

Assessment of claimed benefits of collective bargaining by gynaecologists

Report for Southern Cross Medical Care
Society

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1. Introduction and summary

1. On 19 May 2026, the New Zealand Gynaecology Association Inc ("**NZGA**") applied to the Commerce Commission for authorisation to engage in collective negotiations with Southern Cross Medical Care Society (trading as Southern Cross Health Insurance ("**SCHI**") and/or private hospitals in relation to the provision of private gynaecological services to SCHI-insured patients ("**the Application**").
2. We understand that the proposed arrangements would permit NZGA to negotiate price and non-price terms on behalf of participating members, exchange information necessary for those negotiations, develop a common contractual framework on which individual agreements could be based, give effect to the resulting arrangements, and engage in a collective standstill/boycott agreement.
3. The Application arises from SCHI's proposed extension of its Affiliated Provider ("**AP**") funding model to gynaecological surgery. Under the fee-for-service ("**FFS**") model that currently exists in relation to gynaecological surgery, the gynaecologist and anaesthetist engage directly with the patient and determine the surgical fee, the hospital separately provides the facilities and supporting services, and the insurer reimburses the patient, or pays benefits subject to the policy.
4. Under the proposed AP model, SCHI would instead negotiate and agree a bundled procedure price with a hospital. The hospital would in turn negotiate and contract with each of the gynaecologist and anaesthetist to bilaterally agree the payments that each of those providers receives.
5. We have been engaged by SCHI to provide an economic assessment of the claimed benefits in the Application.
6. A summary of our findings is as follows:
 - A. The Application's price-related benefits assume current FFS gynaecology fees are at the workably competitive level and that detriments would therefore arise from SCHI negotiating lower prices.
 - B. Information asymmetries and the structure of principal-agent relationships¹ between doctors, patients, hospitals and insurers means that independent fee setting by gynaecologists cannot be assumed to result in competitive prices. The current FFS model likely provides only weak competitive discipline over gynaecologists' surgical fees because:
 - i. Insured patients and referrers (such as GPs) generally have limited *ability* to observe, compare, and assess specialist surgical fees before treatment decisions or referrals are made. Specialist recommendations, perceived clinical quality or reputation, and availability often play a more significant role in provider selection for patients than price. Therefore, insured patients' and referrers' ability to exercise competitive pressure over surgeon fees through informed price comparison is likely to be constrained. As a

¹ In the economics literature, the type of information asymmetry where one entity (the agent) makes decisions on behalf of another party who bears the costs and/or benefits of those decisions (the principal) is known as a principal-agent problem. See Section 2.3.

- result, fee competition is unlikely to operate in the same way as it does in markets where prices are transparent to, and readily comparable by, customers (or their agents).
- ii. Insured patients' and referrers' *incentive* to exercise competitive pressure over surgeon fees are also likely to be constrained where their SCHI policy provides full reimbursement of eligible surgical fees, this being the case for most policy types. In those circumstances, patients do not experience out of pocket costs and therefore have limited economic incentive to select providers on the basis of price.
 - iii. Hospitals compete to attract surgeons, but that competition relates to facilities and support services rather than the surgeons independently determined surgical fee.
 - iv. Insurers fund treatment costs but, under the existing framework, lack any effective *ex ante* mechanism to negotiate surgical fees directly with individual surgeons.
- C. Observed outcomes are consistent with existing gynaecology surgical fees being above competitive levels. In particular, New Zealand private gynaecology surgical fees:
- i. Vary significantly for the same procedures;
 - ii. Exceed relevant Australian [];
 - iii. Have risen materially faster than inflation and []; and
 - iv. Are higher than [].
- D. The AP model is a mechanism for SCHI to address lack of workable competition and information problems:
- i. There is no evidence that the AP outcome without collective bargaining would push prices below sustainable (i.e. workably competitive) levels. [], and []. Furthermore, SCHI's experience introducing AP arrangements for other specialties does not indicate that the model results in lower procedure volumes. In addition, a reduction in fees towards competitive levels would not, by itself, suggest that quality would decline.
 - ii. Reducing fees towards the workably competitive level would have efficiency and distributional benefits:
 - a. **Allocative efficiency:** Reducing economic rents by bringing the price of surgical services more closely into line with the underlying economic cost of supplying them. To the extent this reflects efficient pricing, it would allow a given pool of insurance premiums to fund a greater quantity or range of healthcare services.
 - b. **Reduced adverse selection:** Adverse selection in insured health care arises when rising premiums cause healthier, lower-risk members (who expect to claim less) to reduce or cancel their cover, leaving a higher-risk pool with higher average claims and creating further pressure for premium increases, which in turn may cause more members to cancel or reduce cover.
 - c. **Reduced pressure on public system:** Maintaining the affordability and scope of private health insurance can reduce pressure on the public health system. With lower premiums, fewer patients would be expected to shift from privately funded to publicly funded care, reducing additional public expenditure, waiting times and wider costs associated with delayed treatment.

iii. Incentives under the AP model suggests its introduction will be efficiency enhancing:

- a. Hospitals are better placed than individual patients to negotiate with surgeons because they are informed, repeat purchasers able to compare prices, costs, and quality across the provider with whom they contract.
- b. SCHI and hospitals retain strong incentives to maintain adequate provider participation, access and quality, and hospitals would continue to compete for gynaecologists under the AP model.

7. In the rest of the report we:

- A. Summarise the health economics literature relevant to assessing the claimed price benefits of authorisation (section 2);
- B. Set out the theoretical framework for why the claimed benefits of authorisation rely on the assumption that gynaecological surgical fees are currently workably competitive (section 3);
- C. Assess whether the structure of the principal-agent relationships are likely to result in strong competitive constraints on surgical fees under the FFS model (section 4);
- D. Examine empirical evidence on whether current gynaecology prices are likely workably competitive (section 5); and
- E. Consider the potential efficiency improvements as a result of gynaecology becoming an AP only specialty (section 6).

2. Economics of health insurance

8. This section introduces the key concepts and principles of health economics that underpin the analysis in this report. It draws on the relevant health economics and insurance literature to provide the theoretical framework for the analysis, with differences between the literature and the SCHI context highlighted where relevant.
9. The key findings from the literature are:
 - A. **Health insurance allows individuals to manage uncertainty:** Because illness and healthcare costs are unpredictable and unevenly distributed, risk-averse individuals value insurance as a way to replace potentially catastrophic medical expenses with predictable premiums. Insurance pools spread risk across many members, making healthcare costs more stable and affordable.
 - B. **Insurance premiums reflect expected claims costs:** Premiums are primarily determined by expected claim costs across the insured pool. As average claims cost per member increases, premiums must also rise.
 - C. **Higher provider prices ultimately increase insurance costs:** Persistent increases in healthcare prices raise insurers' average claims costs, reducing any surpluses over claims costs unless offset by higher premiums or lower claims volume. Insurers respond by increasing premiums, removing or reducing benefits, or negotiating lower provider prices.
 - D. **Information asymmetry weakens competition:** Patients, doctors, and insurers each possess different information, creating principal-agent problems. Because patients cannot easily judge treatment quality or necessity, and insurers cannot directly observe clinical decisions, normal competitive pressures on price are reduced.
 - E. **Insurance creates moral hazard and adverse selection:** Comprehensive insurance lowers patients' out-of-pocket costs, encouraging greater healthcare utilisation (moral hazard). At the same time, people with higher expected healthcare costs are more likely to purchase generous coverage (adverse selection), which can increase premiums and potentially trigger an adverse selection "death spiral".
 - F. **Rising premiums reduce insurance coverage:** Higher premiums or reduced benefits make private health insurance less attractive, particularly for lower-risk individuals. This can worsen adverse selection, increase reliance on public healthcare, and encourage insurers to introduce greater cost-sharing through higher deductibles or coinsurance.

2.1. Risk aversion and pooling

10. The value of health insurance stems from the fact that the need for medical treatment, and the associated expenditure, is inherently uncertain. Although individuals may have some information about their health, the timing and cost of illness is often unpredictable.² Medical spending is also highly variable, with a relatively small proportion of the population incurring

² David M. Cutler and Richard J. Zeckhauser, "The Anatomy of Health Insurance," in *Handbook of Health Economics*, vol. 1A, ed. Anthony J. Culyer and Joseph P. Newhouse (Amsterdam: Elsevier, 2000), pp. 571.

large healthcare costs within any given year. The combination of uncertainty and expenditure variability is what creates demand for health insurance.

11. Risk-averse individuals value insurance because it protects against the financial consequences of requiring substantial medical care. Rather than bearing the full cost of illness at the time it occurs, insured individuals pay a predictable premium in exchange for coverage of uncertain future expenses. This effectively smooths consumption across health states.³
12. By pooling risk across many individuals, insurance converts a large, uncertain loss for any one person into a small, more certain cost shared across the group. The benefits of risk pooling increase with both the size and diversity of the insurance pool.⁴ Consistent with the law of large numbers, larger pools yield more stable and predictable aggregate claims as random variation in individual health claims smooths out across a sufficiently large group. Pool composition also matters because a more diverse pool spanning individuals with varying levels of health risk distributes the financial burden more broadly and reduces the average cost per member, making coverage more affordable for the group as a whole.

2.2. The aggregation of claims costs and insurance premiums

2.2.1. Determinants of insurance premiums

13. The premium charged by a profit maximising insurance company for a given policy is based on the expected payout, which is the average amount paid out for a large group of insured persons, plus administrative costs, reserve funds, and profits of the insurer.⁵
14. Choi, Hardigree, and Thistle (2002) put forward a general form for the determination of the price of insurance, or premium, capturing the various components as follows:⁶

$$P = \frac{\mu}{1+r} + c + R(r, S, \sigma^2) \quad (\text{Equation 1})$$

15. Where:

P is the price insurance policies are sold at (or the premium);

μ is the expected claim per policy;

r is the interest rate;

c is the expenses per policy;

R is the risk premium;

S is the surplus of capital; and

σ^2 is the variance of claims.

³ David M. Cutler and Richard J. Zeckhauser, "The Anatomy of Health Insurance," in *Handbook of Health Economics*, vol. 1A, ed. Anthony J. Culyer and Joseph P. Newhouse (Amsterdam: Elsevier, 2000), pp. 574.

⁴ Folland, Sherman, Allen C. Goodman, and Miron Stano. *The Economics of Health and Health Care: international Edition*. 8th Edition. (New York: Routledge, 2017). p. 214.

⁵ Dewar, M., Diane. *Essentials of Health Economics*. (Jones and Bartlett Publishers, 2010). pp. 31-32.

⁶ Choi, Seungmook, Don Hardigree, and Paul D. Thistle. "The property/liability insurance cycle: A comparison of alternative models." *Southern Economic Journal* 68, no 3 (2002): 530-548, p. 536.

16. The term $\mu/(1+r)$ represents the actuarially fair component of the premium, i.e., the discounted value of the expected claim per policy.
17. For example, the actuarially fair premium is set such that it is equal to the expected value of any compensation paid out. For a representative insured, if the insurer expects a 10% probability of the insured making a claim to cover a \$50,000 surgical procedure in a given year, the actuarially fair premium is $0.1 \times \$50,000 = \$5,000$.
18. In practice, insurers estimate the expected claim payment across all policyholders covered by a particular policy type. The parameter μ therefore represents the insurer's expected claim payment per policy, across the entire insured population for that policy.
19. The premium, P , and the average claim per policy, μ , have a positive relationship, as shown by the above equation. Thus, assuming all else remains constant, if the average claim per policy, μ , increases, premiums can be expected to increase.
20. Choi, Hardigree and Thistle (2002) also show that an insurer's profit/surplus is given by:⁷

$$\pi(q) = pq - \frac{xq}{1+r} \quad (\text{Equation 2})$$

21. Where:
 - A. $\pi(q)$ is the present value of underwriting profit.
 - B. p is price net of expenses.
 - C. q is the number of policies issued.
 - D. x is the average claim per policy.
 - E. r is the interest rate.
22. The above equation shows that, holding the price of insurance constant, an increase in the average claim per policy reduces insurer profitability/surplus. As claims costs increase, the margin earned on each policy declines and, in turn, total profits/surplus across the insurer's portfolio decline. If average claims costs rise beyond the price of insurance net of expenses, the insurer will incur losses.
23. Persistent inefficient pricing in any material category of insured healthcare services therefore contributes to higher average claims costs across the insurer's portfolio. Although any individual claim represents only a small proportion of total claims expenditure, sustained increases in the prices of a material category of insured services increase the insurer's aggregate claims liability and, consequently, the average claim per policy (x in Equation 2). Unless offset by lower claims costs elsewhere, this reduces insurer profitability/surplus. Insurers must therefore restore profitability/surplus by increasing the price of insurance, reducing the average claim per policy, or some combination of the two.
24. Insurers have a number of mechanisms available to reduce the average claim per policy. Broadly, these mechanisms can be characterised as either demand-side or supply-side

⁷ Choi, Seungmook, Don Hardigree, and Paul D. Thistle. "The property/liability insurance cycle: A comparison of alternative models." *Southern Economic Journal* 68, no 3 (2002): 530-548, p. 532.

responses.⁸ Demand-side responses seek to reduce claims expenditure by increasing the share of healthcare costs borne by policyholders, which reduces demand for insured healthcare services. Supply-side responses instead seek to reduce the cost of supplying healthcare by influencing the prices paid for services.

2.2.2. Increased claims costs may lead to higher insurance premiums

25. One response available to insurers is to increase the price of insurance. This may occur either by spreading higher claims costs across the broader insured population or by aligning premiums more closely with the expected claims costs of particular groups.
26. Where insurers continue to pool risks across a diverse set of policyholders, sustained increases in average claims cost per member are reflected in the overall cost of providing insurance, and therefore in premiums charged across the group. This is known as community-rating.⁹ Therefore, persistent inefficient pricing in any given category of insured healthcare services will, over time, place upward pressure on premiums, or result in less generous policy benefits, across the wider insured population. Although only a subset of policyholders directly utilise the affected services, the resulting increase in claims expenditure is shared across the insurance pool through the pricing of insurance products.
27. Over time, these effects may also exacerbate the adverse selection problems discussed in Section 2.3.3. While insurers may use age, product and other rating factors to better align premiums with expected claims costs, sustained increases in healthcare costs are still likely to place upward pressure on premiums and/or reduce the level of coverage over time. As premiums increase or policy benefits become less generous, lower-risk individuals may find private health insurance less attractive relative to their expected healthcare costs and choose to reduce or forgo coverage.¹⁰ This leaves a higher-risk insured pool, placing further upward pressure on average claims costs and premiums.
28. Economic theory predicts that an increase in insurance premiums reduces the amount of insurance consumers optimally purchase.¹¹ Holding all else constant, higher premiums increase the price consumers pay to transfer health expenditure risk to an insurer, reducing the quantity of insurance demanded. Consequently, persistent increases in claims costs arising from inefficient provider pricing can be expected to reduce private health insurance coverage, leaving more individuals exposed to healthcare costs or reliant on publicly funded healthcare.
29. Alternatively, insurers may seek to improve the alignment between the subset of customers who generate the higher claims costs and those who bear the resulting burden of higher premiums. Rather than spreading higher claims costs across all policyholders, insurers may differentiate price increases in premiums or policy terms according to the expected cost of providing coverage to particular groups. In competitive insurance markets, this tendency

⁸ Wynand, P. M. M., Van De Ven, and Randall P. Ellis. "Risk adjustment in competitive health plan markets." In *Handbook of health economics*, vol. 1, pp. 755-845.

⁹ Pauly, Mark V. "The welfare economics of community rating." *Journal of Risk and Insurance* (1970): 407-418.

¹⁰ Buchmueller, Thomas. "Community rating, entry-age rating and adverse selection in private health insurance in Australia." *The Geneva Papers on Risk and Insurance-Issues and Practice* 33, no. 4 (2008): 588-609.

¹¹ Folland, Sherman, Allen C. Goodman, and Miron Stano. *The Economics of Health and Health Care: international Edition*. 8th Edition. (New York: Routledge, 2017). pp. 221-222 (Figure 8.3).

towards risk-adjusted pricing is known as the equivalence principle.¹² Where persistent increases in claims costs are concentrated within a particular demographic group, insurers therefore have incentives to impose higher premiums or less favourable policy terms on that group.

30. Gender-based pricing is one form of risk-based insurance pricing, under which insurers classify policyholders by observable characteristics, such as age and gender, that are statistically associated with differences in expected claims costs.¹³ Where claims experience indicates that women and men within particular age bands generate systematically different expected costs, actuarially risk-based pricing would tend to produce different premiums or policy terms for those risk classes. If risk-based pricing were not implemented, then higher costs attributable to one group would be recovered across the entire insured pool. This would result in higher premiums across the group.

2.2.3. Increased claims costs may lead to reductions in policy coverage

31. Insurers may also redesign insurance products to reduce the average claim per policy (x in Equation 2). One mechanism is to increase policyholder cost-sharing through higher excesses or co-payments (copay).¹⁴ By requiring policyholders to bear a greater proportion of healthcare costs, such provisions reduce the insurer's expected claims liability and, consequently, the average claim per policy. Increasing excesses reduces the insurer's liability for claims and, where excesses become sufficiently large, may also reduce healthcare utilisation as individuals choose to self-insure for lower-value care.¹⁵ Similar effects arise from copay arrangements, under which policyholders bear a fixed proportion of treatment costs. Higher levels of copay have the effect of shifting the demand curve inwards. As insured customers face a cost that is closer to the true resource cost of treatment, they reduce the quantity of care consumed.¹⁶

2.2.4. Application to SCHI as a Friendly Society

32. We note that while the framework set out above applies generally across profit-maximising insurers, SCHI is a "Friendly Society" and therefore has no external shareholders and operates in the interests of its members. We are instructed that consistent with SCHI's pricing principles, premiums are set to meet expected claims costs, operating expenses, and solvency requirements. Thus while SCHI is not targeting profits for shareholders in its pricing, the relationship between expected claim costs and premiums still holds. As a result, increases in

¹² Wynand, P. M. M., Van De Ven, and Randall P. Ellis. "Risk adjustment in competitive health plan markets." In *Handbook of health economics*, vol. 1, pp. 755-845.

¹³ Einav, Liran, and Amy Finkelstein. "Selection in insurance markets: Theory and empirics in pictures." *Journal of Economic perspectives* 25, no. 1 (2011): 115-138.

¹⁴ Dewar, M., Diane. *Essentials of Health Economics*. (Jones and Bartlett Publishers, 2010). p. 5.

¹⁵ Folland, Sherman, Allen C. Goodman, and Miron Stano. *The Economics of Health and Health Care: international Edition*. 8th Edition. (New York: Routledge, 2017). pp. 228-229.

¹⁶ Folland, Sherman, Allen C. Goodman, and Miron Stano. *The Economics of Health and Health Care: international Edition*. 8th Edition. (New York: Routledge, 2017). p. 230.

provider costs ultimately place upward pressure on premiums, policy coverage and terms, or SCHI's financial position, rather than generating shareholder returns.

2.3. Information asymmetries weaken competitive constraints

33. The proposition that independently determined prices are efficient rests on the assumption of symmetric information. As Arrow's (1963)¹⁷ foundational analysis recognised, uncertainty about illness, diagnosis, and the efficacy of treatment causes medical-care markets to depart systematically from the conditions under which ordinary competitive markets are expected to produce efficient outcomes.
34. In reality, healthcare markets exhibit significant information asymmetries that can weaken competitive constraints.¹⁸ The type of information asymmetry where one entity (the agent) makes decisions on behalf of another (the principal) is known as a principal-agent problem in the economics literature. The market for healthcare is characterised by significant principal-agent problems involving patients, physicians, and insurers.
35. These relationships should not be understood as a single principal-agent relationship. Rather, the patient ordinarily delegates substantial clinical decision-making authority to the physician, while an insurer funds much of the resulting expenditure but is not ordinarily present when the clinical and purchasing decisions are made. In addition, the patient possesses information about their health and behaviour that may not be available to the insurer. Each participant therefore holds information that is relevant to the decisions and costs borne by the others.¹⁹
36. In the patient-physician relationship, the patient as the principal relies on the physician as the agent to diagnose the conditions, explain the available options, and recommend a course of treatment. Physicians possess substantially greater clinical knowledge than patients, and acquiring equivalent information is generally impractical, particularly when treatment is urgent, complex, or highly specialised. Patients cannot readily observe whether a recommended procedure was necessary, whether an alternative treatment would have been suitable, or whether the quantity, intensity, and pricing of services supplied were efficient.
37. In addition, patients typically rely on general practitioners (GPs) to recommend and refer them to specialists. This creates an additional layer of information asymmetry, as patients must rely not only on the specialist's recommendations regarding treatment, but also on the referring general practitioner's choice of specialist.
38. A related agency problem arises from the triangular relationship between the patient, physician, and the insurer.²⁰ The insurer funds a significant proportion of healthcare expenditure on behalf of an insured patient but does not have access to the same information as the physician about the patient's clinical condition, treatment options, or the complexity of the procedure. Although the insurer may obtain clinical information to assess eligibility for

¹⁷ Arrow, K. J. (1978). Uncertainty and the welfare economics of medical care. In *Uncertainty in economics* (pp. 345-375). Academic Press.

¹⁸ Folland, Sherman, Allen C. Goodman, and Miron Stano. *The Economics of Health and Health Care: international Edition*. 8th Edition. (New York: Routledge, 2017). p. 273.

¹⁹ Dewar, M., Diane. *Essentials of Health Economics*. (Jones and Bartlett Publishers, 2010). p. 26.

²⁰ David M. Cutler and Richard J. Zeckhauser, "The Anatomy of Health Insurance," in *Handbook of Health Economics*, vol. 1A, ed. Anthony J. Culyer and Joseph P. Newhouse (Amsterdam: Elsevier, 2000), pp. 588-590.

cover, it is not involved in the clinical decision-making process. As a result, the insurer relies heavily on information provided by the physician. Once an eligible procedure is approved for funding, the insurer is generally obliged to meet the cost of treatment. Neither the patient nor the physician bears the full cost of the recommended procedure, the majority of which is instead borne by the insurer.

39. Therefore, the treatment decision, purchasing decision, and funding obligation are divided between different parties. Specifically, the individual making the treatment decision does not bear the full financial consequences of that decision, while the party funding the treatment does not directly determine the services provided. This separation weakens the competitive constraint that informed consumers place on prices, reducing incentives for providers to compete on price.

2.3.1. Healthcare as a credence and reputation good

40. The economics literature has long recognised that healthcare services differ fundamentally from ordinary consumer goods because they are "credence goods": goods (or services) for which the seller possess better information than the buyer and the utility impact is difficult for consumers to evaluate.²¹ Unlike conventional products, patients cannot readily assess either the quality of treatment or, in many cases, the treatment they require, even after the service has been provided.
41. A reputation good is a differentiated service for which consumers search primarily by seeking recommendations from friends, relatives, and other trusted sources. Medical care is a leading example. When search operates in this way, the demand facing an individual provider may be substantially less price elastic than demand in a market where consumers can readily compare price and quality.²²
42. Information problems of the kind observed in healthcare services sometimes have a counterintuitive effect on market outcomes. Standard price theory predicts that an increase in the number of competing sellers drives price downwards towards marginal cost. However, this may not be true for reputation goods. For these goods, as the number of providers increases, information about each provider becomes more dispersed, consumer search may become less effective, and the demand facing each provider may become less price elastic. Under those conditions, an increase in the number of independently pricing providers may cause equilibrium prices to rise rather than fall.²³

2.3.2. Moral hazard

43. In practice, insurance changes the price faced by the patient when care is consumed. An insured patient generally responds to the deductible, co-payment, or coinsurance amount

²¹ Dulleck, Uwe, and Rudolf Kerschbamer. "On doctors, mechanics, and computer specialists: The economics of credence goods." *Journal of Economic literature* 44, no. 1 (2006): 5-42.

²² Satterthwaite, Mark A. "Consumer information, equilibrium industry price, and the number of sellers." *The Bell Journal of Economics* (1979): 483-502.

²³ Satterthwaite, Mark A. "Consumer information, equilibrium industry price, and the number of sellers." *The Bell Journal of Economics* (1979): 483-502.

rather than the full resource cost of treatment.²⁴ Where the insurer pays most or all of an additional dollar of expenditure, the patient has a weaker financial incentive to compare prices, select a lower-cost provider or decline treatment whose incremental benefit is small relative to its full cost.²⁵

44. Moral hazard can therefore produce allocative inefficiency where the incremental cost of bringing the resources to market (marginal cost) exceeds the valuation in the market to those who buy the resources (marginal benefit).²⁶ From an economic perspective, the additional health benefits generated for patients by some treatments may be smaller than the additional resources required to provide them.²⁷ The misallocation of resources among goods (more healthcare being consumed than "should" be according to consumer preferences) creates a deadweight loss.
45. Health insurance therefore involves an inherent trade-off between risk sharing and allocative efficiency. While more comprehensive insurance provides greater protection against financial risk for insured individuals, it also weakens the price signals that encourage the efficient use of healthcare resources.

2.3.3. Adverse selection

46. Adverse selection is another phenomenon that results from asymmetric information. In the insured-insurer relationship, the individuals who choose to purchase health insurance have more information about characteristics affecting expected claims, including their own health and behaviours, than the insurer. Those who expect higher expenditure therefore tend to place greater value on comprehensive insurance than those who expect lower expenditure.²⁸
47. Where insurers cannot perfectly observe and price each individual's risk, higher-risk individuals may be disproportionately represented among those purchasing or retaining generous cover, while lower-risk individuals may purchase less cover or remain uninsured. As described above, insurance premiums must reflect the expected claims costs of the pool. A pool containing a disproportionate share of high-risk individuals will therefore have higher premiums than one containing a representative mix of risks.²⁹

²⁴ Folland, Sherman, Allen C. Goodman, and Miron Stano. *The Economics of Health and Health Care: international Edition*. 8th Edition. (New York: Routledge, 2017). pp. 226-233.

²⁵ This type of moral hazard, in particular, is termed *ex post* moral hazard as it comes into play once the need for healthcare has already arisen. See Peter Zweifel and Willard G. Manning, "Moral Hazard and consumer incentives in health care," in *Handbook of Health Economics*, vol. 1A, ed. Anthony J. Culyer and Joseph P. Newhouse (Amsterdam: Elsevier, 2000), p. 413.

²⁶ Folland, Sherman, Allen C. Goodman, and Miron Stano. *The Economics of Health and Health Care: international Edition*. 8th Edition. (New York: Routledge, 2017). pp. 229.

²⁷ This also applies to the weakening of consumers' incentives to consider the price or efficiency of healthcare when selecting providers or treatment options, even where the quantity of healthcare demanded may be relatively inelastic.

²⁸ David M. Cutler and Richard J. Zeckhauser, "The Anatomy of Health Insurance," in *Handbook of Health Economics*, vol. 1A, ed. Anthony J. Culyer and Joseph P. Newhouse (Amsterdam: Elsevier, 2000), p. 607.

²⁹ Rothschild, Michael, and Joseph Stiglitz. "Equilibrium in competitive insurance markets: An essay on the economics of imperfect information." In *Uncertainty in economics*, pp. 257-280. Academic Press, 1978.

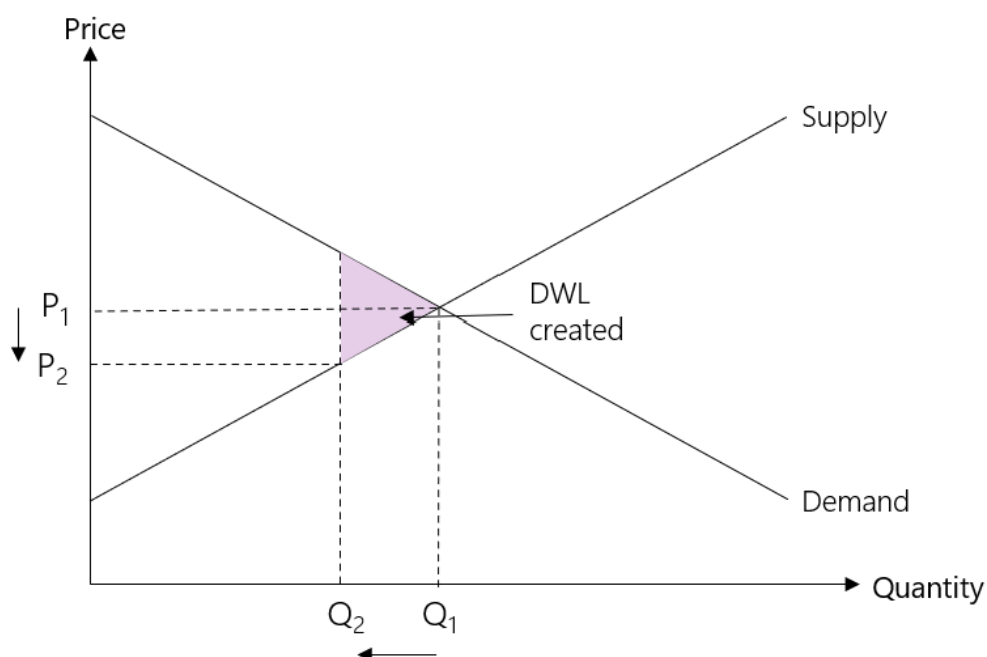
48. Adverse selection may create a reinforcing cycle. Higher claims costs lead to higher premiums, which may induce relatively low-risk individuals to reduce or discontinue coverage. Their departure increases the average risk of the remaining pool and places further upward pressure on premiums. This mechanism is described in the economics literature as the adverse selection "death spiral", where adverse selection, left unaddressed, results in a disappearance of the most generous plans from the market over time.³⁰

³⁰ Cutler, David M., and Sarah J. Reber. "Paying for health insurance: the trade-off between competition and adverse selection." *The Quarterly Journal of Economics* 113, no. 2 (1998): 433-466.

3. The claimed price-related benefits of authorisation assume gynaecology prices are competitive

49. The price-related benefits claimed in the Application rely on an assumption that the prices currently charged for gynaecology services are at the workably competitive level. [11.5(d)] of the Application expressly states that "[p]rices are currently set independently by gynaecologists in workably competitive markets."
50. On this basis, the Application argues that a material reduction in compensation could weaken incentives to invest in training, technology and innovation, reduce clinical quality, and induce gynaecologists to leave private practice or cease treating SCHI members.³¹
51. The economics literature recognises that prices being pushed below the competitive level create efficiency losses. Where prices move below the level necessary to sustain efficient supply, providers may reduce investment, restrict the quantity of services, or exit the market altogether. By weakening suppliers' incentives to invest, innovate, and expand capacity, prices below the competitive level give rise to a deadweight loss (Figure 1), which represents the value of mutually beneficial transactions that could have occurred.

Figure 1: Inefficiency from price below competitive level



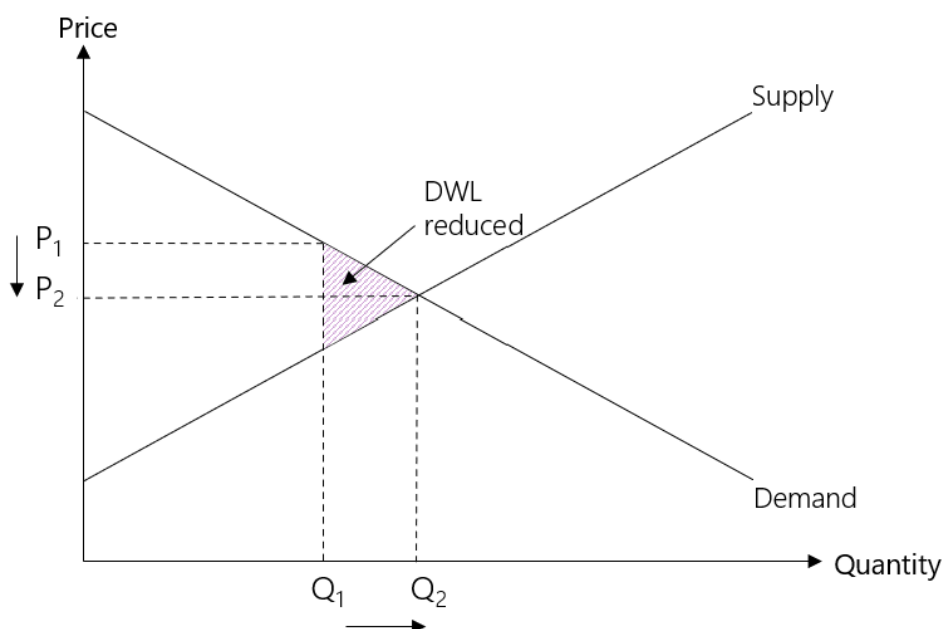
52. However, in this context, gynaecologists' fees cannot be assumed to be competitive simply because they are set independently by individual practitioners. As set out in the economics literature summarised in Section 2, market failures can result in surgical prices being set above

³¹ For example, at [11.21] of the Application.

competitive levels even where there are number of gynaecologists independently setting prices.

53. If current fees are above workably competitive levels, which the literature suggests as plausible under the current structure, then the implementation of new contracting models by SCHI to reduce those fees may move prices towards, rather than away from, competitive levels. Standard economic theory would regard such an outcome as correcting a market failure, and therefore, efficiency-enhancing. If providers are able to charge supracompetitive prices because of market failure, reducing those prices towards competitive levels reduces the allocative distortions associated with that market failure. To the extent that supracompetitive prices deterred otherwise efficient treatment or increased the cost of financing healthcare, reducing those prices increases economic welfare (see Figure 2 below)

Figure 2: Efficiency from price moves towards competitive level



54. In addition, if prices are currently above competitive levels, this results in specific efficiency and distributional issues in insurance markets, as discussed in Section 2.2. In particular, prices above workably competitive levels will induce adverse selection effects and make risk-based pricing more likely.

4. There do not appear to be workably competitive constraints under the current FFS model

55. As discussed in Section 3 above, the price related benefits claimed in the Application rest on the assumption that gynaecology surgery prices are competitive. In this section we conceptually assess whether the structure of the relationships under which gynaecology services are provided is likely to yield competitive outcomes.
56. At a high-level, private health insurance separates clinical decision-making from responsibility for funding care. The patient contracts with the surgeon for clinical services and separately contracts with SCHI for reimbursement of eligible healthcare costs, subject to the policy's terms, limits, exclusions and excesses. The objectives of SCHI, its members and surgeons overlap, but are not identical. Members value timely access to appropriate care, provider choice and protection against unexpected healthcare costs. Surgeons possess substantially better information about diagnosis and treatment, and their recommendations are principally informed by clinical considerations and patient outcomes.
57. SCHI, by contrast, operates an insurance pool and must balance the value of funded care against claims costs, premiums and continued insurance participation (see Section 2.2) for a detailed discussion). This separation means that the parties making and acting on clinical decisions do not generally bear the full financial consequences of those decisions, while SCHI bears much of the resulting cost without directly participating in the setting of the surgeon's fee. SCHI therefore undertakes to fund treatment within the scope of the insurance product purchased, rather than every treatment option that a clinician might regard as optimal.

4.1. Competition between gynaecologists for patients

58. The first relevant relationship is between patients and gynaecologists. We understand that patients are typically referred to surgeons for treatment by a general practitioner, or other health professional, with self-referral being relatively uncommon. We are instructed that referrals are commonly influenced by factors such as professional relationships, reputation, waiting times, and convenience, rather than comparative information on prices or objectively measured clinical outcomes.
59. In addition to this, there appears to be little transparency regarding gynaecologists' surgical fees. We understand prices are generally not published, and patients have limited ability to compare prices charged by different surgeons before treatment. More fundamentally, setting aside the lack of transparency, patients typically lack the clinical knowledge required to assess whether differences in fees reflect corresponding differences in quality, complexity, or value. As a result, patients are generally unable to determine whether a higher-priced surgeon represents better value for money, or whether comparable treatment could be obtained at a lower cost.
60. Further to this, insured patients frequently do not bear the full cost of the surgeon's fee where their SCHI policy provides full reimbursement of eligible surgical fees, which we are instructed is the case for most policy types. Patients therefore have little incentive to compare prices or select surgeons based on efficiency and value for money. Likewise, the referrers (such as GPs)

do not bear the cost of the surgeon's fees and therefore, have limited incentive to consider these when making a referral (particularly for an insured patient).

61. These characteristics are consistent with the types of information asymmetries discussed in the economics literature outlined in Section 2.
62. Taken together, these features suggest that competition between surgeons for patients is not primarily based on price. Rather, patients' choices are likely to be driven by referral pathways and other non-price factors, while their ability to exercise competitive discipline over surgeon fees through informed price comparison is likely to be limited.

4.2. Competition between hospitals for gynaecologists

63. The second relevant relationship is between the surgeon and the hospital. Under the FFS model, hospitals compete to attract surgeons, who may be credentialed at one or more facilities, as surgeons influence the flow of patients to a facility. As stated at [5.39(b)] of the application:

"Hospitals must compete to attract surgeons (who influence a patient's choice of hospital) by providing quality services to both surgeons and patients, including infrastructure, technology, and personnel."

64. Accordingly, hospitals have strong incentives to attract and retain surgeons in order to secure surgical activity at their facilities. Competition between hospitals therefore occurs through the quality and attractiveness of their facilities and services, including operating theatres, equipment, nursing support, and administrative support.
65. Importantly, however, this competition does not extend to the surgeon's surgical fee under the current FFS model. Under the framework as described at paragraphs [5.39]- [5.42] of the Application, the surgeon engages directly with the patient for the provision of professional services, while the hospital separately supplies the facilities within which those services are delivered. The surgeon independently determines the surgical fee, which is subsequently funded by the patient or reimbursed by the insurer in accordance with the patient's policy. Hospitals therefore compete to attract surgeons, but surgeons' surgical fees sit outside that competitive process. As a result, the competitive relationship between hospitals and surgeons does not constrain surgical fees.³²

4.3. Relationship between insurers and gynaecologists

66. The third relevant relationship is between the insurer and the gynaecologist. We understand that under the current FFS model, the insurer funds the entirety³³ of the cost of treatment through the patient's insurance policy, but it is not ordinarily a party to the contract for the supply of the surgeon's professional services. Rather, the contractual relationship for those services remains between the surgeon and the patient, while the insurer separately contracts with the patient to provide insurance cover, subject to the terms of that policy.³⁴ Despite

³² Technically hospitals and surgeons provide economically complementary services. Accordingly, hospitals would prefer surgeons to charge less, as this would increase demand for hospitals. However, for the reasons described, hospitals do not appear to have any influence over surgeons' fees under the FFS model.

³³ With the exception of plans with co-pay and/or annual excesses.

³⁴ Figure 3 in the Application.

bearing most or all of the resulting financial cost, under the current FFS model, SCHI has no *ex ante* contractual mechanism through which it can negotiate or otherwise constrain the surgical fee before the treatment is provided. This limits its ability to manage treatment costs in a way that balances the value of funded care against the financial sustainability of the insurance pool.

67. This mirrors the principal-agent problem between the physician and the insurer as described in the literature outlined in Section 2. Specifically, the insurer bears the financial cost of treatment but is not present when treatment decisions are made and generally lacks the clinical information necessary to independently assess the necessity, complexity, or value of treatment.

4.4. Conclusions

68. Taken together, these features suggest that the current FFS model provides only weak competitive discipline over gynaecologists' surgical fees. Specifically:
- A. Insured patients' incentive and ability to exercise competitive discipline over surgical fees through informed price comparison is likely to be limited.
 - B. Referrers (e.g., GPs) also have limited incentive (and probably ability) to identify the most cost effective surgeon for an insured patient.
 - C. Hospitals compete to attract surgeons, but that competition relates to facilities and support services rather than the surgeon's independently determined surgical fee.
 - D. Insurers fund treatment costs but, under the existing framework, lack any *ex ante* mechanism to negotiate surgical fees directly with individual surgeons.
69. The result is that none of the principal market relationships are likely to place strong competitive pressure on surgical fees. This is important because the Application's claimed detriments from the exercise of countervailing power depend on the premise that existing prices already reflect workably competitive outcomes. Therefore, the existence of independent pricing of surgical fees by individual gynaecologists cannot be taken as evidence that the resulting prices reflect workably competitive outcomes.

5. Observed outcomes under the current model suggest gynaecology prices are not competitive

71. In this section, we consider whether the observed outcomes in the market for private gynaecological services in New Zealand are consistent with the theoretical predictions on market failure as outlined in the literature.
72. The available evidence indicates that the market for private gynaecological services is not currently workably competitive. Specifically, the market has the following identifiable features that, taken together, appear to be inconsistent with workably competitive outcomes:
- A. High degree of variation in fees, not explained by quality;
 - B. High fees compared to Australian [];
 - C. Comparatively high fees, which have risen in real terms and []; and
 - D. Higher prices than [].

5.1. High degree of variation in fees

73. There is also substantial variation in the FFS fees charged by gynaecologists for the same surgical procedures. Figure 3 shows the average and maximum FFS surgeon fees charged in 2024 for a range of gynaecological procedures.

Figure 3: []

74. The variation in fees is considerable. Across all the procedures shown in Figure 3, the highest recorded FFS fee was consistently well above the average fee for the same procedure. Given that fee comparisons are made within the same surgical description, these differences cannot readily be explained by variation in the underlying procedure.
75. In workably competitive markets, prices for comparable services (homogenous products) would ordinarily be expected to converge, unless higher prices reflected superior quality or materially higher costs. We are instructed that the observed variation in fees do not reflect differences in quality. The 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.

5.2. NZ fees are significantly higher than those in Australia

76. The available evidence suggests that gynaecology surgeon FFS fees charged to SCHI are substantially higher than comparable fees in Australia. We understand that gynaecologists in both countries undertake largely the same specialist training through the Royal Australian and

New Zealand College of Obstetricians and Gynaecologists (RANZCOG).³⁵ Accordingly, specialist qualifications and training requirements are comparable.

77. Figure 4 []³⁶

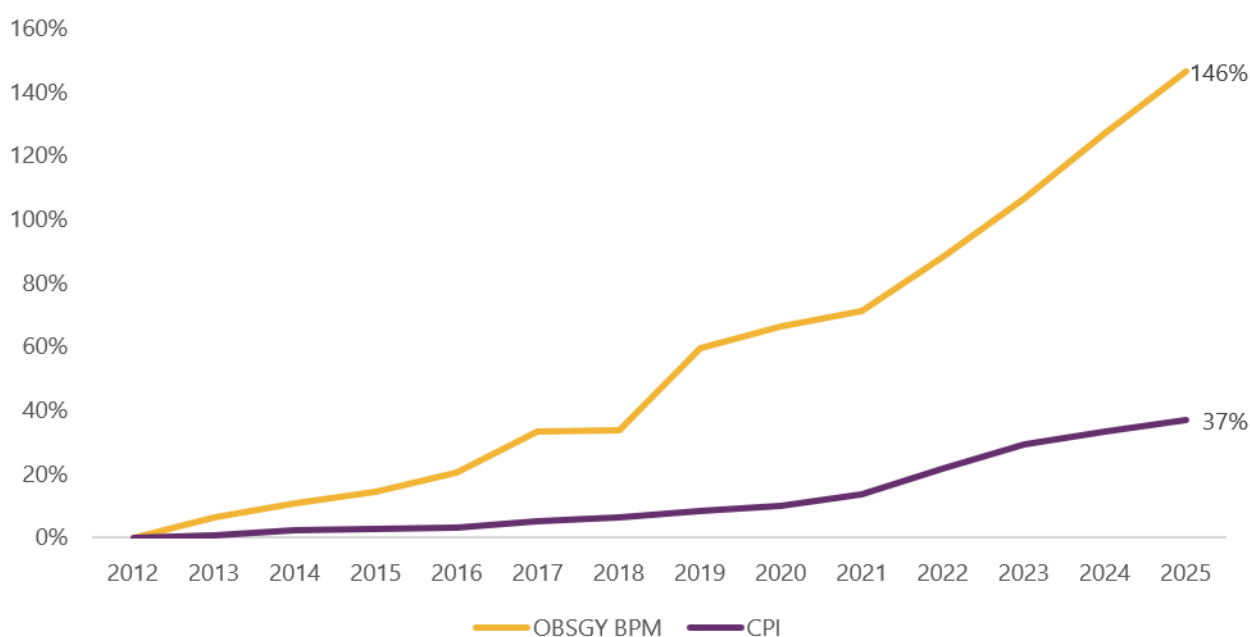
78. This figure shows that the average FFS fees charged by gynaecologists to SCHI exceed []. Across the procedures examined, the average FFS fees are [] higher than [].³⁷

Figure 4: []

5.3. Prices have risen in real terms

79. Figure 5 compares the growth in the average per minute FFS surgical rates charged by Obstetrician-Gynaecology physicians (OBSGY) to SCHI and growth in the Consumers Price Index (CPI) between 2012 and 2025. It shows that FFS rates increased substantially faster than general inflation, indicating that gynaecologist surgical fees have risen in real terms over the period.

Figure 5: Cumulative growth in OBSGY FFS rate per minute vs CPI



Source: NERA analysis of SCHI data.

³⁵ Specialist gynaecologists in both New Zealand and Australia are trained and accredited through the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), meaning they are subject to a common specialist training programme, curriculum, examinations, and professional standards. See "Training Programs", RANZCOG, accessed July 21, 2026, [Link](#).

³⁶ []

³⁷ []

80. Between 2012 and 2022, the cumulative increase in the average OBSGY FFS rate per minute was 146%. Over the same period, the cumulative increase in CPI was 37%. This represents a real increase in gynaecology surgical fees of approximately 80%³⁸, adjusting for CPI inflation.

5.4. Higher prices than []

81. The available evidence suggests that gynaecology surgeons charge higher FFS rates than []. We are instructed that these higher prices are not attributable to differences in surgical complexity or other cost drivers.
82. Figure 6 compares the distribution of prices billed per minute across [] at the first quartile, median, and third quartile. Prices are measured on a dollars-per-minute basis to control for differences in the duration of surgical procedures. We understand the [].³⁹
83. This figure shows that gynaecology has the highest billed-per-minute rates across the entire distribution: at the 25th percentile, median, and 75th percentile, the billed-per-minute rate exceeds that observed in []. As an example, the median billed-per-minute rate for gynaecology is [], compared with [], representing a premium of approximately [].

Figure 6: []

84. As already shown in Figure 5 above, the growth in gynaecology fees has materially outstripped inflation since 2012. This could simply reflect a real increase in costs of being a gynaecologist. However, gynaecology fees have also grown at a greater rate than []. Figure 7 displays the cumulative percentage growth in the FFS dollar billed per minute for [] with 2012 used as a base.

Figure 7: []

85. From 2012 to 2018, the percentage increase in the FFS rate of []. However, from 2018 onwards, the OBSGY FFS rate per minute was increasing faster than []. We are instructed that this divergence is not explained by any associated change in the complexity or quality of gynaecology procedures.

³⁸ The real increase is calculated by $\frac{1+RPM\ growth}{1+CPI\ growth} - 1 = \frac{1+0.146}{1+0.37} - 1 = 0.796$.

³⁹ [5.2(b)(iv)] of SCHI's submission on SoPl, dated 16 June 2026.

6. The AP model is a mechanism to address lack of workable competition and information problems

86. This section considers the likely effects of the AP model in the absence of collective bargaining, and whether collective bargaining is required to produce an efficient outcome:
- A. First, we find no evidence that the AP model will result in prices below the workably competitive level, such that outcomes for patients would deteriorate.
 - B. We then consider the efficiency benefits of prices moving towards the workably competitive level as a result of the AP model. To the extent that the AP model brings prices closer to the workably competitive level, this results in allocative efficiency gains from lower prices, the reduction in adverse selection pressures, and the benefits of maintaining private health insurance coverage.
 - C. Finally, we outline the incentives created by the AP model. The commercial incentives facing SCHI and private hospitals are aligned with those of patients. Specifically, the incentive to maintain competitive prices and ensure adequate access to services and high-quality care for patients exists under the AP model.

6.1. No evidence AP contracts would produce inefficient outcomes in the absence of collective bargaining

87. An AP outcome would be inefficient if gynaecology fees were pushed below the workably competitive level such that the supply or quality of gynaecological services were reduced below efficient levels.
88. As already discussed in Section 4 and Section 5 of this report, gynaecology surgical prices under the current FFS model are likely above the efficient level. As such, the current FFS prices are unlikely to provide an appropriate competitive benchmark. Under the existing FFS model, patients, referrers and hospitals are unlikely to place strong competitive pressure on gynaecologist fees, and SCHI as the funder has no effective *ex ante* mechanism for negotiating those fees.
89. To the extent that current prices are above the workably competitive level, SCHI implementing the AP contracting model to negotiate with hospitals a reduction in costs would not, by itself, indicate that prices are likely to reduce below the competitive level. Rather than pushing prices *below* the competitive level, prices might be pushed *towards* the workably competitive price.
90. Further to this, we understand that the []:⁴⁰
- A. []; and
 - B. [].
91. Although these comparisons may not be individually conclusive measures of the competitive price, taken together, they do not support the proposition that the prices likely to result under an AP framework will be below a sustainable or efficient (i.e. workably competitive) level.

⁴⁰ At [6.2(i)] of SCHI's submission on SoPI, dated 16 June 2026.

92. We also understand that evidence from other specialties does not indicate that the AP model systematically reduces output or quality. SCHI's data show that procedure volumes have continued to increase in specialties that have moved substantially into the AP model.⁴¹ SCHI's patient survey data also do not show poorer reported outcomes for AP-only surgical specialties than for FFS gynaecology.⁴² These comparisons do not establish that the transition caused higher volumes or better outcomes, and they are not a substitute for monitoring gynaecology-specific outcomes. They nevertheless do not support a general proposition that AP contracting necessarily results in under-supply or poorer quality.
93. Taken together, the evidence does not support the proposition that the AP model without collective bargaining will result in an inefficient outcome.

6.2. Reducing gynaecology fees closer to the workably competitive level would result in efficiency gains

94. The reduction in SCHI's claims costs (flowing from lower gynaecologist surgical fees) that would likely occur as a result of the transition of gynaecology surgery to the AP model would likely be efficiency enhancing.
95. These benefits would include:
- A. The allocative efficiency benefits of lower prices.
 - B. The portfolio-wide benefits that reduce issues from adverse selection as result of sustainable premiums.
 - C. The maintenance of insurance coverage such that it reduces the burden on the public healthcare system.

6.2.1. Lower prices improve allocative efficiency

96. As set out in Sections 4 and 705 above, the structure under which gynaecology services are provided in the FFS model suggests there are not workably competitive constraints and there is evidence that gynaecology prices under the current FFS model are above the workably competitive level.
97. Where prices are above the competitive level, they exceed the marginal social cost of supplying the service, resulting in an inefficient allocation of resources and a deadweight loss to society. As set out in Section 2.3, in these circumstances reducing prices towards the competitive level improves allocative efficiency by bringing the price of surgical services more closely into line with the underlying economic cost of supplying them. To the extent this reflects efficient pricing, it affects the quantity, quality and affordability of services. For example, by preventing increases in premiums or co-payments, preserving insurance coverage, or enabling a greater quantity or range of healthcare to be funded from a given pool of premiums.⁴³

⁴¹ Figure 18 of SCHI's submission on SoPI, dated 16 June 2026.

⁴² Figure 19 of SCHI's submission on SoPI, dated 16 June 2026.

⁴³ Section 2.2 sets out the effects of inefficient pricing in healthcare markets.

98. Collective bargaining may weaken this mechanism to the extent it results in compensation materially above the AP outcome without collective bargaining, and the latter is closer to the competitive level. The higher collectively negotiated price would preserve some of the existing economic rent accruing to surgeons, rather than correct an inefficiently low price. In those circumstances, collective bargaining would reduce rather than increase allocative efficiency.

6.2.2. Lower claims cost escalation reduces adverse selection pressures

99. As explained in Section 2.2, expected claims expenditure is a central component of the cost of supplying health insurance. All else equal, lower gynaecology claims costs would reduce the pressure for SCHI to respond through higher premiums, increased excesses or co-payments, or narrower policy coverage.
100. The AP model provides a mechanism for moderating both the level and future growth of those claims costs. Specifically, we understand that procedure prices and the basis for subsequent price adjustments will be agreed prospectively between SCHI and the relevant hospital (with the hospital in turn reaching agreements with gynaecology surgeons). SCHI submits that negotiated prices will be informed by “health sector metrics and/or economy-wide inflation measures”.⁴⁴ This limits the scope for unanticipated claims cost escalation for SCHI and permits prices to be reviewed against objective benchmarks.
101. All else equal, reducing the level or rate of growth of gynaecology claims costs can be expected to reduce the corresponding pressure on premiums and/or policy coverage. This mitigates the adverse selection mechanism discussed in Section 2.3.3 of this report. It would also reduce the pressure on SCHI to introduce gender-based pricing in response to higher claims costs among its insured female population, an approach that the literature suggests may be rational where one group of insured persons is expected to generate disproportionately higher claims costs.
102. This could allow more individuals of different risk profiles to maintain, or expand, health insurance coverage with SCHI. The magnitude of this benefit will depend on gynaecology’s share of total claims costs and the extent to which the claimed cost savings are reflected in premiums or policy benefits. Nevertheless, directionally, as highlighted in the literature, lower expected claims costs help preserve a broader and more stable insurance risk pool.

6.2.3. Maintaining insurance coverage reduces the burden on the public healthcare system

103. As demonstrated by the mechanism outlined in Section 2.2 of this report, if gynaecology claims costs continue to increase above efficient levels, insurers’ responses to cost escalation can cause some consumers to discontinue their private health insurance, or reduce cover for more expensive categories of treatments.
104. We note that not every person who loses or reduces cover will obtain treatment publicly: some may self-fund or defer treatment. However, a proportion can be expected to shift from privately funded to publicly funded care.

⁴⁴ [4.5] of SCHI’s submission on SoPI, dated 16 June 2026.

105. The public healthcare system in New Zealand faces significant capacity constraints. A March 2026 NZIER report to Southern Cross Medical Care Society⁴⁵ found that in 2024/25, the average number of days an individual using the public health system spent on the waitlist for elective procedures was 86.4. This was significantly higher than the average for individuals seeking private treatment to be paid pursuant to their policy with SCHI, which was 39.4.⁴⁶ The difference emphasises the greater available capacity in the private health system relative to the public health system.
106. In particular, for the four gynaecological procedures considered in the NZIER report,⁴⁷ the difference in wait times between the public system and SCHI was approximately 35 days. To the extent that higher premiums or narrower coverage cause some patients to move from private to public care, those patients are likely to wait longer for treatment. The additional demand may also increase congestion in the public system and extend waiting times for existing public patients.
107. Such a shift gives rise to both direct and indirect costs. The public system bears the direct costs associated with increased demand. Longer wait times can also generate wider social costs through absenteeism, presenteeism,⁴⁸ and reduced working hours.⁴⁹

6.3. The AP model is incentive compatible

108. The AP model allows SCHI and hospitals to control costs while retaining incentives to generate efficient outcomes. Both SCHI and hospitals bear costs if prices are set so low that an adequate network of gynaecologists will not participate, quality falls, or access to services deteriorates.

6.3.1. SCHI's incentives are aligned with the interests of patients

109. SCHI earns revenue by attracting and retaining insured members. Its members value insurance partly because it provides timely access to an adequate range of healthcare providers.
110. At sub-competitive prices, there is a risk that gynaecologists would choose not to contract with AP hospitals and therefore SCHI's members would have reduced access to gynaecology services. To prevent such an outcome, SCHI has the incentive to maintain wide access to services for its members. Similarly, SCHI will want to ensure that gynaecologists earn enough to maintain quality of treatments provided.
111. In addition to this, SCHI's objective function differs from that of a conventional profit-maximising, or shareholder-owned, insurer. As stated at [2.2] of SCHI's submission, SCHI is a

⁴⁵ New Zealand Institute of Economic Research, *Comparison of wait times HealthNZ and Southern Cross Medical Care Society* (NZIER report to Southern Cross Medical Care Society), March 2026.

⁴⁶ NZIER report to Southern Cross Medical Care Society, p. 4.

⁴⁷ Hysterectomy, hysteroscopy D&C +/- other proc, colposcopy with biopsy, and endometriosis surgery were considered.

⁴⁸ "Presenteeism" is defined as the act of going to work despite medical illness, and therefore, functioning below capacity.

⁴⁹ NZIER. "Comparison of wait times", Report to Southern Cross Medical Care Society (March 2026), p. 9.

Friendly Society. It has no external shareholders and does not distribute profits. To the extent that SCHI reduces claims costs through more efficient procurement, the resulting financial benefits could therefore support more affordable premiums, enhanced member benefits, improved services, and/or strengthen the long-term sustainability of SCHI. SCHI's status as a Friendly Society therefore reduces the risk that it would have an incentive to suppress provider remuneration below efficient levels merely to maximise profits.

112. This member-focused approach is reflected in SCHI's claims expenditure. As stated at [2.3(b)] of SCHI's submission, in the year ended 30 June 2025, 94% of SCHI's premium revenue was returned to members through funding their healthcare costs, above the market average of 76%.
113. An AP price that materially reduced the availability or quality of gynaecological care would therefore diminish the value of SCHI's insurance products and risk member dissatisfaction or departure.
114. SCHI's incentive is therefore not to minimise surgeon remuneration or the care funded to individual members. Prices or coverage settings that materially reduce provider participation or quality of care, would affect access for members and consequently reduce the value of, and demand for, its insurance product. SCHI is therefore incentivised to balance cost containment against access and quality to maintain an efficient supply of gynaecology services.

6.3.2. The AP model does not remove the incentive for hospitals to compete for gynaecologists

115. Private hospitals invest in operating theatres, equipment, nursing capability and other supporting infrastructure.⁵⁰ Those investments presumably involve substantial fixed and sunk costs. Hospitals therefore require sufficient surgical activity to utilise that capacity and recover those costs.
116. Surgeons are important to that activity because they influence where their patients receive treatment and may be credentialled at multiple hospitals.⁵¹ NZGA itself states at [5.13] that private hospitals "need to attract surgeons to their facilities".
117. We understand that the AP model changes the contractual and funding arrangements through which gynaecological procedures are paid for. Specifically, SCHI would agree a bundled procedure price that it pays to the hospital, which would then contract with the surgeon and anaesthetist and reach agreement on how the bundled payment is allocated between the relevant providers. NZGA characterises this as repositioning surgeons from customers of hospitals to "downstream subcontractors subject to insurer-driven terms".
118. However, as is the case under the FFS model, the surgeon would continue to provide an essential input into the hospital's supply of surgical services under the AP model. A hospital cannot earn the relevant bundled payment or utilise its theatre capacity without attracting suitably qualified surgeons to perform procedures.

⁵⁰ The Application at [5.13].

⁵¹ The Application at [5.39(b)].

119. Further to this, assuming gynaecologists continue to be credentialed at multiple hospitals, they retain bargaining leverage with individual hospitals.
120. Accordingly, it is not clear why the introduction of the AP model would cause hospitals to cease competing for gynaecologists. The claim that hospitals would cease competing for gynaecologists is made at several places throughout the Application, e.g., at paragraphs [1.7] and [5.57].
121. The Application does not demonstrate the mechanism through which competition between hospitals disappears. Rather, the bundled payment appears to act as a budget constraint within which hospitals continue to compete for surgeons. Hospitals remain free to determine how much of the bundled payment they are willing to allocate to surgeon remuneration, accepting a lower retained portion for the facility component where necessary to attract or retain surgeons.

6.3.3. Hospitals are better placed to mitigate issues emerging from information asymmetries

122. Section 2.3 of this report explained that healthcare markets are characterised by significant information asymmetries. In particular, patients are typically one-off purchasers of healthcare services and generally lack the expertise or information necessary to assess whether differences in surgeons' fees reflect corresponding differences in quality, complexity, or value. As a result, patients are poorly placed to exercise competitive discipline over prices.
123. The AP model implements a negotiation process in place of the current unilateral setting of surgical fees by individual surgeons. Under the AP model, hospitals negotiate and reach agreements on a bundled procedure price with SCHI while simultaneously engaging with medical professionals, such as gynaecology surgeons, regarding the remuneration for their component of the procedure. SCHI provides hospitals an indication of the surgeon fee component that it expects the bundled price to accommodate. Where the hospital considers that the proposed bundled price is insufficient to cover the remuneration of the relevant providers, the hospital and SCHI negotiate further over the bundled procedure price.⁵² Therefore, rather than the patient's insurer reimbursing a surgeon's independently determined fee after treatment, hospitals negotiate up front (for a fixed period of time) with SCHI a bundled procedure price that includes the surgeon fee component.
124. Unlike individual patients, hospitals will become repeat purchasers of surgical services. For example, a patient might purchase one of a specific type of treatment through their lives, while a hospital might purchase hundreds of such treatments in a given year. They will therefore negotiate with multiple surgeons over time, observe historical prices across a large number of procedures, observe prices across providers, and have a better understanding of the costs associated with providing treatment.
125. Consequently, hospitals are better placed than individual patients to evaluate whether differences in remuneration are justified by factors such as clinical complexity, experience, quality or other legitimate cost drivers.

⁵² [4.4] of SCHI's submission to NZCC.

126. This arrangement can mitigate some⁵³ of the information asymmetries present under the FFS model by introducing informed, repeat purchasers into the negotiation process. This strengthens the ability of remuneration to reflect observable differences in costs and value, while reducing the scope for fees to be sustained at levels that are not supported by complexity, quality or other relevant economic factors.

⁵³ Information asymmetry is unlikely to be completely eliminated as hospitals may not fully observe clinical complexity or quality.

7. Conclusions

127. The Application's price-related benefits assume current FFS gynaecology fees are at the workably competitive level and that detriments would therefore arise from SCHI negotiating lower prices.
128. Information asymmetries and the structure of principal-agent relationships⁵⁴ between doctors, patients, hospitals and insurers means that independent fee setting by gynaecologists cannot be assumed to result in competitive prices. The current FFS model likely provides only weak competitive discipline over gynaecologists' surgical fees because:
 - A. Insured patients and referrers (such as GPs) generally have limited ability to observe, compare, and assess specialist surgical fees before treatment decisions or referrals are made. Specialist recommendations, perceived clinical quality or reputation, and availability often play a more significant role in provider selection for patients than price. Therefore, insured patients' and referrers' *ability* to exercise competitive pressure over surgeon fees through informed price comparison is likely to be constrained. As a result, fee competition is unlikely to operate in the same way as it does in markets where prices are transparent to, and readily comparable by, customers (or their agents).
 - B. Insured patients' and their referrers' *incentive* to exercise competitive pressure over surgeon fees are also likely to be constrained where their SCHI policy provides full reimbursement of eligible surgical fees, this being the case for most policy types. In those circumstances, patients do not experience out of pocket costs and therefore have limited economic incentive to select providers on the basis of price.
 - C. Hospitals compete to attract surgeons, but that competition relates to facilities and support services rather than the surgeons independently determined surgical fee.
 - D. Insurers fund treatment costs but, under the existing framework, lack any effective *ex ante* mechanism to negotiate surgical fees directly with individual surgeons.
129. Observed outcomes are consistent with existing gynaecology surgical fees being above competitive levels. In particular, New Zealand private surgical gynaecology fees:
 - A. Vary significantly for the same procedures;
 - B. Exceed relevant Australian [];
 - C. Have risen materially faster than inflation and []; and
 - D. Are higher than [].
130. The AP model is a mechanism for SCHI to address lack of workable competition and information problems:
 - A. There is no evidence that the AP outcome without collective bargaining would push prices below sustainable (i.e. workably competitive) levels. [], and []. Furthermore, SCHI's experience introducing AP arrangements for other specialties does not suggest that the

⁵⁴ In the economics literature, the type of information asymmetry where one entity (the agent) makes decisions on behalf of another party who bears the costs and/or benefits of those decisions (the principal) is known as a principal-agent problem. See Section 2.3.

Public version

model results in lower procedure volumes. In addition, a reduction in fees towards competitive levels would not, by itself, suggest that quality would decline.

- B. Reducing fees towards the workably competitive level would have efficiency and distributional benefits:
 - i. **Allocative efficiency:** Reducing economic rents by bringing the price of surgical services more closely into line with the underlying economic cost of supplying them. To the extent this reflects efficient pricing, it would allow a given pool of insurance premiums to fund a greater quantity or range of healthcare services.
 - ii. **Reduced adverse selection:** Adverse selection in insured health care arises when rising premiums cause healthier, lower-risk members (who expect to claim less) to reduce or cancel their cover, leaving a higher-risk pool with higher average claims and creating further pressure for premium increases, which in turn may cause more members to cancel or reduce cover.
 - iii. **Reduced pressure on public system:** Maintaining the affordability and scope of private health insurance can reduce pressure on the public health system. With lower premiums, fewer patients would be expected to shift from privately funded to publicly funded care, reducing additional public expenditure, waiting times and wider costs associated with delayed treatment.
- C. Incentives under the AP model suggests its introduction will be efficiency enhancing:
 - i. Hospitals are better placed than individual patients to negotiate with surgeons because they are informed, repeat purchasers able to compare prices, costs, and quality across the provider with whom they contract.
 - ii. SCHI and hospitals retain strong incentives to maintain adequate provider participation, access and quality, and hospitals would continue to compete for gynaecologists under the AP model.



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