Public Version

# NZGA/SCHI: Review of Link Economics Report

Report for Southern Cross Medical Care Society

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# 1. Introduction and summary

1. We have been asked by Southern Cross Medical Care Society, trading as Southern Cross Health Insurance ("**SCHI"**), to review the report prepared by Link Economics[1] reviewing the Commerce Commission's draft determination to deny authorisation for the New Zealand Gynaecology Association ("**NZGA**") to collectively bargain with SCHI ("Link Economics report").
2. The Link Economics report is based on five core premises:
   A. That while the existing fee-for service ("**FFS**") prices are above the competitive (efficient) level, the proposed Affiliated Provider Scheme ("**APS**") prices would be below the competitive (efficient) level, such that authorisation would move prices in the factual closer to the efficient level.[2]
   B. That the "pay transparency" literature provides an analogue for understanding the likely effects of the proposed arrangements on gynaecologists' bargaining power.
   C. That gynaecologists' fees would fall by 48% following the transition from FFS to the APS under the counterfactual.
   D. That the conduct for which authorisation is being sought would not result in much extra bargaining power for gynaecologists, because individual gynaecologists would still negotiate and contract independently, albeit with the benefit of collectively negotiated benchmark prices.
   E. That the proposed APS for gynaecologists is more comprehensive and will be implemented differently compared to the APSs that have been implemented for other specialities.
3. The first and second premises are not supported by sound economic reasoning or the available evidence, as we demonstrate in this report and our first report. We are instructed that the third, fourth, and fifth premises are inconsistent with the factual evidence, as explained in the SCHI cross-submission.
4. On this basis, the following core claims of the Link Economics report fall away:
   A. That SCHI is exercising monopsony power. [3]
   B. That APS prices in the counterfactual would fall below the efficient level, while factual prices under authorisation would move closer to that level (see [51] and Figure 1 of the Link Economics report).
   C. That the higher fees resulting from authorisation would improve economic efficiency by preventing reductions in the supply of gynaecological services that would otherwise arise under the APS in the counterfactual.[4]

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1 Link Economics, *Assessment of Economic Issues in the Draft Determination on the NZGA Authorisation* (20 October 2026),

2 Link Economics report, Figure 1.

3 Link Economics report, [23].

4 Link Economics report, [5], [47].

D. That the empirical analysis in our previous report dated 3 August 2026 is irrelevant to the NZCC's assessment of the proposed authorisation. [5]

E. That authorisation would increase gynaecologists' "bargaining position" by less than 2% to 4%.[6]

# 2. Monopsony power and efficient pricing

5. The Link Economics report argues that SCHI has monopsony power and is exercising it, relying primarily on SCHI's share of private health insurance funding and the claimed magnitude of the reduction in gynaecologists' fees following the transition from FFS to the APS.[7] SCHI's cross-submission to the NZCC Draft Determination responds factually to both of these points. We note in particular that SCHI estimates the APS would reduce the average amount paid per surgical episode by approximately [ ][8] compared to FFS, substantially less than the approximately 48% reduction claimed by Link Economics.

6. We note the Link Economics report accepts that existing FFS prices are above the efficient level (see [51] and Figure 1 of its report). This is in line with the conclusion from the empirical evidence presented in Section 5 of our 3 August 2026 report, being that FFS prices are likely above workably competitive levels. A reduction from existing FFS prices could therefore reflect a movement towards the efficient level by reducing (inefficient) rents, rather than the exercise of monopsony power. We note that the NZCC's Draft Determination also finds that prices under authorisation could exceed existing FFS levels, noting that NZGA may seek to negotiate fees significantly higher than those currently charged by the majority of gynaecologists (at [191]).

7. The Link Economics report argues that APS prices would fall below the efficient levels because SCHI's management incentives and imperfect information (we refer to this generally as "agency issues") would lead it to prioritise price reductions at the expense of supply and quality.[9] However, the Link Economics report does not explain why these claimed considerations would override SCHI's (and hospitals') incentives to maintain supply and quality.[10] SCHI and hospitals have strong incentives to ensure that the prices they pay are sufficient to maintain an adequate supply and quality of gynaecological services for members/patients. The ongoing nature of APS contracting also allows SCHI to observe and respond to any deterioration in service availability or quality. As explained in SCHI's cross-submission,[11] there are instances where SCHI has increased APS prices to maintain adequate provider coverage. Thus, while Link Economics is correct that management are not "all knowing", it appears empirically that they have reacted when required to maintain supply and quality.

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5 Link Economics report, [74].

6 Link Economics report, [48].

7 Link Economics report, [15]-[23].

8 SCHI cross-submission on NZCC Draft Determination, [8.2].

9 Link Economics report, [25]-[32].

10 [86C] of our 3 August 2026 report.

11 SCHI cross-submission on NZCC Draft Determination, [6.1(e)(ii)]).

8. It is also important to remember that we have a series of natural experiments to test the Link Economics claim that SCHI is exercising monopsony power and that agency issues would override SCHI's incentives to maintain supply and quality - the introduction of the APS for other specialties. If quantity and quality of those procedures did not reduce following the introduction of the APS, then it is inappropriate to claim that the APS would reduce quantity and quality for gynaecologists (i.e., that price would be below the efficient level).
   A. As explained in SCHI's cross-submission to the Draft Determination (at [2.3(e)], procedure volumes have continued to increase following APS transitions in other specialties, rather than declining as might be expected if the new contracting arrangements materially discouraged service provision.
   B. As set out in SCHI's cross-submission to the Draft Determination, APS-only surgeries in other specialties receive more positive patient-reported outcomes than gynaecology surgeries funded under FFS.[12] This is inconsistent with the suggestion that the APS model compromises the quality of healthcare services.
   C. The Link Economics report claims that the APS has never been comprehensively rolled out to other specialties, including to complex procedures.[13] So, the claim is that the APS for gynaecologists would be an unusually comprehensive one. We understand this is not correct.[14] There is therefore no basis to disregard the experience of other specialties transitioning to the APS when assessing the likely effects of the APS for gynaecology.

# 3. Unsupported claims about effects of authorisation

## 3.1. Pay transparency literature

9. The Link Economics report relies on the literature on pay transparency to argue that prices under the factual would be less than 2-4% higher than under the counterfactual.

10. In particular, the Link Economics report draws on a paper by Cullen and Pakzad-Hurson,[15] which examines the effects of pay transparency on wage bargaining between employers and employees. The Link Economics report interprets that paper as showing that collective bargaining produces wages 2% to 4% higher than would otherwise arise. This view is summarised at [48]:

    *"In that literature, collective bargaining by labor results in prices 2-4% higher than occurs without collective bargaining."*

11. The Link Economics report treats that range as an upper bound on the price effect of authorisation, arguing that the effect would be smaller in the present case because, in its view,

12 SCHI cross-submission on NZCC Draft Determination, [5.1(e)(iii)].

13 Link Economics report, [69].

14 SCHI cross-submission on NZCC Draft Determination, [5.1(b)].

15 Cullen, Zoë B., and Bobak Pakzad-Hurson. "Equilibrium effects of pay transparency." *Econometrica* 91, no. 3 (2023): 765-802.

SCHI is more powerful than the employers considered in the literature and the factual does not involve collective bargaining.

12. The Link Economics report is therefore proposing a benchmark for the price effect of authorisation in the present case on the basis of what it interprets collective bargaining as achieving in response to price transparency. This is a poor analogue for a number of reasons:

    A. First, the fact of price transparency is not relevant and has no clear equivalent in the present case whether in the factual or counterfactual. The literature examines the effect of employers introducing greater transparency over the wages paid to all their employees, allowing employees to observe and respond to differences in remuneration.[16] Neither the factual nor the counterfactual involves SCHI or hospitals introducing transparency over the fees negotiated with gynaecologists. Here, the change between the factual and counterfactual is the introduction of collective negotiations over prices charged by gynaecologists.

    B. Second, the literature concerns wage-earning employees *within the same firm*. As explained in Section 4 of our first report, gynaecologists are independent service providers who independently set prices for their services, operate in markets characterised by significant information asymmetries, and provide services to patients whose costs are largely met by third-party insurers. These features affect how and what prices are set within the market. The findings from a model of wage negotiations between employers and employees within a firm therefore cannot be assumed to apply to negotiations over gynaecologists' fees across the majority of the market.

    C. Third, the Link Economics report draws conclusions that are not supported by the findings of the literature it cites. The Cullen and Pakzad-Hurson paper examines the effect of introducing pay transparency under different pre-existing wage-setting arrangements, not the effect of introducing collective bargaining. This distinction is crucial because the change between the factual and counterfactual in the present case is the introduction of collective bargaining over prices.

13. Moreover, the mechanism that the findings of the literature are based on do not apply here. The authors find that pay transparency reduces wages where employees negotiate individually, but has a smaller effect where collective bargaining arrangements are already in place. This is because the mechanism driving wage reductions depends on employees having individual bargaining power in the first place. Where wages are already collectively determined, employees have less scope to use information about their colleagues' wages to renegotiate, so the mechanism is weakened. It is therefore unclear on what basis the Link Economics report draws the following inference from the literature (at [48]):

    "*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*."

[16] Cullen, Zoë B., and Bobak Pakzad-Hurson. "Equilibrium effects of pay transparency." *Econometrica* 91, no. 3 (2023): 765-802, p. 6.

14. The literature does not assess the effects of introducing collective bargaining and therefore provides no basis for Link Economics' proposed mechanism whereby collective bargaining offsets employers' bargaining power through bilateral monopoly negotiations.
15. Accordingly, the 2-4% wage effects estimated in the pay transparency literature provides no basis for quantifying the effect of the proposed arrangements on gynaecologists' fees.
16. Finally, we note that despite the Link Economics report's assertion that gynaecologists would not engage in collective bargaining in the factual, we are instructed that NZGA has applied for authorisation allowing gynaecologists to collectively bargain.

## 3.2. NZGA survey evidence

17. The Link Economics report relies on a survey or surveys, the results of which "were only visible to Link Economics and Matthews Law" (footnote 20). This obviously makes it hard to assess the robustness of the survey design, including the appropriateness and framing of the questions asked, the representativeness of respondents, and the reliability of the resulting estimates.

# 4. Link Economics' assessment of our first report

18. The tables below summarise our responses to the Link Economics report's criticisms of the empirical analysis in our first report.
19. Table 1 outlines the Link Economics report's comments on our analysis of price changes over time (Section 5.3 of our original report), and our responses to those comments.

**Table 1: Analysis of price changes over time**

| Link Economics comment | NERA response |
|---|---|
| "*NERA has effectively assumed that there are no explanators of changes over time other than a use of market power.*" [79] | There is no such assumption. As we stated at [72] of our first report, our conclusion is based (holistically) on the evidence in section 5 of our original report taken together, rather than price trends alone. |
| "*If some of the OBSGYN 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.*" [80] | To the extent that more complex procedures take longer, our analysis accounts for this by measuring fees on a per minute basis. An increase in the number of robotic procedures under the APS does not, in itself, imply higher fees per minute for FFS procedures. |
| "*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…. The analysis effectively assumes that the proportion of non-theatre* | Like Link Economics, we are not aware of any evidence that the ratio of non-theatre to theatre time has changed over time. Furthermore, given Figure 7 of our first report, to be a relevant explanator, the increase in the ratio of non-theatre to theatre time would have to be greater for gynaecology than for the other specialties included in the comparison in in Figure 7. |

| | |
|---|---|
| *to theatre time has remained constant over time. It could be that this is true, but the analysis has not commented on that."* [82] | |
| "*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*." [84] | We are instructed that SCHI's historical billing data is sufficient to identify both the complexity and specific type of procedure. Relevant invoice information includes theatre times, length of stay, and descriptions of the (often multiple) procedures delivered in a single surgery. |
| "*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.*" [85] | We also compare OBSGY fee growth with other surgical specialties, which helps account for broader cost pressures affecting surgical services. As we stated at [72] of our first report, our conclusion is (holistically) based on the evidence in section 5 of our original report taken together, rather than price trends alone. |
| "*The information we have been able to collect did not support the results found by NERA.*" [86]-[88] | The Link Economics report acknowledges that the pricing information it uses is neither representative nor conclusive.[17] Its most comprehensive dataset comprises just two procedures performed by a single gynaecologist.[18] |

20. Table 2 sets out the Link Economics report's comments on our analysis of fee dispersion (Section 5.1 of our original report), and our responses to those comments.

**Table 2: Analysis of fee dispersion**

| Link Economics comment | NERA response |
|---|---|
| "*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*." [90a] | It is unclear why fixed costs would be higher in smaller geographic markets. Presumably the Link Economics report is assuming that lower volumes in smaller markets lead to higher average costs. However, fixed costs might be lower in those markets due to, e.g., lower rents.<br>Indeed, additional data provided by SCHI shows that gynaecologists in smaller provincial markets generally charge lower fees than those in larger cities (see Appendix A). For example, [ ] of providers in Te Whatu Ora's Central region,[19] excluding Wellington, fall within the lowest [ ] percentile of fees nationally, compared with [ ] in Auckland. This is inconsistent with Link Economics' claim that smaller markets have higher prices. |

17 Link Economics report, [88].

18 Link Economics report, [86].

19 The Central region includes Whanganui, Hawke's Bay, Manawatū, Horowhenua, Tararua, Wairarapa, Wellington, Kāpiti, and Hutt Valley.

| | |
|---|---|
| | In addition, as shown in Figure 9 of SCHI Submission to NZCC in response to NZGA Authorisation Application, [ ], indicating a high degree of variation within the same geographic market. |
| "*If an underlying input [e.g., reputation for skill] varies, then so will prices*." [90b] | As noted at [75] of our first report, we are instructed that the observed variation in fees do not reflect differences in quality.<br>We also understand that SCHI's surveys have found no correlation between price and quality.[20] |
| "*…gynaecologists that have a specialty area will have a different mix of procedures to others, which will affect the comparability of their fees*." [90c] | As is clear from the text of [73] and the labelling of the x axis of Figure 3 of our first report, our analysis compares fees for the same surgical procedures, rather than average fees across different gynaecologists' procedure mixes. |
| "*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*." [90d] | Figure 3 of our first report shows substantial fee dispersion for the same procedures, with maximum fees exceeding minimum fees by between [ ] and [ ]. The analysis distinguishes between simple and complex procedures (for example, [ ] are separate entries in Figure 3), and substantial fee dispersion remains within these groups. |
| "*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*." [91] | Section 4 of our first report explains why the current FFS model likely provides only weak competitive discipline over individual gynaecologists' surgical fees given the information asymmetries and agency issues that limit the ability and incentives of patients, referrers, hospitals, and insurers to constrain those fees. |

21. Table 3 sets out the Link Economics report's comments on our comparison of gynaecological surgical fees in New Zealand and Australia (Section 5.2 of our original report), and our responses to those comments.

**Table 3: Comparisons with fees in Australia**

| Link Economics comment | NERA response |
|---|---|
| "*…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*." [95] | Our comparison uses comparable gynaecological surgical *procedures* in New Zealand and Australia, rather than the overall mix of procedures. This criticism therefore does not apply. |
| "*…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* | We use the [ ] in our comparison. [ ]. Importantly, we are instructed that the total fee charged by a surgeon does not depend on whether it is paid by Medicare, a private insurer, or the patient. Our comparison is about the level of surgeons' fees, not how those fees are split between different sources of payment. |

[20] SCHI cross-submission on NZCC Draft Determination, [18.2(b)(i)].

| | |
|---|---|
| *before relying on any trans-Tasman comparison*." [96] | |
| "*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*." [97] | As stated above, [ ]. Further, public-sector remuneration compensates gynaecologists for their public-sector services, rather than cross subsidising the fixed costs of private practice.<br>We understand from SCHI that the only common costs of practising as a gynaecologist across the public and private sectors consist of the following:<br>1. The annual practising certificate and registration fees;<br>2. College and professional association membership;<br>3. Training and continuing professional development (Maintenance of Professional Standards, or MOPS); and<br>4. Professional indemnity cover.<br>In addition, higher public remuneration in Australia would increase the opportunity cost of doing private work instead of being full time in the public system, so it is not clear why higher public compensation would imply lower efficient private fees in Australia. |
| "*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*." [98] | We understand GST is not applicable to health services in Australia[21] and all NZD pricing used in our analysis excludes GST to ensure a like-for-like comparison. |

[21] See, Australian Tax Office, "Medical services", Link.

# Appendix A. Geographic distribution of pricing

**Table 4: Distribution of gynaecologists by average fee percentile and geographic region, FY2024**

| Group | Up to 30th | 31st–50th | 51st–70th | 71st+ | Total count |
|---|---|---|---|---|---|
| Auckland + Waikato (city) | [ ] | [ ] | [ ] | [ ] | [ ] |
| Northern + Midland provinces (Northland, BoP, Lakes, Tairāwhiti, Taranaki) | [ ] | [ ] | [ ] | [ ] | [ ] |
| Wellington region (city) | [ ] | [ ] | [ ] | [ ] | [ ] |
| Central provinces (HB, MidCentral, Whanganui, Wairarapa) | [ ] | [ ] | [ ] | [ ] | [ ] |
| Canterbury region (city) | [ ] | [ ] | [ ] | [ ] | [ ] |
| South Island provinces (Nelson Marlborough, Southern) | [ ] | [ ] | [ ] | [ ] | [ ] |

*Source: SCHI analysis*

*Note: We understand the percentiles to be based on the national distribution of gynaecologists' average fees per minute of theatre time.*

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