which is not price transparency) increases the bargaining position of the gynaecologists by less than 2-4%. We arrive at this number by analogy from the price transparency literature. In that literature, collective bargaining by labor results in prices 2-4% higher than occurs without collective bargaining. The reason for this is price transparency gives employers the ability to make *within-firm* all-or-nothing offers, and collective bargaining allows labor to respond as a bilateral monopolist. In our case, (1) SCHI is much more powerful than an employer in a standard industry in that it is able to set rates for most gynaecologists to the point that independent private hospitals follow its lead, and (2) gynaecologists do not have access to collective bargaining, but only to NZGA's benchmarks, so are much weaker than labor negotiating collectively. These two factors together suggest that, from the narrow perspective of bargaining power, gynaecologists cannot be expected to achieve anything like the 2-4% gains collective bargaining provides in the pay transparency case. This makes the 2-4% the upper bound of bargained wage recovery.

49. Second, with authorisation, negotiations between NZGA and SCHI and/or its exclusive agents will lead to more efficient pricing because SCHI and its exclusive agents will gain a better understanding of key aspects of gynaecological supply and access to more accurate information (for example, on complex cases). While this will result in more efficient outcomes (explained more in our analysis of potential losses) beyond those that the change in bargaining position would secure, we are not able to quantify the impact of this. However, given SCHI's market power and strong desire to reduce costs "come what may" we do not expect the summed impact of both factors to press gynaecological rates above efficient levels: they are likely to remain inefficiently low, even if better than in the factual.

3.2 What if gynaecologists really could collectively bargain?

50. The Commission in some places suggests that gynaecologists have substantial market power with the implication that gynaecologists with SCHI, through its exclusive agents, would be bilateral monopolists.²⁵ As is clear from the previous section, there are no grounds for considering individual gynaecologists in the factual or counterfactual as having substantial market power.²⁶ However, if it were true that authorisation would grant the gynaecologists substantial market power making a bilateral monopoly, then standard theory suggests that would imply a relatively efficient market outcome.²⁷ In that unreal case that the individual gynaecologists would be able to operate as a single seller, the Commission would have to explain why the parties would be unable to find their way to an efficient outcome.
51. The following diagram provides an illustrative view of how we would expect pricing outcomes to compare across FFS, bilateral monopoly (referred to as BM in the diagram), the factual, and the counterfactual.²⁸ While bilateral monopoly outcomes would be expected to be more efficient than the factual (and FFS), the arrangements proposed under the authorisation would not result in bilateral monopoly, which means that the gynaecologists' fees would be

²⁵ Speaking of "four types of participants who have a stake in the fee bundle for gynaecological surgery[:]" "SCHI as funder, hospitals as lead contractors and facility providers, and gynaecologists and anaesthetists as service providers to hospitals" (¶172), the Commission says, "anaesthetists have the greatest ability to walk away if their portion of the bundled fee is unacceptably low and are therefore least likely to bear financial impacts in response to change in gynaecologist fees" ¶173. "By contrast," the Commission says, "private gynaecologists and SCHI are much more dependent on each other. SCHI offers gynaecology surgery benefits on almost all of its plans, and estimates it funds approximately [] of gynaecology surgery in New Zealand across the public and private sectors or approximately [] across the private sector... [Thus] any material increase in the bundled fee for gynaecology surgical procedures will largely be borne by SCHI and its members, and conversely, any decrease in that funded fee will be borne by [gynaecological] surgeons." ¶177. While the redacted text is unavailable to us, we presume it indicates that SCHI funds a large proportion of gynaecologist surgery in New Zealand, including in the private sector. Later, the Commission says "an unwillingness on the part of NZGA to agree to proposed APS fees would manifest in hospitals being unable to sign up a critical mass of gynaecology surgeons such that the hospital would be unwilling/unable to sign a SCHI APS contract for gynaecology surgery within the current funding envelope" (¶182).

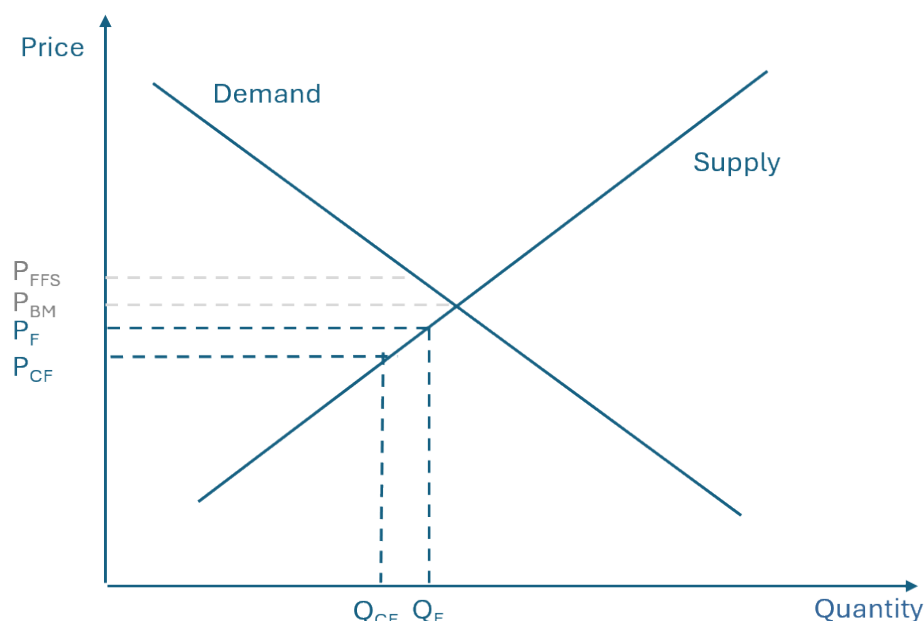
²⁶ For example, no single gynaecologist could make an all-nothing-offer beyond their practice.

²⁷ For an example applying to labour, Cullen and Pakzad-Hurson, 2023, 766. It is true that with sufficient uncertainty, bilateral monopolists may misunderstand each other's bargaining power, leading to prolonged disputes. However, in this case the bottom line is the individual gynaecologists still have very limited bargaining power, and so will be forced to accept SCHI's ultimate offer. What NZGA is banking on their ability to help SCHI understand how much its members stand to gain from more reasonable terms, rather than hoping by hard bargaining to extract 2-4% over the counterfactual wage rate.

²⁸ We do not know what the relatively of the pricing outcomes would be across the 4 scenarios, however, the order from highest to lowest pricing outcome is consistent with our expectations

somewhat below the efficient level, with fees under the counterfactual being lower still (and even less efficient).

Figure 1: Illustrative example of prices and quantities of gynaecology procedures under FFS, BM, the factual and the counterfactual



3.3 Impact on insurance premiums

52. The Commission's preliminary view is that any increase in gynaecological rates would be passed through to insurance premiums and that this would reduce insurance enrolments reducing allocative efficiency (¶¶201).²⁹ But this does not show whether prices are efficient. Prices that more efficiently reflect costs send the correct signals to insurance customers. The Commission's preliminary view probably should be interpreted as saying it believes prices in the factual are efficient and so higher prices would cause efficiency losses in the insurance market. However, given the substantive evidence on SCHI's monopsony power above, and on the documented likely resulting market failures below, the Commission must consider whether prices in the factual are more efficient than in the counterfactual.

3.4 Change to the supply of gynaecology services

53. In the Draft Determination, the Commission examines the impact of the Authorisation on the supply of gynaecologists (¶¶275-291), and expresses the preliminary view that "there is likely a small benefit from a greater supply of gynaecologists in the factual compared to the counterfactual." The Commission's analysis focusses primarily on whether established gynaecologists would exit and move to Australia. However, as we discuss below, this does not adequately account for the responses of marginal decision-makers. The issue of whether

²⁹ To support its argument that costs differences must be passed through to insurance subscribers, the Commission points to losses SCHI incurred in the past couple of years (¶¶200). These losses have been recently reversed (Southern Cross 2026 Annual Report), demonstrating that SCHI past losses were unrelated to the prices of gynaecological services, which in any case are small fraction of SCHI's overall costs. See also ¶¶328-345 where the Commission discusses this belief at length (¶¶328-345). None of this demonstrates allocative efficiency loss.

complex procedures will be adequately addressed in the counterfactual is also highly relevant to how the supply of gynaecology services will change with authorisation.

54. When examining the change to the supply of gynaecological services, the Commission again considers that SCHI is incentivised to ensure fees are at a level to maintain adequate supply of gynaecological services for its members. As discussed above in section 2.3, we do not find that this reflects practicalities of human behaviour. For brevity, we do not repeat that discussion here.

Reduction of complex procedures

55. A standardised list of procedures and accompanying prices will often not adequately reflect the complexity, time and resources required for certain operations. At the same time, unusual or complex cases are difficult to contract for because not all clinically relevant dimensions of cost, effort and quality can be specified or verified in advance. A standardised or bundled price therefore transfers risk to the provider (gynaecologists and hospitals) and in some instances, though not necessarily by their choice, the patient, when procedures vary in ways that are imperfectly captured by observable patient characteristics. If payment does not adequately adjust for complexity, providers may respond by avoiding high-cost patients, reducing unmeasured aspects of quality, narrowing the services supplied, or seeking to have atypical cases excluded from the standard arrangement. Facing reduced choices, some patients may switch to the public system, while others may not receive adequate treatment. Wait times will also likely increase in both systems.
56. Measures such as risk corridors can mitigate these incentives, but this requires sufficiently detailed information and creates trade-offs between accurate compensation, cost-control incentives and administrative complexity. Authorisation provides a means for NZGA and SCHI to collaborate on approaches to complex procedures to ensure cost oversight and control while giving gynaecologists reassurance that they will not unnecessarily bear financial risk of treating complex cases.
57. Concerns by NZGA's members about the implementation of the APS in the counterfactual are strongly reflected in a survey that the NZGA ran among its members, in which [] of respondents said they would stop complex procedures if the APS is implemented without authorisation.

Behaviour on the margin and the long-term compounding effects

58. In discussing supply responses, the Commission does not address behaviour on the margin. This is a critical failure. The Commission explains why gynaecologists with established practices would not be likely to leave New Zealand for Australia, and notes factors beyond income influence gynaecologists' location choices (¶287). The Commission concludes "it is unclear whether [lower fees] would make a significant difference to... whether [gynaecologists would] stay in New Zealand." But that does not follow from the facts the Commission outlines. For example, entering and newly established gynaecologists' incentives to leave New Zealand would be much higher than those for established gynaecologists, and more so to gynaecologists in training whose country of origin is not New Zealand.³⁰ Similarly, today there

³⁰ Again, it is not relevant that "younger gynaecologists, may be likely to leave New Zealand in both the factual and counterfactual" (¶288). What is relevant is whether even more of that group are inclined to leave New Zealand.

would be gynaecologists who have been considering leaving New Zealand for a range of reasons, but who on balance had decided to stay. A material change in their expected remuneration would likely change that decision. Even a small annual loss of gynaecologists relative to the factual, would over a few years have substantial adverse effects.

3.5 *Reduction in the number of procedures performed by private gynaecologists in the counterfactual*

59. In addition to intentions to cease providing complex procedures, the survey by NZGA of its members' intended response to the proposed pricing under the APS showed [] of respondents saying that they would reduce work hours by around 30%), with [] indicating they would retire early, and [] indicating that they would move overseas. (see the survey results in **Error! Reference source not found.** below).

Figure 2: Survey of NZGA members' intended response to AP scheme without the Authorisation

Source: NZGA anonymous workforce survey

Notes: 129 responses

60. The survey provides useful evidence of intended responses, which we use to estimate the number of procedures that will no longer be provided. Assuming, for example, that expressed intentions overstate eventual action, with only a 75% follow-through rate, we estimate that in response to the introduction of APS (that is, the move from FFS to the counterfactual) the capacity to perform 8,200 procedures will be lost. That estimate includes private and public procedures, of which approximately 6,600 would be private (assuming that those who choose to stop complex procedures or to reduce work do so across both private and public in proportion to their current mix of private and public work).

Figure 3 Estimation of reduction in the number of procedures provided per annum by private surgeons

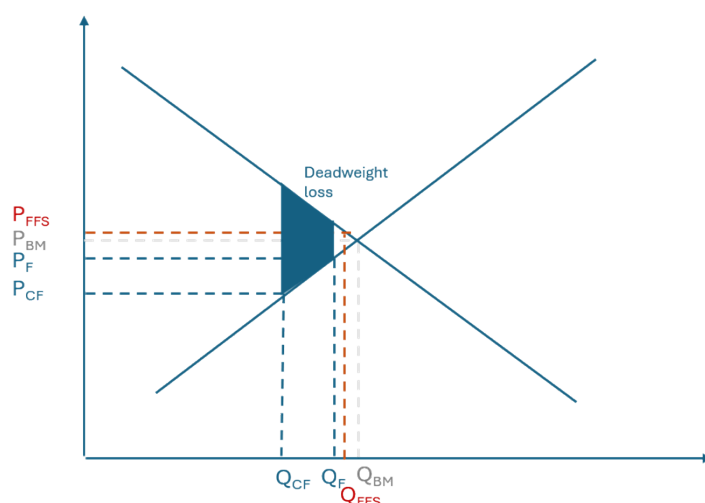
	Survey Response - Proportion of surgeons who would make a change if AP is implemented as currently proposed by SCHI	% assumed to follow through	Number who action change	% of total procedures no longer supplied	Total private + public procedures no longer supplied by NZGA surgeons per yr	Number of private procedures no longer supplied
Will not offer complex procedures						
Will reduce work (by ≈30%)						
Retire						
Move overseas						
No change						
Total change					8200	6616

Notes: We assume a total of [] procedures per year per surgeon, which is based on actual procedures during 2025 at a 2-surgeon practice. We also assume that the average private-public mix is [], which is sourced from an NZGA survey of its members.

3.6 The effects of reduced supply of private gynaecology procedures in the counterfactual

61. In the short and medium term, the reduced supply of private gynaecology procedures in the counterfactual that arise from exit (emigration and retirement) or a partial withdrawal of services (ceasing provision of complex surgeries or reducing hours) will result in lower total economic surplus than in the factual (or equivalently, increased deadweight loss), as well as longer wait times for public services.

Figure 4: Illustration of deadweight loss that can be avoided in the factual (as compared with counterfactual)



Note: The prices, and relativities between them, are unknown.

62. Even over the longer term it is not clear the withdrawn capacity from private services would be fully replaced by additional capacity in the public hospital system unless some change in pay or conditions in the public wards would induce that supply, or whether the necessary government funding to cover the cost of the increased volume of public surgeries would be available.

3.7 Impact on public healthcare system and efficiency of mixed model

63. Gynaecologists have good incentives to have a mix of private and public sector work as it provides an efficient means of recovering fixed costs, incentives that would not change if authorisation were granted. On average, the private sector work provides a larger per procedure or per patient contribution toward such costs, and thus a mixed practice effectively allows pricing down the demand curve (efficient price discrimination). As a result, the sub-optimal pricing that would result without authorisation would damage the public health system in the counterfactual due to exit by existing gynaecologists, and reduced entry into the field. In contrast, claims that higher gynaecologist charges, by raising insurance rates, would drive more people toward the public sector resulting in poorer service, these are a second order effect.³¹ But the bottom line is more efficient prices resulting from authorisation will, relative to the counterfactual without authorisation, reduce wait-times, dual practice exit and SIMG dependence in provincial centers.³²
64. More than 50% of private gynaecologists contribute to the public health system (that is, they work at both places).³³ If an APS is introduced at the current proposed levels, the financial viability of private practice may be undermined, potentially leading some experienced gynaecologists approaching retirement to retire earlier and others to leave New Zealand (as per the survey results described above). Junior consultants establishing their private practices may also decide that continuing in private practice is no longer financially sustainable.
65. The experience of gynaecological oncology provides a relevant warning about the potential consequences of losing specialist expertise overseas. We understand that according to RANZCOG approximately 50% of gynaecological oncologists who went overseas for training did not return. While this experience cannot be directly extrapolated to the entire gynaecology workforce, it illustrates the risk that the loss of specialists may be long-term and that their return cannot be assumed.
66. Given that more than half of private gynaecologists also contribute to public services, any resulting workforce attrition could have consequences beyond private practice, further reducing the availability of specialists to the public system, exacerbating existing workforce pressures, and limiting patient access to timely gynaecological care.

³¹ ¶¶37, ¶¶339, ¶¶342, and ¶¶356.

³² The Commission (¶¶411-416) lists conflicting evidence, primarily from gynaecologists, some saying providers facing lower rates at private hospitals, would do more work in the public system, and others saying more complex procedures would become less available to patients in the public health system. The Commission does not draw any strong conclusions here.

³³ NZGA anonymous workforce survey

3.8 Longer term increased funding requirements for government

67. As discussed above, in the short term the public health system is unlikely to be able to increase capacity sufficiently to address the reduced supply of privately provided services. Over the longer term, if the public health system were to expand capacity to provide services that are no longer provided through private health insurance, this would place an extra burden on Te Whatu Ora – Health NZ to fund the surgeons, anaesthetists, and hospitals. We understand that NZGA has prepared an estimate of the increased public funding that would be required to address that demand, so we have not attempted to duplicate that analysis.

3.9 Transactions costs

68. The Commission considers transaction costs at length and finds that authorisation would add transaction costs relative to the counterfactual. In coming to this preliminary conclusion, the Commission has relied on observations made about the outcomes where an APS arrangement has been applied to other specialists and also relies on a view that gynaecologists are heterogenous in their pricing expectations which would make collective negotiations more complex.
69. We understand that while the APS arrangement has been applied to certain procedures provided by other specialists, no one specialist group has had APS applied to cover all procedures. In contrast, APS would be applied to the entirety of procedures provided by gynaecologists, including complex cases. As a result, the experience in applying APS to other types of specialists cannot be taken to imply that the process of implementation for gynaecology will be straightforward. We also understand that APS has been applied in different ways (for example, in some cases APS simply refers to the setting of standard prices paid by SCHI to surgeons rather than adopting the back-to-back contracting model with hospitals) and so any attempt to draw inference from other APS applications about what would occur in the counterfactual needs to carefully consider whether there were difference in the way that APS is applied, including whether the scale of the price reductions was comparable.
70. The fact that gynaecologists have applied for authorisation for collective bargaining when others did not immediately highlight that there may be some significant differences in the smoothness of implementation as between the limited application for other specialists and blanket application for gynaecologists. As a result, it is quite plausible that without the authorisation, gynaecologists will seek to have detailed engagement with hospitals (at least, and likely also SCHI) in the counterfactual. This is even more the case, given the results of the survey cited in section 3.4 that show the NZGA members intend significantly changing (or ceasing) their business operations if the authorisation is not approved. We understand that NZGA have previously provided a submission with information on engagement costs in the counterfactual, and so we do not attempt to duplicate those estimates.
71. To the extent that the Commission finds that negotiations in the counterfactual will be limited, this would seem to indicate that SCHI has monopsonist power.
72. Lastly, transaction costs are not usually considered critical to economic efficiency unless they are so large as to prevent what would otherwise be efficient contracting take place. No such suggestion is made here and nor would it be credible. The fact that NZGA and its members are

fully willing to bear their side of these costs, which are relative to the operations of a given gynaecologist, as compared with those of a hospital or SCHI, implies they are quite small.

4 Review of the empirical analysis in the NERA report

73. Section 5 of the report prepared by NERA in cross-submissions on the SOPI presents empirical analysis, including analysis of fees over time, fee dispersion, comparison with other specialists, and comparisons with fees in Australia. On the basis of that analysis, NERA concludes that “The available evidence indicates that the market for private gynaecological services is not currently workably competitive.”³⁴
74. NERA’s discussion is largely irrelevant to the question of whether the authorisation will result in a net public benefit. Rather than considering public benefits and detriments of the authorisation relative to the relevant counterfactual, NERA has focused on outcomes under the FFS.
75. It is not clear whether the Commission has relied on NERA’s empirical analysis, either directly or contextually, but based on our review we would recommend that the Commission disregard the analysis. If the Commission is inclined to place any weight on NERA’s empirical analysis then before doing so it should heavily scrutinise the methodology and assumptions upon which it is based and interrogate the data sources that were used. As NZGA’s members have described, it is highly unlikely that the invoice information SCHI has, and which was presumably used to create the dataset that NERA has largely relied upon, allows appropriate controls for a wide-range of cost-causal factors. Thus, it is critical that the Commission carefully validates, either directly, or through third-party review, that data.
76. We do not have access to the full confidential version of the NERA report, including several charts and parts of the text that have been redacted, and therefore have not been able to fully test the analysis. However, in this section we identify issues and questions about the analysis and data sources that the Commission would need to consider if it were to rely on the analysis either directly or for background context.
77. Throughout the analysis, NERA notes that it was instructed to make a number of assumptions. While it is usual for experts to be instructed to make assumptions, the client or their legal advisors will then typically provide other evidence regarding the validity of those assumptions. This is critical if the analysis is to be relied on. The assumptions that NERA has been instructed to make are fundamental to the analysis but SCHI has not provided evidence (for example, prepared by an independent medical specialist) to test or support those assumptions.
78. Finally, while the empirical analysis of price changes presented by NERA report is essentially irrelevant at one level—it does not compare the world with and without the authorisation, holding constant in both case SCHI’s affiliated provider program—it also epitomizes the problem SCHI has. To the degree that its data is misleading, as we suspect it must be, then, beyond invalidating NERA’s analysis, it demonstrates how difficult it will be for SCHI to set efficient prices for procedures, which is exactly the problem the authorisation addresses.

³⁴ NERA Report, para 72.

4.1 Analysis of price changes over time

79. NERA's analysis looks at the cumulative growth in the OBGYN FFS per minute over the period 2012 to 2025 and compares it with CPI. Critical to assessing the trend is whether there are other factors that would explain the trend over time – NERA has effectively assumed that there are no explanators of changes over time other than a use of market power. Even then, if there was no change in market power over the period it is not clear why specialists would have chosen to use it more in the latter period of the time series (which is what would have to have happened in order for the margin to increase over time).

Composition of FFS over time

80. The time series presented by NERA in Figure 5 is of OBGYN FFS procedures. If some of the OBGYN procedures have come under the APS during the period examined by NERA, and we understand that they have - such as robotic surgeries – then that would affect the consistency and comparability over time of the series. For example, one gynaecologist that we spoke with said that in years where they performed robotic hysterectomies, the remaining laparoscopic hysterectomies would have been for complex patients only. This would contribute to the average cost of FFS procedures in later periods being higher than in earlier periods.

Mix of procedures over time

81. Aside from some procedures moving outside of FFS during the observed period, there may also have been a change in the mix of procedures over time either as technology and surgical procedures have evolved or if there has been a change over time in the types of procedures required by patient conditions. For example, we note that the data used includes obstetrics and that the rate of caesarian births has increased markedly over time, particularly since 2018.³⁵ We are not suggesting that the change in caesarian births explains why the average OBGYN FFS rate has increased, but it is an example of why careful examination of the data is needed along with consideration of whether there are changes that need to be controlled before drawing conclusions on trends or their reliability.

Unitisation by theatre time

82. Price has been expressed in Figure 5 as “per minute”. However, it is not clear what the measure of time used for unitisation is. It seems most likely that it is measured per minute of theatre time. Theatre time only captures a proportion of the time relevant to a procedure. We understand from discussions with surgeons that other time involved includes planning, pre-surgery preparation, talking with the client prior to surgery and finalising consent forms, speaking with the client's family or other support after surgery, writing up operation notes and other related paperwork, regular required meetings with other surgeons to discuss complex surgeries and multidisciplinary meetings (MDMs) to discuss complex cases that involve other types of specialists, ward visits for patients that stay in hospital, and follow-up consultations with the patient. The analysis effectively assumes that the proportion of non-theatre to theatre time has remained constant over time. It could be that this is true, but the analysis has not commented on that.

³⁵Te Whatu Ora, Maternity Clinical indicator trends: <https://tewhatuora.shinyapps.io/maternity-clinical-indicator-trends/>

83. It is outside of our expertise to provide any conclusion on whether or not that assumption is valid, but it does appear to us that this is an assumption that needs to be tested. For example, discussions with NZGA have indicated that as the technology used in gynaecology procedures has evolved, the planning time has increased relative to operating time. We also understand from discussions with NZGA that MDMs have increased in recent years, so surgeons are now spending more time on meetings.

A need to better understand the source of the data used

84. NERA has not described the source of the information used, aside from the fact that it was provided by SCHI. We expect that this information was most likely sourced from billing data. We understand from discussions with NZGA that the information contained in the billing data may not necessarily be sufficient to identify the complexity of the procedure or the specific type of procedure. While this would not necessarily impact on the high-level trend over time, it would impact on SCHI's ability to detect any relevant changes over time that would affect the mix of procedures, and therefore to be able to use the data to draw conclusions on whether trends reflect price behaviour of gynaecologists or of changing mixes of procedures, or other factors.

Comparison with CPI is not meaningful

85. NERA at 5.3 finds "FFS rates increased substantially faster than general inflation." Comparison of surgeon's fees with CPI is not meaningful. A more useful comparison would be with a measure that captures the change over time in costs of providing medical services. NZGA has identified key inputs that have driven cost changes over time to include nursing salaries, administrative staff costs, rents for consulting rooms, insurances, medical consumables, accreditation costs, IT costs, compliance requirements and hospital charges.³⁶

The information we have been able to collect did not support the results found by NERA

86. We sought to test NERA's conclusions by collecting pricing information from gynaecologists. We primarily received current pricing rather than historic information as time series for a comparable period to that considered by NERA wasn't typically retained, or the practice had not been in operation for that period of time. However, the information that we did receive about trends over time indicated [] NERA's findings. The most comprehensive dataset we received from a gynaecologist included all operations conducted from [] to 2026 for 2 procedures [], along with the charges for each. That showed a compound annual growth rate of [] for the first procedure and [] for the second. Both are [] the trend in NERA's analysis which seems to provide a compound annual growth rate of 7.2%. With regard to the second procedure, the gynaecologist noted that for years where [] procedures were used in the [] that the pricing in the series was for [] patients only, implying that this was part of the reason for [] in later years.
87. Some of the other gynaecologists provided an indication of how prices have changed over time. For example, one gynaecologist said that prices have changed by [] in the last year, but generally [].

³⁶ NZGA cross-submission – p. 6.

88. The information we collected is by no means representative or conclusive, but in combination with the issues described above on the shortcomings of the methodology, it does throw into question the results found by NERA.

4.2 Analysis of fee dispersion

89. NERA at 5.1 states that “observed fee dispersion therefore suggests that some gynaecologists are able to charge substantially higher prices for the same procedures, which is consistent with weak competitive constraints.”
90. There are several points to be made here. First, it is difficult to engage with these claims without access to the data they rely on or the results they produce.³⁷ For example, it is not clear whether, and if so, how, SCHI has controlled for cost and quality differences. Narrowly focusing on the same procedure does not do this as several examples will illustrate:
- a. If markets are geographic, as they are for gynaecology, and production involves fixed costs, as setting up a practice does for gynaecology, smaller markets will see higher prices.
 - b. If an underlying input varies, then so will prices. E.g., if some gynaecologists have built a reputation for being highly skilled, their prices will be higher than their less experienced or less acknowledged colleagues. Such Ricardian rents are not indicative of market power but arise due to efficient price signaling in the face of a scarcity of expertise.
 - c. Along the same lines, gynaecologists that have a specialty area will have a different mix of procedures to others, which will affect the comparability of their fees.
 - d. The same procedure conducted by the same team in the same location can still vary in difficulty and required time and effort, something that is often known in advance. Again, price variation for this reason would be efficient and is to be expected.
91. Second, NERA’s strong market power claims regarding gynaecologists are *ad hoc*. NERA provides little explanation for why different gynaecologists would have different levels of market power, and how that changed to produce the changes in outcomes NERA points to. This lack emphasizes the need to ensure adequate account has taken of all factors that have a material impact on price.
92. Further, the presence or absence of market power on the part of the gynaecologists in the world without the affiliated provider program, does not shed much, if any, light on the power they would have in the factual against counterfactual, and more pertinently, on the differences between the outcomes under the two scenarios. For example, it seems probable that there will be too little price dispersion under the affiliate provider program, with SCHI’s top-down approach failing to account for relevant differences between otherwise similar procedures. The authorisation will almost certainly ameliorate, if not fully overcome, that problem.

4.3 Comparisons with fees in Australia

93. NERA makes a comparison between average FFS fees in NZ and a measure of fees in Australia (due to redactions we cannot see what measure that is nor what the source was).

³⁷ Figure 3 remained redacted in the confidential version of the report that we were provided by the Commission.

94. International comparisons can be useful but must be undertaken with care so as to adjust for relevant differences across comparator countries. This includes difference in the mix of procedures across countries as well as differences in funding models.
95. We do not have access to either the data used for the analysis or the results of that analysis (Figure 4 was redacted from the confidential version of the report that we were provided). As a result, we were unable to test whether there was a difference in the mix of procedures between NZ and Australia and, if so, how these were controlled for. For example, we presume that the NZ data that NERA has used includes obstetrics, which were included in the time series. In that case, the difference in approach to Lead Maternity Carers (LMC) between New Zealand, where midwives are the LMC in more than 90% of births, in contrast to Australia where there is more use of obstetricians, needs to be accounted for.³⁸ We cannot tell if it was.
96. As NZGA stated its cross submission to the SOPI (para 2) in regard to the comparisons with Australia, there are 3 sources of payments in Australia including Medicare and the Gap fee. We are not familiar with the details of the Australian funding arrangement, but note that this would need to be examined before relying on any trans-Tasman comparison.
97. Crucially, the relative funding for the public vs private hospital systems needs to be considered in comparing charges in Australia in NZ. We understand that fees for gynaecologists in the public health system are significantly higher in Australia than in NZ. As a result, gynaecologists in Australia would be able to recover more of their fixed costs from the public system than their counterparts in NZ. This would mean that efficient fees in NZ could well be higher in NZ than in Australia and, consequently, that any finding that private fees are higher in NZ does not imply that gynaecologists in NZ have a higher degree of market power. Differences in the average mix of private and public work across the two countries would also affect the comparison.
98. It is not clear whether the comparisons are inclusive or exclusive of GST, but medical services are treated differently between NZ and Australia, which would be relevant if the comparisons use data that is inclusive of GST.
99. International comparisons can also be affected by different regulatory requirements – for example, we understand that NZ and Australia have different rules regarding mandatory chaperones for medical procedures. We do not have the expertise to comment on how this would affect NERA’s comparison but it is a further example of factors that need to be carefully examined before drawing conclusions.

4.4 Comparisons with fees of other specialists

100. NERA’s analysis compares fees with those of []

³⁸ <https://www.midwife.org.nz/news/media-release-10-june-opportunities-to-strengthen-equitable-access-to-continuity-of-care/>

Appendix A Analysis of FFS and counterfactual pricing

Difference in prices between the FFS and the counterfactual

101. To examine the difference in prices we requested price lists from NZGA members. We received price lists for 13 practices that each had varying numbers of surgeons. With input from NZGA we identified a common procedure that corresponded to each of the Minor, Moderate, Major and Complex categories, which were Simple hysteroscopy (Minor), Laparoscopic surgery for Stage 2 to 3 Endometriosis (Moderate), Simple Laparoscopic Hysterectomy (Major), and Complex Myomectomy Laparoscopic >7cm (Complex). We (Link Economics) had identified the myomectomy procedure because it was clearly identifiable in the hospital pricing with an AP code. NZGA suggested that although the myomectomy procedure identified is a complex procedure, examining another complex procedure would also give further insights into pricing and coding implications. We proceeded with examining pricing for both complex procedures.
102. We identified the price that would be charged by each practice for each procedure. We note that there can be some variation across practices regarding inclusions in the price.
103. We then calculated the average price for each of the 4 procedures. The data used and the averages are displayed in Table 1.
104. NZGA also asked members to send Link Economics pricing received from hospitals. We extracted the pricing for each procedure for each hospital, which are displayed in the lower half of Table 1. The results showed that on average the hospital proposed AP pricing was lower than the current FFS pricing by [] for Minor, [] for Moderate, [] for Major and [] for Complex (Myomectomy).
105. We then calculated a weighted average across the 4 categories of complexity, which was 48%. In other words, our pricing comparison found that the proposed AP hospital pricing for the procedures selected and using the information available to us was 48% lower than gynaecologists' existing pricing. We used two different sets of weights to calculate the weighted average: the first was based on the actual mix of cases from one gynaecology practice, and the other set was based on a survey of NZGA members. The weighted average calculated using the two sets of weights was very similar: 47.6% using the actual weights from one practice; and 48.3% using the weights from the NZGA member survey.
106. We do not purport this to be a comprehensive analysis. Interpretation of results should take into account a number of caveats including that the responses to request for pricing schedules are a sample only and that sample may have a self-selection bias – for example, those practices who are most affected by the APS changes may have been more likely to respond to the price survey. As mentioned above, there may be differences across practices in terms of what is included, and those inclusions may differ from the hospital coding. Further, hospitals that are still in the negotiating phase with SCHI may be more likely to secure a higher fee for surgeons than those that have already distributed pricing. Nevertheless, our findings are broadly consistent with NZGA's previously expressed view that the pricing reductions proposed are approximately 50%.

Table 1: Comparison of FFS prices with prices proposed by hospitals

Complexity	Minor	Moderate	Major	Complex
Definition	Minor Procedures	Moderate Endometriosis	Hysterectomy, pelvic floor repair, hysterectomy with stage 3 endometriosis or after 3 caesareans	Severe endometriosis, myomectomy, hysterectomy with morcellation, laparoscopic Burch, TLH with severe endometriosis
Code	AP1095	Average of AP1081 & AP1082	AP1204	AP1091
Case mix – []				
Case mix – Survey	30%	26%	33%	11%
Procedure surveyed	Simple hysteroscopy	Stage 2 to 3 Lap Endometriosis	Lap Hysterectomy – Simple	Myomectomy Lap >7cm Complex
Individual Gynae prices (GST incl)				
Practice 1				
Practice 2				
Practice 3				
Practice 4				
Practice 5				
Practice 6				
Practice 7				
Practice 8				
Practice 9				
Practice 10				
Practice 11				

Practice 12				
Practice 13				
Summary stats - GST inclusive				
Average				
Min				
Max				
GST exclusive				
Average				
Min				
Max				
Hospital prices				
[]				
[]				
[]				
[]				
[]				
[]				
[]				
Summary stats - GST inclusive				
Average				
Min				
Max				
GST exclusive				
Average				
Min				
Max				
Percent difference between hospital rate and current FFS practice rate				

Table 2: Response to NZGA survey on mix of procedures

	Complex	Major	Moderate	Minor	Total
Respondent 1					100%
Respondent 2					100%
Respondent 3					100%
Respondent 4					100%
Respondent 5					100%
Respondent 6					100%
Respondent 7					100%
Respondent 8					100%
Respondent 9					100%
Respondent 10					100%
Respondent 11					100%
Respondent 12					100%
Respondent 13					100%
Respondent 14					100%
Respondent 15					100%
Respondent 16					100%
Respondent 17					100%
Respondent 18					100%
Respondent 19					100%
Respondent 20					100%
Respondent 21					100%
Respondent 22					100%
Respondent 23					100%
Respondent 24					100%
Respondent 25					100%
Respondent 26					100%
Respondent 27					100%

Respondent 28					100%
Respondent 29					100%
Respondent 30					100%
Respondent 31					100%
Respondent 32					100%
Respondent 33					100%
Respondent 34					100%
Respondent 35					100%
Respondent 36					100%
Respondent 37					100%
Survey Average	11%	33%	26%	30%	100%

[] actual cases 2025					
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107. The complex case used in the above calculations was the myomectomy, which was chosen because the pricing is easily identifiable. However, we understand from discussions with NZGA that there are a number of other complex cases where the price reduction can be quite different. The complex example suggested by NZGA was based on an actual case and was described as follows: “**hysterectomy for a 14-week size uterus with stage 4 endometriosis with Bilateral endometriomas + laparoscopy with ureteric catheter insertion**. A truly complex case with added patient factor of multiple previous surgeries including 2 open surgeries.”
108. To examine the pricing for this example, we surveyed practices that had previously provided price lists. Some responded that they would refer this type of complex case to another surgeon, some did not respond, and others provided an estimate of price or a range with varying detail on how it was calculated. The descriptions provided included noting: that a surgeon of another specialty would need to be included; that the exact price would depend on surgical findings, and that the surgery would involve significant time and risk.
109. It is evidently difficult to price a complex case like this as a hypothetical example, however based on the averages of the ranges given, we calculated the average charge to [] excluding GST. To compare this with a proposed APS price from the hospital pricing, we drew on information provided by a surgeon who had performed the procedure on which the example was based. That surgeon’s observation on the relevant AP coding was:

Under the new code set, I will not be able to apply an appropriate code to this patient. The largest code that could be applied would be for 340 minutes for stage 4 endometriosis, which excludes colorectal surgeon performing bowel resection. This will require multiple discussions with the insurer to have a colorectal surgeon involved. The patient stayed in hospital for 4 days.

110. On the basis of this information, we used AP code 1084 (Lap Endometriosis ASRM Stg4). The average pricing (including GST) across the hospital price lists provided was [

] So, for this complex example the proposed AP hospital prices are 66% below the current FFS prices. If we use this complex example instead of the myomectomy then the weighted average across procedures is 52%, which again is similar to the estimate of 50% previously stated by NZGA.

111. This example does not included bundled discounts, however included in the description of proposed hospital pricing provided to us was the following discounting requirements for additional procedures: []. While a number of gynaecologists mentioned that they typically discount for additional procedures, they also stated that [] is significantly deeper than their current discounts.

Table 3: Second complex case

	2nd complex example: hysterectomy for a 14-week size uterus with stage 4 endometriosis with Bilateral endometriomas +/-cystoscopy wit ureteric catheter insertion. A truly complex case with added patient factor of multiple previous surgeries including 2 open surgeries
Practice 1	
Practice 2	
Practice 3	

Practice 4	
Practice 5	
Practice 6	
Practice 7	
Practice 8	
Practice 9	
Practice 10	
Practice 11	
Practice 12	
Practice 13	

Comparison of hospital pricing

112. We also examined the variation in pricing across hospitals and present a comparison of pricing for the hospitals available to us for a selection of procedures. We note that the pricing proposed by [] is identical for all codes in this selection.

Code type	Code	Short description									
Primary	AP1204	Lap Hysterectomy Simple									
Primary	AP1208	Lap Hysterectomy Complex									
Primary	AP1095	Hysteroscopy Theatre									
Primary	AP1080	Lap Endometriosis ARSM Stg1									
Primary	AP1081	Lap Endometriosis ASRM Stg2									
Primary	AP1082	Lap Endometriosis ASRM Stg3									

Primary	AP1083	Lap Endometriosis ASRM Stg4									
Primary	AP1078	Prophylactic Salpingectomy									
Primary	AP1079	Prophylactic Oophorectomy									
Primary	AP1089	Myomectomy Lap <=4cm Standard									
Primary	AP1090	Myomectomy Lap >4cm Standard									
Primary	AP1091	Myomectomy Lap >7cm Complex									
Primary	AP1092	Myomectomy Open <=4cm Standard									
Primary	AP1106	Myomectomy Open >4cm Complex									
Primary	AP1482	Oophorectomy &/or Salpingectomy Standard									

Primary	AP1483	Oophorectomy &/or Salpingectomy Complex									
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Appendix B Comments on material presented in the report by Professor King

113. When read carefully and in its entirety, the King report appears to be in many respects consistent with the Application.
114. Although Prof. King highlights cases where collective bargaining may be a cause of concern, the conduct involved is very different from what is proposed by NZGA. For example, in the USA example, the King report (p.3) describes: “FTC Actions... frequently prohibit [physician] association[s] 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.” The authorisation seeks none of these abilities.
115. While NZGA are seeking to be the sole representative of gynaecologists for the purposes of developing benchmarks, they are not proposing anything like the concerning behaviour described by Prof. King – the activities proposed in para 2.4 of the Application preserve Participants’ individual autonomy to contract, negotiate and participate, except for the limited obligations imposed by the Standstill Agreement.
116. In addition, numerous countries included in Prof. King’s examples have markets that are considerably less concentrated than NZ. For example, SCHI’s market share in NZ is similar to the combined share of the largest three private health insurers in Australia. As a result, the relative bargaining power positions of the insurers and physicians may be expected lead to very different outcomes.
117. King recognizes key risks associated with the counterfactual, p. 6 “failure to adequately compensate gynaecologists and restricting coverage for services can... result in reductions in access to care... gynaecologists may... leave New Zealand... further reducing access in both the public and private system,” and “access to gynaecological services in the public system is under significant strain, with... women waiting several months for a specialist appointment and... several more months for surgery.” (footnotes omitted).
118. King opens the door a little to NZGA’s proposal, at p. 6, “The market power held by SCHI is quite dominant and threatens to artificially depress prices paid to healthcare providers... 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.”
119. Authorisation is expressly designed to deal with these problems, but King doesn’t cover setting indicative rates. Yet, without some capacity for agreed upon indicative rates, it’s hard to see how there wouldn’t be a failure to adequately compensate service providers. King’s solution is that “the Commerce Commission could agree to review prices paid to private healthcare providers... 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.” While this solution does not lie within the power of the Commerce Commission under authorisation, the present authorisation request comes close to proposing something similar, but left to NZGA and SCHI, with a longer period between review.

Appendix C References

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