

COMMERCE ACT 1986

Notice by New Zealand Gynaecology Association Inc seeking authorisation under section 58(1), (2), (6B) and (6D) (and interim authorisation under section 65AAA)

Restrictive trade practices

The Registrar
Competition Branch
Commerce Commission
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19 May 2026

CONTENTS

1.	OVERVIEW	3
2.	EXECUTIVE SUMMARY	4
3.	APPLICANT & PARTICIPANT DETAILS	14
4.	RATIONALE FOR THE APPLICATION	15
5.	BACKGROUND.....	16
6.	THE PROPOSED ARRANGEMENTS	28
7.	RELEVANT MARKETS	32
8.	THE COMMISSION HAS JURISDICTION TO GRANT AUTHORISATION	34
9.	FRAMEWORK FOR ASSESSING NET PUBLIC BENEFITS OF COLLECTIVE BARGAINING.....	36
10.	COUNTERFACTUAL(S).....	42
11.	APPLYING THE NET PUBLIC BENEFIT TEST.....	45
12.	APPLICATION FOR INTERIM AUTHORISATION	58
13.	CONFIDENTIALITY	59
	DECLARATION.....	60
	APPENDIX 1 – CONTACT DETAILS OF RELEVANT PARTIES TO THE PROPOSED ARRANGEMENTS.....	61
	APPENDIX 2 – NZGA’S CURRENT CHRONOLOGICAL SUMMARY OF SCHI’S CONDUCT	63
	APPENDIX 3 – LIST OF FURTHER DOCUMENTS PROVIDED WITH APPLICATION	64
	APPENDIX 4 – ANALYSIS OF [] & []	65
	APPENDIX 5 – EXAMPLE STANDSTILL DEED	66

1. OVERVIEW

- 1.1 Southern Cross Medical Care Society and/or hospitals are proposing new affiliated provider arrangements relating to gynaecological surgery. Under current arrangements the insurer/funder pre-approves the cost of surgery with its members/insured (or pays to a level or declines). Under Southern Cross's proposal there will be significant changes in clinical and contractual relationships which have the potential to impact numerous related markets.
- 1.2 The proposal would see hospitals being head contractors, apparently with a financial distribution from Southern Cross and recommendations about the split of funding between the hospital, anaesthetists and gynaecologists, but with hospitals ultimately determining that allocation. Early indications are that all gynaecologists, regardless of expertise or experience, would be paid the same amount by each hospital and that the amounts offered by each hospital will generally be much the same (ie largely consistent national pricing). Currently hospitals compete to attract surgeons, including gynaecologists. However under the proposal, the insurer/hospital would become the funder/provider (of hospital services) and "customer", potentially losing or adversely impacting the patient/clinician relationship, and potentially dampening competition between hospitals (or worse).
- 1.3 Gynaecologists generally support Southern Cross's objective of maintaining affordability for its members, however they are concerned at the lack of engagement by Southern Cross and consider that there are high risks of inadequately informed decisions, leading to unintended consequences to the detriment of the New Zealand public (mainly female patients). Not only are there broader public interests than Southern Cross members, but management views and decisions (often non-medical) may well be suboptimal compared to alternatives, including more market-based measures.
- 1.4 Gynaecologists have sought to engage with Southern Cross, so that if/when it implements its proposal, it is making fully (or at least better) informed decisions. Southern Cross initially refused to engage, insisting only on bilateral negotiations. This creates high risk of significant information asymmetries and could be expected to lead to suboptimal outcomes.
- 1.5 Southern Cross continued to refuse to engage, despite the later formation of the New Zealand Gynaecology Association representing over 90% of all private gynaecologists and designed to be competition-compliant, including ensuring that the officers were not "in competition", compliance measures in place (including compliance guidelines for all members), and the involvement of a lawyer with significant competition experience in relevant meetings.
- 1.6 NZGA therefore has no choice but to seek authorisation to collectively bargain as it does in this application. It does so in the hope that Southern Cross, in imposing its new model, will engage and has sufficient regard to the short and long-term impacts on women's health on a fully or at least better-informed basis. NZGA cannot, of course, force Southern Cross to agree to terms.
- 1.7 However it seems that Southern Cross will likely resist bilateral discussions and may still have little interest in engaging even if authorisation were granted for collective bargaining only. Accordingly, this application also separately seeks authorisation of a limited short-term standstill agreement, so that Southern Cross is more inclined to engage with NZGA. This is not a collective boycott, and gynaecologists would continue to compete as they do now. The Southern Cross / hospitals proposal implies an understanding between at least some hospitals to stop competing for surgeons to operate at their hospitals (ie to reverse the current relationship under which they compete to attract surgeons). At the very least they would seem to need sufficient comfort that their competitors would do the same before embarking on such a significant change. That said, it is not clear that all hospitals wish to make this change, although they face a powerful funder with its own affiliated hospital chain (the largest in New Zealand).
- 1.8 Interim authorisation is sought due to the pressure being placed on gynaecologists to effectively participate on unknown terms or be excluded under time constraints. It is necessary to maintain the status quo before market structure is permanently changed.

2. EXECUTIVE SUMMARY

Introduction

- 2.1 This application seeks authorisation and interim authorisation under sections 58(1), (2), (6B), (6D) and 65AAA of the Commerce Act 1986 (**Act**) to collectively bargain with health insurance funder Southern Cross Health Insurance (**SCHI**)¹ and / or hospital(s).
- 2.2 The application is made by the New Zealand Gynaecology Association Inc (**NZGA** or **Applicant**) on behalf of its members² (**Participants**).
- a. NZGA would lead collective negotiations on behalf of its members, acting as the exclusive bargaining party at the negotiating table with SCHI.
 - b. NZGA would consult individual members (who put forward their requests, concerns, risks etc to NZGA) and then negotiate requested changes with SCHI.
 - c. Any negotiated changes would be circulated to NZGA members for further feedback before changes are settled with SCHI.
- 2.3 The Applicant seeks authorisation for a period of 10 years (and seeks interim authorisation) to:
- a. Collectively bargain with SCHI and / or hospital(s) for the provision of private gynaecological services³ to SCHI-insured patients (including to periodically negotiate any further changes as needed during this period);
 - b. Enter into a limited Standstill Agreement between the Participants to defer any contracting with SCHI for a period of 6 months (as set out in Section 6) to:⁴
 - i. Facilitate proper and meaningful engagement by SCHI to negotiate with NZGA; and
 - ii. Reduce pressure on individual gynaecologists to commit to significant change before or while negotiations are taking place (ie a collective refusal to sign but not a 'boycott' in any traditional sense as members would still compete in all regards to provide services as they do today).

In other words, the Standstill Agreement is intended to encourage SCHI to engage in meaningful discussions with NZGA, but the decision will ultimately be SCHI's;
 - c. Engage in discussions and exchange information to the extent relevant and reasonably necessary for those collective negotiations;
 - d. Enter into individual bilateral agreements between individual gynaecologists and SCHI and /or hospital(s) based on a common set of reference terms (ie a contractual framework) as collectively negotiated; and

¹ See paragraphs 5.18 to 5.19 for further details on Southern Cross entities and a structure diagram. As we set out in paragraph 2.18, the Commission previously determined that SCHI is "associated" with SCH and that the two should be treated as one.

² As discussed in Section 6 below, this will include any of NZGA's current and future members (as set out in any amendments to the application) that choose to participate in the Proposed Arrangements.

³ Private gynaecology services for the purposes of this application are defined broadly to cover any comprehensive care provided to patients in relation to the female reproductive system by a gynaecology specialist and includes (but is not limited to) consultations, diagnosis, screening, contraceptives and fertility and surgical services.

⁴ The Applicant submits that, to the extent that the limited Standstill Agreement raises discrete concerns, the Commission may treat the standstill as a standalone request for authorisation which could be varied or subject to conditions separately.

- e. Give effect to the provisions of agreements and / or separate agreements based on the reference terms collectively negotiated (including any revisions from time to time).

2.4 For the avoidance of doubt:

- a. The Proposed Arrangements do not involve entering into contracts, arrangements or understandings regarding services provided by Participants to their patients;
- b. **Participation is voluntary** and Participants may opt out of the Proposed Arrangements at any time following notice under the Standstill Agreement;
- c. Subject to the Standstill Agreement, all Participants remain free to engage in bilateral negotiations with hospitals (albeit such bilateral negotiations are unlikely to be fruitful based on recent experience);
- d. There is no member-to-member commitment under the Proposed Arrangements other than under the Standstill Agreement; and
- e. The Applicant seeks to negotiate with:
 - i. Southern Cross Medical Care Society (**SCMCS**)⁵;
 - ii. all SCMCS interconnected bodies corporate (as identified in Figure 1 at paragraph 5.18) and associated persons; and / or
 - iii. hospitals,

to the broadest extent necessary to enable effective collective bargaining of the provision of private gynaecological services. (Noting that the proposed contractual arrangements and counterparties under SCHI's Proposal remain unclear.)

Further detail and scope are set out in Section 6 (**Proposed Arrangements**).

- 2.5 The scope of potential conduct under the application is sufficiently broad to enable objectives and outcomes ultimately be dictated by SCHI including whether SCHI is willing to consider and implement any of the Applicant's proposals (Noting that even with the encouragement of a limited standstill SCHI could still 'walk away' and unilaterally determine its approach after the standstill ends).
- 2.6 The application is made in response to a proposed restructure of contracting, funding and patient relationships, which SCHI seeks to impose, **the details of which are unclear**. The Applicant therefore seeks authorisation to advocate for SCHI making an informed decision that properly considers clinical views regarding a patient-focused, clinically workable and sustainable framework for the provision of private gynaecological services.
- 2.7 SCHI is refusing to engage with the NZGA board, for stated Commerce Act reasons, and are instead (via hospitals) pressuring individual gynaecologists to submit their proposed fees for review and counter-offer or 'miss out' entirely on funding for SCHI members despite providing no clarity about the scope of any contracts under the proposed contractual framework (see Figure 4 at paragraph 5.47).

⁵ SCHI is the 'brand' name used by SCMCS (trading as Southern Cross Health Society) which owns the "Southern Cross" entities (not hospitals).

- 2.8 On that basis, interim authorisation is also sought to:
- a. Alleviate the disproportionate pressure on individual gynaecologists to adhere to imminent time-constraints being placed by SCHI and / or hospitals;
 - b. Temporarily pause any potentially irreversible changes while they can be assessed more carefully; and
 - c. Allow the Applicant to give effect to the Proposed Arrangements and prepare for collective bargaining (which should reduce the information asymmetries currently present and allow gynaecologists to better understanding what they are signing up to).

Rationale for the application

- 2.9 Ultimately this application is about seeking engagement from SCHI so that it makes informed decisions on a proposed fundamental restructuring of the provision of private gynaecology services. SCHI's Proposal would materially alter contracting, funding and (weaken) patient-clinician relationships, with potentially irreversible adverse impacts on competition, clinical autonomy (displacing with management non-clinical decision making), and patient outcomes (women's health).
- 2.10 The Applicant seeks authorisation (and interim authorisation) to collectively bargain as SCHI has refused to engage with NZGA due to Commerce Act concerns and is instead insisting on bilateral negotiations with individual gynaecologists (which raises a number of issues around effective negotiation).
- 2.11 Collective bargaining creates an opportunity for the parties to explore any opportunities to pursue better alternatives that are mutually beneficial, reducing costs for SCHI whilst maintaining the quality and sustainability of gynaecological services.
- 2.12 The Applicant does not seek to prevent SCHI from implementing its proposal. Rather, it seeks to ensure that any implementation is based on fully informed decision-making, with proper clinical and market input (SCHI can ultimately decide what happens and could ignore any suggestions by NZGA). A limited Standstill is also sought to encourage meaningful engagement by SCHI of any collective negotiation authorised (and maintain the status quo).
- 2.13 We expand on the rationale in Section 4.

Background

SCHI's Proposal

- 2.14 It appears SCHI (via hospitals) is proposing (on a 'take it or leave it' basis) a radical restructure of the contractual framework and remuneration model for the provision of private gynaecology services (**SCHI's Proposal**):⁶
- a. SCHI would impose back-to-back contracts with hospitals as head contractors, who would negotiate contracts with gynaecologists as subcontractors.
 - b. SCHI would pay hospitals bundled fees (surgeon, anaesthetist and hospital fees) and may have provided recommended pricing for how the bundled fees should be split.

⁶ SCHI's Proposal follows a recent 2022 trial [()] of implementing an AP-only model replacing Fee-for-Service for all procedures.

- c. Hospitals would in turn procure gynaecology services from individual clinicians for (significantly) reduced compensation (up to 30 to 50%⁷) at a set ‘common price’ (in other words, one price with no price signals).
- d. SCHI and / or hospitals are currently requesting gynaecologists to provide their expected fees which the hospitals may then use to negotiate with SCHI.⁸ The communications imply there will be one price set for each procedure under codes. SCHI is effectively reversing the current contractual framework by requiring gynaecologists to sell services to hospitals. SCHI’s Proposal appears to involve parallel contracting arrangements with hospitals, including SCHI Affiliated Southern Cross Hospitals (**SCH**), which raises questions of a potential ‘*hub and spoke*’ cartel (or cartel-like arrangements with comparable effects).⁹
- e. SCHI would assign each procedure a code and fixed fee (**AP coding**) and it appears that SCHI is determining these fees with minimal clinician input and not providing transparency around how these fees were calculated (or the underlying data used).
- f. The ‘risk corridor’¹⁰ provided under SCHI’s Proposal does not sufficiently detail objective criteria (noting that SCHI has the sole discretion over this determination) upon which a gynaecologist could request further funding when surgeries would / do become more complex than what is funded by SCHI.

2.15 See Figure 4 at paragraph 5.47 for a diagram of the proposed contractual framework.

2.16 SCHI has advised that it intends to contract directly with hospitals, and has stated in meetings with NZGA that it will not negotiate with clinicians individually.¹¹

Potential (adverse) impacts of SCHI’s Proposal

2.17 While the Applicant acknowledges and recognises the benefits that SCHI’s Proposal may bring to its insured members (eg efficiencies of insurance claims processes and providing patients, insurers and providers clear price certainty) there may be detriments and it remains concerned that SCHI may not be making sufficiently informed decisions that support clinical and patients’ best outcomes (including the long term sustainability of gynaecological services to support women’s health). It may also (inadvertently and inappropriately) be interfering with the need to maintain independent clinical decision making.

2.18 SCHI appears to be leveraging its dominance in the health insurance market to influence other related markets, which could (without sufficient engagement to make informed efficient decisions) have adverse competition (and consumer) harm and broader public detriments as

⁷ Anecdotally a large number of the most experienced, skilled and in demand gynaecologists are expected to unilaterally drop their prices 30–50%. Further aggregated data is expected to be assessed to determine the broader average effects.

⁸ Although SCHI and / or hospitals do not appear to be deploying a consistent approach to obtaining fees / estimates.

⁹ Hospitals would cease competing to supply hospital services to gynaecologists (output restriction and / or market allocation) and under SCHI’s Proposal would appear to be engaging in parallel arrangements to acquire gynaecology services with the understanding that their competitors would also entering on similar / same terms with SCHI.

¹⁰ For example, ‘Risk Corridor’ is defined in SCHI’s [] as “*a mechanism that provides additional payment when a procedure takes longer than the average expected time, without altering the price for the applicable service.*”

¹¹ []; and in several face-to-face meetings with gynaecologists.

summarised below. (The Commerce Commission (**Commission**) previously determined that SCHI was “associated”¹² with SCH¹³ and that the two should be treated as one.)

- 2.19 **Adverse impacts of non-price terms:** By way of example only, SCHI’s Proposal may result in:
- a. **Clinically appropriate procedures being excluded:** Some patients with multi-compartment prolapse may clinically require multiple procedures to be performed together in one operation, but the proposed AP coding structure would exclude this approach, resulting in repeat surgery and poorer outcomes. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (**RANZCOG**) has expressed its concerns that SCHI’s AP coding is deficient, in particular in urogynaecology and gynaecology.¹⁴
 - b. **Pelvic floor procedure codes:** SCHI had indicated that pelvic floor procedures would remain outside the Affiliated Provider (**AP**) scheme on a Fee-for-Service basis, however the revised AP coding issued on 2 February 2026 included a number of those procedures.¹⁵
 - c. **Ignoring procedure and patient complexity:** SCHI’s Proposal does not appear to adequately account for variation in surgical complexity (eg severe adhesions, repeat surgery, high BMI patients) or patient factors that will extend their post-operation recovery. While ‘risk corridors’¹⁶ are referenced, there is limited clarity on how these operate in practice. Without this, there is a risk of misalignment between procedural complexity and reimbursement, which may impact access and sustainability. This may have flow-on effects to the public system where patients with marked surgical complexity or medical comorbidities may be directed to public gynaecology care if the AP scheme is not able to meet their complex needs.
 - d. **Adverse impacts on quality, investment (human capital & technology) and innovation:** Including:
 - i. Gynaecologists may be less inclined to compete on innovation (new training, new techniques etc), if compensation is materially reduced and / or below workably competitive pricing. It appears that AP coding does not materially differentiate (or account for) procedures carried out using advanced techniques or new technology (eg robotic surgery, sacral nerve modulator) and therefore does not factor in any investment in training or innovation to promote advancing gynaecological practices (as compared to performed with less advanced or technological techniques).
 - ii. Relatedly there may be less inclination to differentiate (or subspecialise further) if SCHI adopts an inadequate fixed fee model.
 - iii. There could be unintended consequences (eg if some providers sought to increase output speed or quantity by doing ‘easier’ procedures) which is already

¹² [Decision No 537 - Southern Cross Oxford Hospital Ltd and The Oxford Clinic](#) at [34]: “Having taken the relevant factors into account the Commission concludes that there is a community of interest between the Trust and the Society, which can, for the purposes of commerce and competition, be regarded as one.”

¹³ Southern Cross Health Trust which owns and operates Southern Cross Healthcare Limited (Southern Cross Hospitals (**SCH**)) a strong national network of hospitals. See [About Us - Southern Cross Healthcare](#).

¹⁴ []

¹⁵ [] See **Appendix 2** for further details.

¹⁶ As discussed in fn 10, ‘Risk Corridor’ is defined as “a mechanism that provides additional payment when a procedure takes longer than the average expected time, without altering the price for the applicable service.”

compounded by current clinical coding limitations which require some women to undergo multiple operations to achieve a successful outcome.¹⁷

- e. **Reduction in supply or output of gynaecologist services ('labour' markets):** Existing gynaecologists may seek to exit the industry earlier (eg early retirement / offshore exit) or at least exit providing services to SCHI members (the bulk of the private health insurance market).¹⁸ Indeed, RANZCOG acknowledges that there are challenges in recruiting and retaining staff and the gynaecology workforce is more reliant on Specialist International Medical Graduates (**SIMGs**)¹⁹ for staffing (including disproportionately in provincial hospitals).²⁰
- i. Exits from the NZ private sector could also have adverse flow on effects on public sector supply (or overburden the public sector to proportionally service more patients). Anecdotal evidence suggests current wait times for gynaecological surgeries are more than 3 months for private practice and over a year for the public sector.
 - ii. Further, gynaecologists working abroad would be more inclined to defer returning to New Zealand, or not return at all.
 - iii. Gynaecologists conducting postgraduate qualifications may similarly be less inclined to return to New Zealand. As discussed above, RANZCOG identified deficiencies in urogynaecology and gynae-oncology with AP coding, which are subspecialties that are particularly vulnerable areas of exit risk (with low numbers under these subspecialties).²¹
 - iv. Potential gynaecologists may be less likely to pursue this career, for example choosing a specialisation which compensates more fairly.
- f. **Asymmetric contract terms:** For example, the draft [] contract purports to impose one-sided obligations (including obligations to the head-contract without any visibility) for individual gynaecologists. See **Appendix 4** for further analysis of such imbalances.

2.20 **Adverse impacts of uninformed common pricing:** While SCHI, as a dominant funder, may wish to manage costs, SCHI's Proposal effectively seeks to replace (and potentially distort) market signals with its own price/market controls (by setting its own common pricing under AP coding) without adequate consultation of clinicians. This may, especially if set too low, result in:

- a. **(Inappropriately) categorising surgeries in a quantitative manner:** SCHI's Proposal directly conflicts with and second guesses the appropriate care required as it sets common prices too low and without sufficient clinical input (or context) will not account for the qualitative aspects of surgery.

¹⁷ Some clinical coding limitations prevent surgeons from completing all necessary procedures in a single operation. As a result, women may need to undergo multiple general anaesthesia's to achieve results. Although there has been around a 70% improvement since the initial stage, these codes have not yet received full approval from RANZCOG or NZGA.

¹⁸ Anecdotally NZGA has received 4 letters confirming that gynaecologists (and a further letter from an anaesthetist) may exit if SCHI's Proposal goes ahead without change. See **Appendix 3**.

¹⁹ SIMGs refer to medical professionals that have trained overseas (either trainees or specialists) that move to New Zealand to work as a medical practitioner.

²⁰ See [O&G Workforce in Aotearoa New Zealand Report \(2022\)](#).

²¹ Anecdotal evidence suggests that some urogynaecologists/ gynaecologists with special interest may not continue doing pelvic floor surgeries.

- i. Gynaecological surgeries are heterogenous, unpredictable and complexities often arise, with large variability in duration and complexity of surgery based on findings intraoperatively.
 - ii. Despite this, the Applicant considers the ‘risk corridor’²² provided under SCHI’s Proposal does not sufficiently detail objective criteria (noting that SCHI has the sole discretion over this determination which interferes with clinical decisions) upon which a gynaecologist could request further funding when surgeries would / do become more complex than what is funded by SCHI.
 - iii. SCHI’s Proposal may impact the level of care that a patient receives.
 - iv. Indeed, anecdotal evidence suggests that currently SCHI already refuses to exercise ‘risk corridor’ discretion even when complex surgeries are performed.²³ This could be exacerbated under SCHI’s Proposal.
 - v. Gynaecologists would likely be forced to second guess the appropriate care required to treat patients due to conflicts with what is permitted under AP coding.
- b. **Limited support for assistant/second surgeons:** There is limited support and guidance from SCHI regarding billing for assistants or second surgeons in complex procedures, as well as limited recognition of the broader work (‘wrap around service’) required to deliver safe surgical care (including pre-op preparation, multidisciplinary input, and post-op follow-ups). SCHI already limits funding for assistant surgeons even where the operating surgeon considers the case to be complex, which risks undermining clinical judgment. There are concerns that this will be exacerbated under the proposed changes.
- c. **Reduced quality of care (including audit/credentialing):** Surgical care is not limited to just the operation and includes pre and post-operation care by surgeons, nurses and administrative staff. Currently the proposed AP coding and pricing does not appear to account for this.

2.21 If these terms are defined by SCHI and/or hospitals rather than the medical specialists supplying those services, there is a real risk they will be clinically inappropriate, undermining independent clinical decision-making and creating avoidable patient risk.

2.22 For completeness, the Applicant notes their understanding that some hospitals may have their own concerns about SCHI’s Proposal.

No SLC...

2.23 As a starting point, the Applicant considers that the Proposed Arrangements would not have, nor be likely to have, the purpose, effect or likely effect of *substantially* lessening competition (SLC) in any relevant markets (possibly the reverse), nor do they consider that there would be any relevant cartel provisions (at least not protected by a relevant exception).

2.24 However the Applicant’s desire to provide input and negotiate an AP scheme that is safe, reflects clinical best practice and does not create unintended consequences for patients, providers and SCHI necessitates this application.

²² As discussed in fn 10, ‘Risk Corridor’ is defined as “a mechanism that provides additional payment when a procedure takes longer than the average expected time, without altering the price for the applicable service.”

²³ For example, see email chain between [] in **Appendix 3**.

...but the Commission has jurisdiction to assess this application

- 2.25 The “competition threshold” under sections 58(1) and (2) is low, and only requires a lessening of competition, not one that is substantial.²⁴ The Applicant considers that section 27 might apply and this threshold would be met (ie a lessening of competition may arise) to the extent that:
- a. The Proposed Arrangements leads to more standardised price and non-price terms. In other words, in the counterfactual(s) (without the Proposed Arrangements) there may be more diverse price / non-price terms as gynaecologists would have negotiated separately in individual bilateral agreements; and
 - b. A standstill may defer implementation of SCHI’s Proposal.
- 2.26 The cartel prohibition under section 30 is per se broad and any contract, arrangement or understanding between competitors or potential competitors may be captured to the extent it restrains or may restrain independent autonomy in the future. Cartel conduct does not require a nexus to an SLC (or any anti-competitive effects) nor it seems a counterfactual.²⁵ On that basis, one may consider that there might be a cartel provision as:
- a. One or more gynaecologists might be in competition to be included as a supplier of gynaecological services to hospitals under SCHI’s Proposal (ie if current arrangements were reversed); and
 - b. Under that proposal, gynaecologists would be reaching a commitment (as to supply, output or price) in relation to the supply of gynaecological services.
 - i. The Proposed Arrangements (excluding the standstill) could be caught as this involves agreeing common terms upon which supply is made; and
 - ii. Separately for the Standstill Agreement, this would be to agree, for a limited period, not to supply services under any new contract.
 - c. Regardless, for the purposes of sections 58(6B) and (6D), it is not necessary for the Commission to determine whether a particular provision is in fact a cartel provision, provided there are “reasonable grounds” for believing that it might be.²⁶ That standard is met.

Authorisation should be granted

- 2.27 The Applicant considers that there is little, if any, detriment in granting authorisation and interim authorisation (rather the reverse).
- 2.28 Conversely, authorisation for the Proposed Arrangements would likely provide considerable public benefits (largely from mitigating the potential detriments or risks identified with SCHI’s Proposal), including (but not limited to):
- a. **Clarity through clinical governance:** Structured engagement ensures the AP scheme is clinically informed and subject to ongoing review (including coding, eligibility (exclusion and combination rules) and administrative processes). This would produce a workable

²⁴ [Commerce Commission NZBA CIT Authorisation Draft Determination \(24 March 2026\) \(NZBA\)](#) at [46]. See also [s 61\(6A\) of the Act](#) which explicitly states that “a lessening in competition includes a lessening in competition that is not substantial” for the Commission’s jurisdiction.

²⁵ See *Lodge Real Estate Ltd v Commerce Commission* [2020] NZSC 25; see also [John Land Clarifying New Zealand Competition Law: Establishing “Arrangements” between Competitors, the “Controlling” of Price, and Anti-Competitive “Purpose” after Lodge \(2019\) 25 NZBLQ 255.](#)

²⁶ See [s 61\(9\)](#) of the Act.

framework, improve consistency in approvals, reduce disputes and rework, minimise pre-operative uncertainty, and reduce administrative inefficiencies.

- b. **Clinically backed AP coding and patient outcomes:** A properly negotiated coding framework would likely align with clinical care pathways and enable gynaecologists to exercise professional judgment (eg to combine procedures) without artificial constraints imposed by coding or eligibility settings. This reduces the likelihood of fragmented treatment and enables more efficient delivery of care. Expected benefits include fewer repeat procedures, reduced anaesthetic exposure, shorter recovery times, faster access to complete care, and reduced pressure on surgical capacity.
- c. **Regulatory oversight:** Authorisation provides a formal, supervised framework with clear safeguards (including legal oversight and defined scope), reducing Commerce Act risk and limiting unintended coordination outside the authorisation.
- d. **Mitigates or avoids likely adverse impacts of SCHI's Proposal:** As discussed above, collective bargaining reduces the risk of potential adverse impacts of SCHI's Proposal including reduced private capacity, spillover to the public system, and diminished investment and innovation.
- e. **At the very least, proper engagement may lead to greater certainty for all parties and buy-in.**
- f. **Consistent with Australian and NZ collective bargaining authorisations, the usual recognised public benefits:**²⁷ (a) reduced transaction costs,²⁸ (b) more efficient (price and non-price) contract terms, and (c) positive impacts on allocative, productive and dynamic efficiency from alleviating the imbalance in bargaining power.²⁹ These public benefits are provided in more detail in Section 9 and applied in Section 11.

2.29 Therefore, the Applicant submits that the public benefits outweigh any potential detriments and therefore, the Proposed Arrangements should be authorised (including on an interim basis).

Further considerations for interim authorisation

2.30 The (self-determined) urgency imposed by SCHI (and potentially in turn by the hospitals) indicates that interim authorisation should be granted:

- a. To *maintain the status quo* (and prevent the potential harm to competitive dynamics which may be irreversible or difficult to unwind if the contractual framework is changed) while an informed decision is made;
- b. As there could be broader (potentially irreversible) harm to the public (predominantly women) as outlined in this application; and
- c. Given the potential harm to the Applicant (who absent interim authorisation may be forced to enter into economically and / or personally unfavourable contractual arrangements which they are not familiar with and have not had the benefit of seeking legal advice in relation to).

2.31 As discussed above, SCHI's Proposal seeks to replace market signals with price/market controls.

²⁷ See for example [New Zealand Tegel Growers Association Incorporated \[2022\] NZCC 30 \(TGA\)](#) at [109].

²⁸ [TGA \[2022\] NZCC 30](#) at [111].

²⁹ [TGA \[2022\] NZCC 30](#) at [111].

- 2.32 Gynaecologists have been keen to understand the proposal and its impacts, but have noted SCHI has been unwilling or unable to engage meaningfully.
- 2.33 For clarity, NZGA accepts that (if legal) SCHI may impose this model. Its primary goal is to seek to ensure that SCHI does so on an informed basis, minimising unintended consequences, and it is hoped, providing greater clarity for all stakeholders.

3. APPLICANT & PARTICIPANT DETAILS

3.1 This notice seeking authorisation and interim authorisation under sections 58(1), (2), (6B), (6D) and 65AAA of the Commerce Act 1986 (**Act**) is given by New Zealand Gynaecology Association Incorporated (**NZGA** or **Applicant**).

3.2 The contact details for the Applicant are:

New Zealand Gynaecology Association Incorporated
 c/- Tompkins Wake
 Westpac House
 430 Victoria Street
 Hamilton Central 3204
 New Zealand

Attention: []

Parties to the Proposed Arrangements

3.3 The parties to the Proposed Arrangements (**Participants**) are NZGA and any of NZGA's current and future members (as set out in any amendments to the application) that choose to participate in the Proposed Arrangements.

3.4 The names and contact details of identified Participants are in **Appendix 1**. For clarity, all Participants will retain the ability to withdraw from the Proposed Arrangements by notifying the NZGA.

3.5 All correspondence in relation to this notice should be directed in the first instance to:

Matthews Law
 Level 33 Vero Centre
 48 Shortland Street
 PO Box 2579
 Shortland Street
 Auckland 1140

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3.6 NZGA is a gynaecologists body representing 127 out of 141 private gynaecologists in New Zealand (and out of roughly 400 total specialists overall across both public and private systems).³⁰ The NZGA exists to provide national leadership on key issues affecting providers of gynaecological surgery services including advocacy for, and supporting of the sustainability and viability of its members' businesses and services they provide. This ensures continuity of locally accessible and high-quality patient-centric gynaecological surgery services to improve the health of New Zealand's female population.³¹

³⁰ RANZCOG suggests that in 2020 there were 334 active specialists and 130 trainees. See [A looming crisis... or a crisis? The O&G workforce in Aotearoa – Report of the Aotearoa New Zealand O&G Workforce Working Group](#) (July 2022).

³¹ See NZGA Constitution, available on the Incorporated Societies Register at <https://is-register.companiesoffice.govt.nz/>.

4. RATIONALE FOR THE APPLICATION

- 4.1 This application is made to enable informed, structured engagement on a proposed fundamental restructuring of the provision of private gynaecology services. SCHI's Proposal would materially alter contracting, funding and clinical relationships, with potentially irreversible effects on competition, clinical autonomy, and patient outcomes.
- 4.2 The Applicant does not seek to prevent SCHI from implementing its Proposal. Rather, it seeks to ensure that any implementation is based on fully informed decision-making, with proper clinical and market input.
- 4.3 NZGA was established as a competition-compliant medium for collective engagement, precisely to allow balanced and informed discussion of SCHI's Proposal and its system-wide implications. Despite repeated attempts to engage constructively, SCHI has refused to engage with NZGA collectively and has instead insisted on bilateral engagement with individual gynaecologists.
- 4.4 Individual gynaecologists have a limited ability to negotiate effectively with SCHI and / or hospitals, particularly where access to SCHI-insured patients is essential to the commercial viability of private practice. SCHI and / or hospitals have applied time pressure and commercial leverage to require gynaecologists to commit to SCHI's Proposal (despite the lack of contractual clarity and the absence of meaningful engagement on key terms).
- 4.5 This creates a real risk that clinicians will enter into arrangements without sufficient information to assess (or limited ability to negotiate) the clinical, commercial, and patient implications of the proposed changes. The Applicant's concern is not simply that change is proposed, but that it may occur in circumstances where informed, patient-centred decision-making is not possible.
- 4.6 In practical terms, absent authorisation, NZGA is limited to acting as a non-binding advocacy body, which has proven ineffective in securing meaningful engagement. SCHI has declined to engage on a specialty-wide basis citing competition law concerns, while simultaneously seeking information and commitments from individual clinicians. This creates a clear process failure, where engagement is neither informed nor efficient.
- 4.7 The Applicant therefore seeks authorisation to engage in collective bargaining, consistent with the Commission's established recognition of the efficiency benefits of such arrangements. Collective bargaining will enable structured engagement on both price and non-price terms, including pricing structures, risk corridors, coding frameworks, and clinical governance. It will also allow the parties to test, refine, and (where appropriate) pursue alternative or modified frameworks that better promote effective competition, clinically appropriate care, and long-term system sustainability.
- 4.8 A limited Standstill Agreement is therefore necessary to preserve the status quo, alleviate immediate pressure on individual clinicians, and provide a credible incentive for SCHI to participate in collective discussions. Without such a mechanism, SCHI may proceed unilaterally, and any subsequent engagement would be partial, retrospective, or effectively academic.
- 4.9 Authorisation will therefore enable the Applicant to advocate for patient-centred, clinically appropriate outcomes, influence the design and implementation of SCHI's Proposal, and ensure that any resulting framework supports the long-term sustainability of private gynaecology services. It will also produce recognised efficiency benefits, including reduced transaction costs, improved information flows, and more effective negotiation outcomes relative to fragmented bilateral engagement.

5. BACKGROUND

Overview of the New Zealand health sector

Introduction – Decision No 537

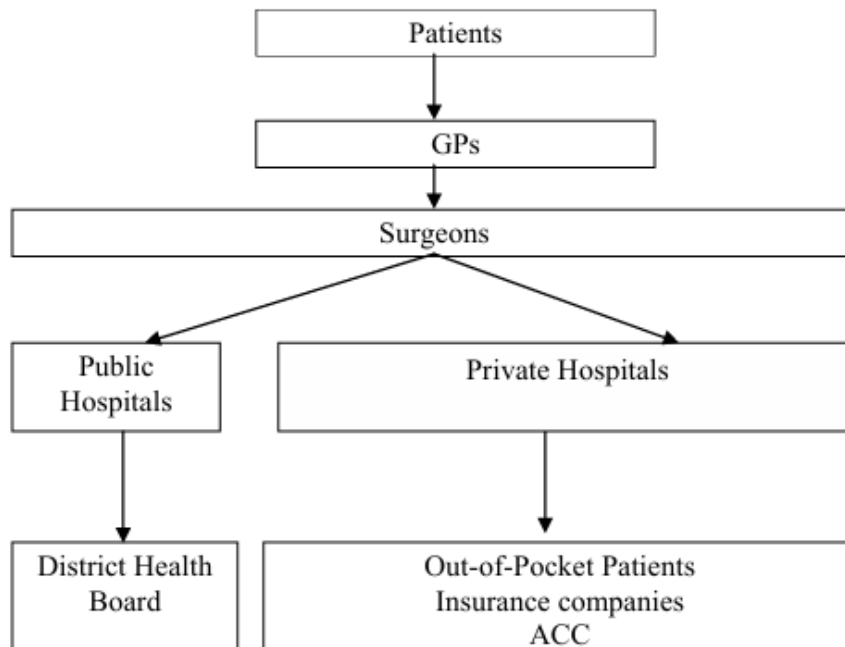
5.1 While an old determination, the Commerce Commission’s (**Commission**) Decision No 537³² provides a good starting point for considering “*the provision of healthcare services in NZ*” where it noted:

37. There is a relatively **complex set of relationships** leading to a particular patient being operated on by a particular surgeon in a particular hospital. As shown in Figure 2 [provided below], **patients are first seen by a primary healthcare provider** (usually a GP). If surgery is warranted, or specialist consultation is required, the patient will be referred to a surgeon. Most GPs will have preferred surgeons they refer patients to.
38. If the surgeon decides that surgery is appropriate, a decision will be made as to the hospital (secondary healthcare provider) where the surgery will be undertaken, depending on the hospital (or hospitals) where that surgeon operates.^[33]
39. Often **the choice of hospital is influenced by the surgeon**. The factors taken into account are **cost, location, timeliness or anticipated quality of care**. Sometimes the patient’s insurer will have an influence on the choice of hospital, in that patients might be encouraged to select a particular option.

[emphasis added]

Figure 2: Main Industry Participants in Healthcare

34



³² [Commerce Commission Decision No 537 – Southern Cross Oxford Hospital Ltd and The Oxford Clinic \(11 November 2004\)](#) (**Decision No 537**).

³³ What hospital is chosen is also influenced by things such as (a) whether surgery is a day-stay procedure or requires inpatient care and (b) patient factors (eg need for high dependency unit after surgery which is only available in some private hospitals).

³⁴ The Applicant notes that there can be multiple sources of referrals outside GPs such as other specialists, physiotherapists/ allied medical health and self-referrals.

- 5.2 Paragraph 41 noted: *“Private hospitals typically do not provide surgeons or the ancillary specialist skills such as the anaesthetists or physiotherapists. These medical professionals contract directly with the patient and therefore bill the patient separately.”*
- 5.3 Decision No 537 also described funding sources, noting paragraph 46: *“The patient finances most elective surgery in private hospitals, either directly or via insurance.”* We expand on, and update, that commentary below.
- 5.4 This market structure largely remains. District Health Boards (**DHBs**) have been replaced by Te Whatu Ora (Health New Zealand) (**TWO**) (which was highly centralised, now less so).

Overall structure of the New Zealand health system

- 5.5 New Zealand operates a mixed public-private health system, in which:
- a. Publicly funded care is provided primarily through the state; and
 - b. Privately funded care operates alongside it, funded by a combination of private health insurance and direct patient payments.
- 5.6 The two systems are not separate silos. They interact continuously through:
- a. Shared workforce (clinicians practise across both);
 - b. Shared infrastructure (patients may move between systems); and
 - c. Funding decisions that influence where and how care is delivered.

Public system: role of Te Whatu Ora (Health New Zealand)

- 5.7 The public system (previously DHBs) is centrally organised through Te Whatu Ora (Health New Zealand) (**TWO**), which:
- a. Plans, commissions, and funds publicly provided health services;
 - b. Owns and operates public hospitals; and
 - c. Employs or contracts a large proportion of the clinical workforce.
- 5.8 Public provision is:
- a. Budget-constrained;
 - b. Subject to prioritisation and waiting lists; and
 - c. Focused on universal access rather than individual choice.
- 5.9 In practice demand always exceeds capacity with minimum 3 months for private and over a year for public systems wait lists. There is a year-on-year increase in demand which cannot be met by public capacity with some delays in surgery running several years. Anecdotal evidence suggests that in some regions there are times when public gynaecology departments decline GP referrals for surgery. So some patients who are eligible for public care choose (or are forced to seek) private treatment to receive timely care.

ACC: a distinct public funder within the system

- 5.10 The Accident Compensation Corporation (**ACC**) occupies a unique position. It is a statutory monopoly insurer for *personal injury*. It funds treatment for covered injuries regardless of fault. In gynaecology this includes maternal birth injuries, treatment injuries (eg mesh, IUDs) and sensitive claims. ACC purchases services from both public providers and private clinicians and hospitals.
- 5.11 ACC sets national pricing schedules (in other words, providers cannot negotiate pricing). It also imposes contractual and compliance conditions. ACC materially influences the viability of private practice in certain specialties as ACC places downwards pressure on price.
- 5.12 ACC has limited involvement in private gynaecology.³⁵

Private system: hospitals, clinicians, and insurers

- 5.13 Private hospitals are independently owned and operated. They provide facilities, theatres, and support services. As noted in Decision No 537.³⁶
- a. They contract with clinicians for admitting rights and use of facilities.
 - b. Hospitals generally do not employ specialists as staff; they earn revenue from facility fees rather than professional fees.
 - c. They need to attract surgeons to their facilities.

Private clinicians

- 5.14 Again as the Commission noted, specialists in private practice typically:
- a. Contract directly with patients for professional services;
 - b. Charge fees on a Fee-for-Service basis; and
 - c. Practise surgeries across multiple hospitals and across public and private settings.
- 5.15 Their ability to practise privately depends, among other things, on access to hospital facilities; and access to funded demand (patients able to pay or obtain reimbursement).

Role of private health insurance

- 5.16 Private health insurance:
- a. Supplements the public system (on average 35% of the population is covered by private health insurance³⁷);
 - b. Funds elective and specialist care; and
 - c. Enables patient choice and continuity.
- 5.17 Insurance does not replace the patient-clinician relationship. Rather:

³⁵ Limited (and anecdotal) evidence suggests less than 1% of all private gynaecology services are paid for by ACC.

³⁶ Decision No 537 at [41].

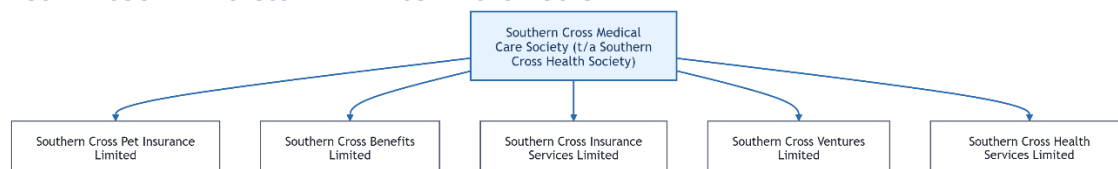
³⁷ See [Ministry of Health NZ Health Survey](#) data from 2024/2025 on Adult Topic: Private health insurance.

- a. Patients remain the contracting party with clinicians; and
- b. Insurers reimburse patients (or pay benefits) subject to policy terms.

Southern Cross Health Insurance (SCHI)

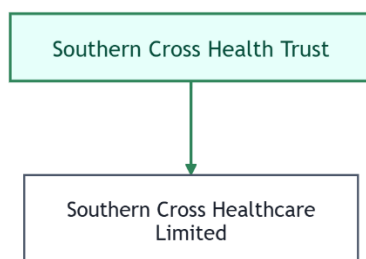
5.18 SCHI is the ‘brand’ name used by Southern Cross Medical Care Society (**SCMCS**) (trading as Southern Cross Health Society (**SCHS**)) which owns the “Southern Cross” entities — See below Figure 1.

FIGURE 1: SOUTHERN CROSS HEALTH INSURANCE STRUCTURE



5.19 Southern Cross Healthcare Limited (ie Southern Cross Hospitals (**SCH**)) is a separate entity owned by Southern Cross Health Trust and not within the SCMCS structure. Regardless, the Commission previously determined that SCHI is “associated” with SCH and the two should be treated as one.³⁸

FIGURE 2: SOUTHERN CROSS HOSPITALS STRUCTURE³⁹



SCHI is the dominant health insurer (and thus funder of private healthcare)

5.20 **SCHI is the dominant private health insurer & has a persistently high market share in NZ:** It has around 60% (lives) or 68% (GWP) share of health insurance.⁴⁰ Other players include nib, AIA, Partners Life, UniMed and Police Health.⁴¹ In many jurisdictions there would be a presumption of market dominance given SCHI’s strong and enduring market share.

- a. For example, in South Africa there is a rebuttable presumption of dominance at 35% and a non-rebuttable presumption of dominance at 45%. Germany has a similar presumption that 40% which can be rebutted.⁴²
- b. Similarly under US Merger Guidelines there is a 30%+ share threshold (accompanied changes in other market concentration indicators).⁴³

³⁸ [Decision No 537 - Southern Cross Oxford Hospital Ltd and The Oxford Clinic](#) at [34]: “Having taken the relevant factors into account the Commission concludes that there is a community of interest between the Trust and the Society, which can, for the purposes of commerce and competition, be regarded as one.”

³⁹ We do not detail for the purposes of this diagram all hospitals owned by SCH.

⁴⁰ See [SCMCS 2025 Annual Report – Summary](#) at p.3.

⁴¹ We have not been able to locate reliable estimates for other insurers’ market shares by lives or GWP available, however, SCHI appears to have access to data from the Financial Services Council to estimate its market shares for its Annual Reports.

⁴² [International Bar Association submission: Review of section 36 of the Commerce Act and other matters](#) at [2.5].

⁴³ [Antitrust Division | 2.1. Guideline 1: Mergers Raise a Presumption of Illegality When They Significantly Increase Concentration in a Highly Concentrated Market | United States Department of Justice.](#)

- c. We understand that in the EU a market share of 50% or more creates a rebuttable presumption of dominance.⁴⁴
- 5.21 **Special status:** SCHI has the benefit of its not-for-profit status, demonstrated by its higher payouts (also suggesting its market presence is greater than its share).⁴⁵ The Commission previously considered that this status did not negate market power concerns.⁴⁶
- 5.22 **Branding & association:** SCHI has further market power due to the strength of its brand and its ‘association’ with Southern Cross Hospitals (**SCH**) (as determined by the Commission).⁴⁷
- 5.23 **Past Commission view:** In Decisions 399 and 404 the Commission was not satisfied the Aetna merger “would not result...[in it] *acquiring or strengthening a dominant position in the medical insurance market.*”⁴⁸ That merger was cleared on the third occasion (subject to divestment of the overlapping business), the Court of Appeal (**CoA**) overturned that finding. However, substantial market power (**SMP**) is much lower threshold than dominance. A critical reason for the CoA’s overturning the Commission was the Commission had determined that there were low barriers to entry and expansion, but it has more recently in general insurance matters reversed that view (correctly).
- 5.24 **SCHI’s AP scheme & actions indicate SMP:** Dictating terms (or seeking to) and / or the AP scheme itself are actions consistent with SMP. The fact that SCHI is seeking to and/or has imposed conditions on hospitals and health providers such as gynaecological suppliers is consistent with SMP (seeking to dictate common prices, particularly for different markets; imposing / requiring agreement to be an AP for providers’ patients / its members being reimbursed etc).

SCHI has funder power which is similar to buyer power and can also raise concerns

- 5.25 SCHI already has funder power. SCHI’s Proposal would essentially make it a customer via hospitals (which raises clinical concerns).
- 5.26 The Commission’s Misuse of Market Power Guidelines confirm this is analysed in the same way as seller power, considering “*whether competition in upstream markets is substantially harmed by the exercise of unilateral buyer power. In these types of cases, harm to competition can also occur in the downstream market where the buyer has power, as a result of the protection of the buyer’s market position.*”⁴⁹
- 5.27 Similarly, in declining the proposed *Foodstuffs* merger Chair Dr John Small stated in the Commission’s media release on 1 October 2024:⁵⁰

...the merged entity would likely be able to extract lower prices from suppliers and/or otherwise adversely impact suppliers in the relevant markets. We are also concerned that the consolidation with the proposed merger would lead to reduced investment and

⁴⁴ [OECD, The Use of Structural Presumptions in Antitrust – Note by the European Commission \(4 December 2024\)](#) at [32].

⁴⁵ See [SCMCS 2025 Annual Report – Summary](#) at p.3.

⁴⁶ In declining clearance for Southern Cross’ proposed acquisition of Aetna Health, the Commission proceeded on the basis that Southern Cross’s ownership structure did not prevent it from possessing and exercising substantial market power in health insurance markets. That proceeded on a full divestment and for other reasons the Court of Appeal ultimately held the merger did not enhance market dominance (ie “control” under the old higher merger test).

⁴⁷ We also note that the definition of “*person*” under [s 2](#) of the Act includes “any association of persons whether incorporated or not”.

⁴⁸ [Commerce Commission Decision No 399: Southern Cross Medical Care Society; Aetna Health \(NZ\) Inc \(Aetna Inc\)](#); [Commerce Commission Decision No 404: Southern Cross Medical Care Society; Aetna Health \(NZ\) Inc \(Aetna Inc\)](#); and [Commerce Commission Decision No 407: Southern Cross Medical Care Society; Aetna Health \(NZ\) Inc \(Aetna Inc\)](#).

⁴⁹ See [Commerce Commission Misuse of Market Power Guidelines](#) at [16], [38] and [77] and *Commerce Commission v Telecom Corporation of New Zealand Ltd* [2010] NZSC 111, [2011] 1 NZLR 577 at [33].

⁵⁰ [Commerce Commission - Commerce Commission declines clearance for the proposed Foodstuffs merger.](#)

innovation by suppliers, meaning reduced consumer choice and/or quality ... for consumers.

[emphasis added]

Relevance of SCHI's market power

5.28 For many clinicians:

- a. They depend on SCHI as access to SCHI-insured patients is **essential** to the viability of private practice;
- b. Gynaecological services are provided under a solo practice or as part of a small group competing with each other for patients;
- c. Alternative insurers do not provide a realistic substitute at scale; and
- d. Exclusion from SCHI reimbursement can result in:
 - i. Loss of a significant proportion of private patients; and
 - ii. Effective exit from private practice.

5.29 This gives SCHI:

- a. Significant buyer-side influence (with access to over 140 private gynaecologists nationally); and
- b. The practical ability to shape terms on which private care is delivered.

5.30 As the largest (by far) health insurer and thus most significant funder of privately funded procedures SCHI has 'monopoly-like' characteristics on the supply side (noting significant switching barriers) and 'monopsony-like' characteristics on the funding side.

- a. On the supply side, SCHI's 'must have' scale, switching barriers and its ability to gatekeep access to its insured patients, gives it the ability to unilaterally shape contractual and market conditions, consistent with 'monopoly-like' characteristics:
 - i. There is limited substitutability given SCHI makes up 60% (lives) of all those insured. Other insurers are significantly smaller and would not provide equivalent volumes of patients to private practices. Becoming an Affiliated Provider for SCHI therefore becomes a 'must have' for private practices.
 - ii. Patients are tied to their insurer (switching barriers) as any pre-existing conditions would not be covered when changing to a new insurer.
 - iii. SCHI largely dictates the eligibility for cover and therefore, effectively sets the parameters under which clinicians may access SCHI-insured patients.
- b. On the funding side, SCHI's 'monopsony-like' characteristics are evidenced by:
 - i. SCHI's market dominance of the demand for private procedures in a pool with few buyers.
 - ii. Limited substitutability of SCHI with other buyers (eg ACC, public, other insurers etc) by private practices.

SCHI can and does dictate or influence price and non-price terms. Indeed, this application is made on that basis to allow the NZGA to better negotiate for an informed decision by SCHI. **Interaction between public, ACC, and private insurance funding**

5.31 From a clinician's perspective, the funding environment is highly constrained:

- a. Public funding is capped and rationed.
- b. ACC funding is compulsory and price-regulated.
- c. Private insurance funding, particularly through SCHI, is dominant but conditional.

5.32 Clinicians therefore:

- a. Cannot freely substitute between funding sources;
- b. Face asymmetric bargaining power when negotiating with large funders; and
- c. Bear most of the adjustment risk when funding terms change.

System-level consequences

5.33 The structure described above means that:

- a. Large funders' decisions can have system-wide effects, not merely bilateral ones.
- b. Changes to private insurance contracting models can:
 - i. Affect clinician supply;
 - ii. Influence patient access and continuity;
 - iii. Place additional pressure on the public system if private capacity contracts; and
 - iv. Place further pressure on the public system where those practitioners working in both the public and private sector either exit the NZ market or do not return from overseas.

5.34 From a competition and public-interest perspective, this makes:

- a. The conduct of dominant funders;
- b. The terms on which private care is reimbursed; and
- c. The ability of clinicians to engage collectively, matters of legitimate regulatory concern.

Why this background matters for authorisation analysis

5.35 This industry structure explains why:

- a. Individual clinicians often lack effective countervailing power;
- b. Collective bargaining may be a proportionate response to funding concentration; and

- c. Interim authorisation (and the Standstill Agreement) would likely be justified to avoid irreversible shifts in market structure while the Commission considers authorisation.

Industry context – gynaecologists

- 5.36 Gynaecologists principally provide gynaecological and associated surgical services to women and their unborn or newborn children, including services in relation to high-risk pregnancies, infertility, miscarriage, ectopic pregnancy, caesarean delivery, and other reproductive health conditions.
- 5.37 All NZGA members operate in private practice. In that setting, surgeons typically:
- a. work with private hospitals for access to theatres, facilities and equipment (who contract with patients to pay for these services); and
 - b. Provide clinical services directly to patients on a Fee-for-Service basis.
- 5.38 Gynaecological services are commonly funded, in whole or in part, through private health insurance held by patients.

Current orthodox contractual framework (Fee-for-Service Model including SCHI AP)

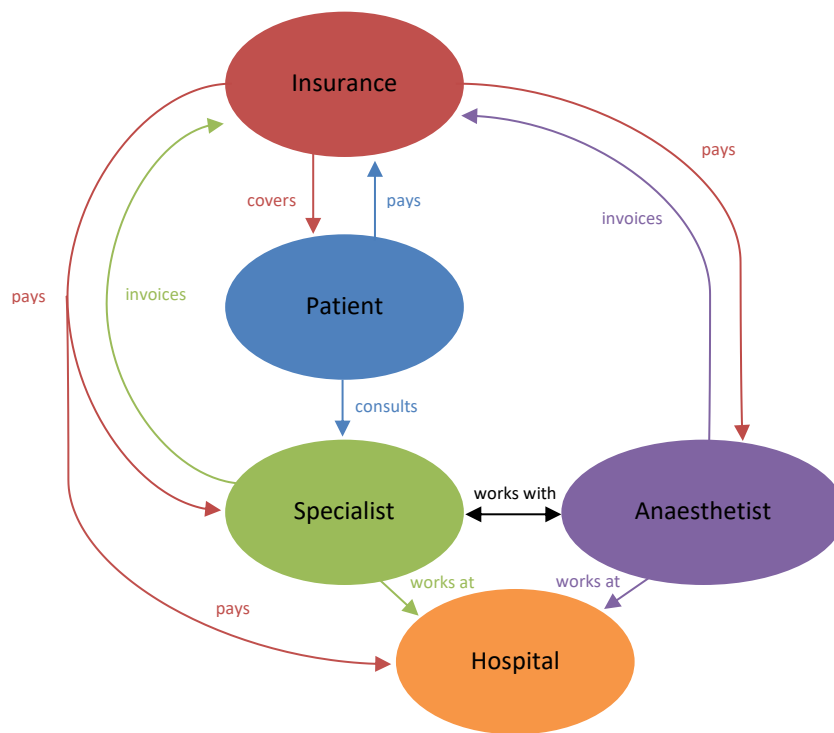
- 5.39 Historically, as noted the contractual framework in private healthcare has been:
- a. **Surgeon–patient relationship:** The primary contract for the supply of clinical services is between the surgeon and the patient.
 - b. **Surgeon–hospital relationship:** Surgeons are independent practitioners who are granted access to private hospitals through credentialling, but are not employed by them and typically operate across multiple sites.
 - i. 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.
 - ii. Some hospitals may hire equipment they do not own for a particular case (eg a MyoSure equipment, Williams needle for bladder Botox) to support surgeons performing procedures in their hospital. Hospitals also provide surgeons with surgical assistants (specially proctored / trained nurses) and often send nurses for specific courses to enable them to be proficient in certain type of surgical assisting.⁵¹
 - c. **Insurer–insured relationship:** Separately, the patient enters into a contract of insurance with the insurer. That contract operates by way of indemnity or reimbursement.
 - d. **Affiliated provider (AP) and approval arrangements:** AP schemes and pre-approval processes govern eligibility for reimbursement, but do not constitute contracts for the purchase of medical services by the insurer. Affiliation or participation arrangements operate as conditions of access to insured patients, not as contracts for the supply of services to the insurer.⁵²

⁵¹ Hospitals pay for RNFSA (Registered Nurse First Surgical Assist) courses which cost \$11,200 over one year per nurse.

⁵² [ACCC Determination Authorisation number: AA1000677](#) (27 February 2025). That authorisation related to collective bargaining by hospital with funders. At [2.20]: “Negotiated fee agreements between private health funds and private hospitals do not apply to the fees charged by specialist doctors for in-hospital treatment.”

5.40 This can be illustrated in the following diagram:

FIGURE 3: CURRENT ORTHODOX CONTRACTUAL FRAMEWORK (FEE-FOR-SERVICE MODEL INCLUDING SCHI AP)



AP schemes

5.41 SCHI operates an AP scheme in respect of gynaecological services.

5.42 The SCHI AP schemes function as certification or prior-approval frameworks. They:

- a. Set eligibility criteria for reimbursement;
- b. Impose quality, administrative and compliance conditions; and
- c. Standardise billing and pre-approval processes.

5.43 Consistent with the orthodox framework described above, AP schemes do not replace the surgeon–patient relationship or the insurer–insured relationship. They operate as conditions of eligibility for reimbursement.

Contractual framework under SCHI’s Proposal (AP-Only Model)

5.44 SCHI has proposed a significant departure from that orthodox framework. SCHI’s Proposal follows a recent 2022 trial [] of implementing an AP-only model replacing Fee-for-Service for all procedures on a limited basis.

5.45 Rather than allowing surgeons and patients to contract freely (subject to reimbursement rules), SCHI has indicated an intention to:

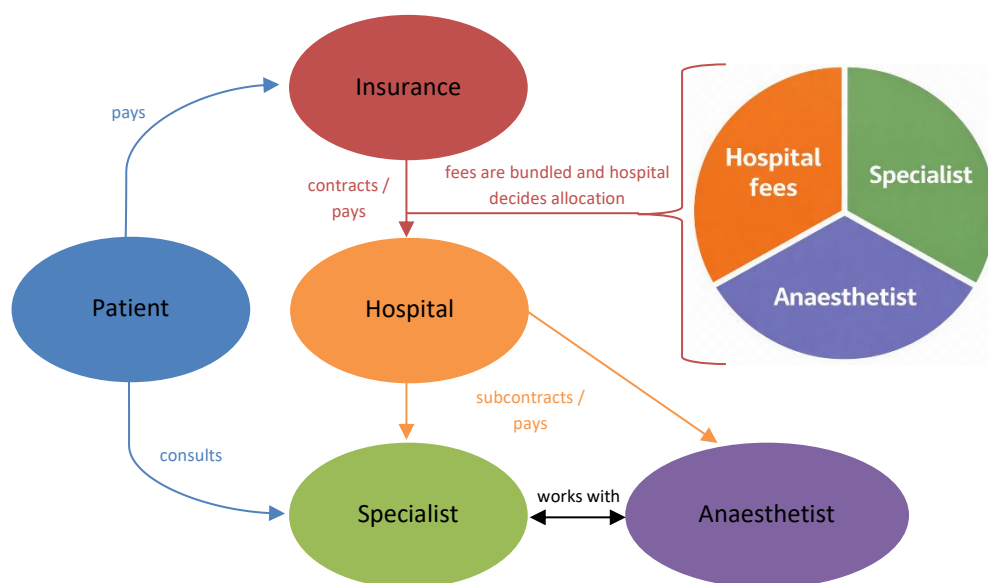
- a. Enter into back-to-back head contracts with private hospitals as head contractors;
- b. Require hospitals, in turn, to subcontract surgeons on standardised terms as a condition of access to SCHI-insured patients;

- c. Pass down bundled fees to private hospitals (ie leaving the hospitals the decision of ‘splitting the pie’). Although NZGA understands that SCHI may have provided ‘recommended’ pricing for how the bundled fees are split.⁵³
- d. Require hospitals to procure gynaecology services from individual clinicians for (significantly) reduced compensation (up to 30 to 50%⁵⁴) at a set ‘common price’ (in other words, one price with no price signals).

5.46 In practical terms, this would reposition surgeons from being customers of hospitals (where hospitals compete to get surgeons operating at their hospital for insurer-funded fees) to being downstream subcontractors subject to insurer-driven terms.

5.47 This can be illustrated in the following diagram:

FIGURE 4: CONTRACTUAL FRAMEWORK UNDER SCHI’S PROPOSAL (AP-ONLY MODEL)



5.48 A comparison of Figures 3 and 4 shows SCHI is purporting to streamline its own dealings under its proposal but as set out in Section 11, SCHI does not appear to have considered the potential impact or (unintended) detriments on patient care (women’s health) and the long-term future of gynaecology.

5.49 SCHI passing down bundled fees to the hospitals could effectively pit hospitals against surgeons and anaesthetist as any negotiations for more fees would result in the hospitals losing more of the ‘pie’ (ie a zero sum game). Hospitals therefore may have a conflict in helping gynaecologists in negotiating with SCHI any increases in fees as needed.

5.50 SCHI’s change in contractual framework appears to be accompanied by:

- a. Fixed or standardised pricing mechanisms;
- b. SCHI establishing new AP coding (ie categorisation) of gynaecology surgeries;
- c. Restrictions on surgeons’ ability to vary terms;

⁵³ This is understood to be the case as the fees under the proposed fees list separately provided by [] and [] were found to be largely identical.

⁵⁴ Anecdotally a large number of the most experienced, skilled and in demand gynaecologists are expected to unilaterally drop their prices 30–50%. Further aggregated data is expected to be assessed to determine the broader average effects.

- d. Potential exclusion from reimbursement where surgeons do not accept the proposed contractual framework (ie non-affiliated); and
 - e. Implementation on a compressed timetable, with limited opportunity for individual negotiation.
- 5.51 Currently robotic procedures and urethral bulking are the only procedures covered by an AP-only model nationally and only a few providers in the country carry this out.⁵⁵ This means that SCHI's Proposal would change the provision of all other private gynaecological services in New Zealand.

Implications for bargaining dynamics

- 5.52 SCHI is New Zealand's largest private health insurer and controls access to a substantial proportion of private healthcare demand. Its policy settings therefore materially affect the commercial viability of private gynaecological practice. Exclusion from SCHI as an Affiliated Provider would result in a private practice losing effectively 60% (lives) of its patients based on SCHI's market share in the private health insurance market.⁵⁶
- 5.53 Where a counterparty controls access to demand, competition authorities have recognised that individual suppliers may be unable to negotiate effectively.
- 5.54 Absent the Proposed Arrangements, individual surgeons face a choice between:
- a. Accepting non-negotiable standard terms; or
 - b. Losing access to insured patients.
- 5.55 SCHI has refused to enter into any contract negotiations with NZGA (or with clinicians individually) and has maintained that it will only contract with hospitals directly. Despite this, SCHI have proposed unilaterally determined fixed surgical fees, without any draft contracts, to individual gynaecologists (placing pressure to sign or risk being removed as an AP without giving gynaecologists reasonable time to seek legal or financial advice).⁵⁷
- 5.56 Previous experiences with SCHI and / or hospitals in negotiating AP contracts for robotic procedures indicate that SCHI's Proposal may be no different (with concerns that SCHI may not be giving clinical views and evidence sufficient weight).⁵⁸

Potential 'hub and spoke' cartel?

- 5.57 SCHI's Proposal appears to involve parallel contracting arrangements with hospitals, including SCH, which may have competition law ramifications from a generic competition law perspective and raises questions of a potential '*hub and spoke cartel*' (or at least have comparable effects to such a cartel):
- a. Hospitals would cease competing to supply hospital services to gynaecologists (where SCHI was the funder), which would appear to be an output restriction and / or market allocation;⁵⁹

⁵⁵ Other than robotic procedures and urethral bulking nationally, there is now 1 provider in Wellington and 1 hospital in Dunedin that are part of an AP-only contracted model with SCHI.

⁵⁶ See [SCMCS 2025 Annual Report – Summary](#) at p.3.

⁵⁷ See Appendix 2 for further details on SCHI's conduct more generally.

⁵⁸ Based on anecdotal evidence provided by one gynaecologist in negotiating an AP scheme for robotic procedures.

⁵⁹ See [section 30A](#) of the Act.

- b. They would, under SCHI's Proposal subcontract to acquire gynaecological services and therefore, adopt at least some of the same terms as each other (including potential exclusionary provisions, ie agreeing not to acquire surgical services from certain non-affiliated gynaecologists), which may raise similar cartel provision concerns; and
- c. Hospitals would be entering these terms (at least) in the knowledge that their competitors were also entering these terms with a consensus or commitment via SCHI.

6. THE PROPOSED ARRANGEMENTS

- 6.1 **Proposed Arrangements** The Applicant seeks authorisation (and interim authorisation) on behalf of current and future members (**Participants**) (as set out in any amendments to the application) that choose to participate in the Proposed Arrangements, to engage in coordinated conduct for the purpose of supporting the ongoing sustainability of gynaecology services and ensuring continued access to quality gynaecology services across New Zealand.
- a. NZGA would lead negotiations on behalf of its members, acting as the exclusive bargaining party at the negotiating table with SCHI.
 - b. NZGA would consult individual members (who put forward their requests, concerns, risks etc to NZGA) and then negotiate changes (on behalf of its members) with SCHI.
 - c. Any negotiated changes would be circulated to NZGA members for further feedback before changes are finalised with SCHI.
- 6.2 Specifically, the Applicant seeks authorisation on behalf of the Participants to:
- a. Engage in collective bargaining discussions with SCHI and/or individual hospitals (or groups of hospitals) in relation to private gynaecology services (including to renegotiate any further changes as needed);
 - b. Enter into a limited Standstill Agreement between the Participants as set out below;
 - c. Engage in discussions and exchange information to the extent relevant and reasonably necessary for those collective negotiations;
 - d. Enter into individual bilateral agreements between individual gynaecologists and SCHI and /or hospital(s) based on a common set of reference terms (ie a contractual framework) as collectively negotiated; and
 - e. Give effect to the provisions of agreements and / or separate agreements based on the reference terms collectively negotiated (including any revisions from time to time).
- 6.3 For the avoidance of doubt:
- a. The Proposed Arrangements do not involve entering into contracts, arrangements or understandings regarding existing services provided by Participants to their patients (ie where gynaecologists compete and will continue to compete);
 - b. **Participation is voluntary** and Participants may opt out of the Proposed Arrangements at any time following notice under the Standstill Agreement;
 - c. Subject to the Standstill Agreement, all Participants remain free to engage in bilateral negotiations with hospitals (albeit such bilateral negotiations are unlikely to be fruitful based on recent experience);
 - d. There is no member-to-member commitment under the Proposed Arrangements other than under the Standstill Agreement; and
 - e. The Applicant seeks to negotiate with:

- i. Southern Cross Medical Care Society (**SCMCS**)⁶⁰;
- ii. all of SCMCS interconnected bodies corporate (as identified in Figure 1 at paragraph 5.18) and associated persons; and / or
- iii. hospitals,

to the broadest extent necessary to enable effective collective bargaining of the provision of private gynaecological services in New Zealand. (The counterparties to any collective negotiations are deliberately broad as the proposed contractual arrangements and counterparties under SCHI's Proposal are unclear and changing. This may be determined by SCHI and/or the hospitals.)

6.4 The scope of the collective negotiations is expected to include (but is not limited to):

- a. Determining whether the proposed new head contractor / sub-contractor model is clinically workable, including exploring (the nature and scope of) alternatives (including the *status quo*) which may better reflect and promote workable and effective competition, and the long-term viability of the provision of gynaecology services to New Zealand women;
- b. Negotiating and refining the AP coding framework (ideally aligning with NZGA and RANZCOG views), including ensuring that coding appropriately reflects clinical practice, complexity of gynaecological surgery, and the ability to combine procedures where clinically indicated (with the aim of settling an understanding of (and the basis for) when gynaecological services may be combined, included or excluded);
- c. Negotiating non-price terms, including matters relating to clinical governance, eligibility criteria, participation requirements (including an open-access type regime, as opposed to excluding potential providers), and dispute resolution processes;
- d. Collective engagement on the general approach to pricing (including understanding the justification for any proposed price reductions) and the application of risk corridors (including clarifying the scope and applicability) with the ultimate aim of preserving the ability for individual clinicians to make independent decisions. This may involve either:
 - i. Negotiating for the ability of gynaecologists to be able to continue competing on price; or
 - ii. (if SCHI maintains common pricing in line with its own proposal) then ensuring that common prices are consistent with the long-term sustainability of private gynaecology practice and determined on a transparent basis (eg clearly linking price increases annually to medical cost inflations and CPI);
- e. Engaging in discussions and exchange of information to the extent relevant and reasonably necessary for those collective negotiations;
- f. Collectively negotiating a set of reference terms (ie a contractual framework);
- g. Entering into individual bilateral agreements between individual gynaecologists and SCHI and / or hospital(s) based on reference terms (ie a contractual framework) as collectively negotiated; and

⁶⁰ SCHI is the 'brand' name used by SCMCS (trading as Southern Cross Health Society) which owns the "Southern Cross" entities (not hospitals).

- h. To the extent relevant giving effect to the provisions of any such agreements resulting from collective negotiation with SCHI and / or hospitals.
- 6.5 The Applicant seeks authorisation for a period of 10 years to:
- a. Engage in a Standstill Agreement for a period of up to 6 months so that the Participants are not pressured to sign and the time is used so that the Proposed Arrangements can be clarified in scope and the Participants can collectively bargain with SCHI during this period;⁶¹ and
 - b. Give effect to any collective agreement and / or separate agreements based on a common contractual framework collectively negotiated between the Applicant and SCHI and / or hospital(s). As discussed, Participants are free to opt out of the Proposed Arrangements at any time at this stage (ie no collective boycott is being proposed).
- 6.6 The duration of 10 years is considered necessary as:
- a. It is expected that collective negotiations with SCHI may take many months to determine; and
 - b. A long-term agreement will likely provide contractual certainty and support consistent future planning and investment.
 - c. It is understood SCHI may wish to renegotiate / change terms every 3 years.
- 6.7 The Commission has also recently acknowledged in the NZBA Draft Determination that “authorisations for a period of approximately 10 years are not unusual”.⁶²
- 6.8 The scope of potential conduct under the application is sufficiently broad to enable objectives and outcomes ultimately be dictated by SCHI including whether SCHI is willing to consider and implement any of the Applicant’s proposals (Noting that even with the encouragement of a limited standstill SCHI could still ‘walk away’ and unilaterally determine its approach after the standstill ends).

Standstill Agreement

- 6.9 The Applicant also seeks a time limited standstill arrangement to enable proper industry engagement with SCHI and relevant counterparties (including hospitals) concerning SCHI’s Proposal. Under this standstill, gynaecologists could adopt a coordinated, temporary deferral (of up to 6 months) on signing up to SCHI’s Proposal (**Standstill Agreement**).
- 6.10 The standstill is sought to avoid parties being forced into uninformed bilateral contracting driven by **deadline pressure and information asymmetry**. The Applicant’s concern is that rushed, incomplete contracting of this nature increases the risk of downstream disputes and conduct concerns — including (without making any allegation or determination about) issues that can arise in pressured contracting contexts such as coercion, unconscionable pressure, and unsubstantiated or insufficiently explained representations about the operation and implications of SCHI’s Proposal.
- 6.11 The standstill provides a short, defined window for information exchange, consultation, and clarification so that collective bargaining (and any subsequent contracting decisions) is made on

⁶¹ As noted by the ACCC “collective bargaining may be insufficient and a collective boycott (or the credible threat of a boycott) may result in benefits.” See [ACCC Determination Authorisation number: AA1000677](#) at [4.56].

⁶² The Commission noted in the NZBA Draft Determination (24 March 2026) at [73] that “authorisations for a period of approximately 10 years are not unusual”.

an informed basis. For the avoidance of doubt, the standstill does not materially affect the bargaining power of the Applicant as SCHI will still dictate outcomes, but the standstill will support NZGA to seek genuine engagement from SCHI with the issues/changes raised (which SCHI will determine whether it accepts).

6.12 The Applicant provides a baseline example of what the Standstill Agreement may look like in **Appendix 5**.

6.13 While currently the Applicant are not likely *in competition* to supply services to SCHI or hospitals, they are potential competitors if SCHI's contractual framework was adopted and would result in gynaecologists being in competition to supply hospitals. Under such counterfactual(s), the Standstill Agreement might be considered an output restriction, for a limited period, not supply services under any new contract and therefore, a cartel agreement.

(Paragraphs 6.2 – 6.9 together forming the **Proposed Arrangements**)

6.14 The Applicant *envisages* that NZGA officers, and NZGA as an entity, will organise and lead collective bargaining discussions with SCHI and/or individual hospitals (or groups of hospitals). This limb is directed at collective process and structure, rather than agreement on individual commercial outcomes.

Proposed conditions

6.15 To support appropriate oversight, transparency and alignment with the public interest, the Applicant would be open to the following conditions as part of any authorisation. Each is intended to support the effective implementation and oversight of the authorised conduct:

- a. **Reporting obligations:** The Participants (or via a representative) could provide regular quarterly reports to the Commission which set out material activities taken under the authorisation.
- b. **Pre-implementation disclosure:** The Participants (or via a representative) could notify the Commission 5 working days prior to any proposed collective agreement/s and/or common contractual framework collectively negotiated is agreed.
- c. **Legal oversight:** All meetings and discussions in relation to the Proposed Arrangements as set out in paragraphs 6.2 to 6.9 will be overseen by an external legal adviser with expertise in competition law to advise attendees if any conduct risks falling outside the scope of the authorisation. This would mitigate the risk of the authorised conduct spilling over into discussions about unrelated topics to ensure that the authorised conduct remains appropriately scoped and that Participants are supported in maintaining compliance throughout the process. This reduces the risk of the Proposed Arrangements leading to unintended public detriment.
- d. **Designated forums:** All authorised conduct will occur within forums between NZGA and SCHI and /or hospitals specifically designated for the discussion of gynaecology services, to ensure structured oversight and compliance with the scope of the authorisation. This reduces the risk of the Proposed Arrangements leading to unintended public detriments.

7. RELEVANT MARKETS

- 7.1 The Applicant considers that the relevant markets impacted under the Proposed Arrangements (and SCHI's Proposal) include (at least):
- a. A national market for the provision of health insurance in New Zealand;⁶³
 - b. Regional markets for the provision of hospital facilities to private gynaecologists. Under which, there would likely be separate markets for the provision of day-stay and in-patient hospital facilities to private gynaecologists; and
 - c. Local markets for the provision of private gynaecology services.⁶⁴ Under which or separately, there are likely to be labour (sub) markets for the supply of gynaecologist services.⁶⁵ Noting that while gynaecologists would be independent contractors under SCHI's Proposal, they would arguably be more analogous to (less protected) employees.
- 7.2 No further delineation for narrower short-stay and in-patient markets is made as the Proposed Arrangements (and SCHI's Proposal) would likely affect both types of surgical services.
- 7.3 For completeness, it is not clear to the Applicant the extent of any flow on effects there may be. There is likely to be a range of potentially impacted markets which the Commission may wish to consider such as:
- a. Markets for the provision of private anaesthetist services for private gynaecology procedures;
 - b. National and regional public sector markets for the provision of gynaecology services.
- 7.4 For example, SCHI's Proposal also impacts anaesthetist fees for gynaecology procedures, potentially affecting labour submarkets for the supply of private anaesthetists who provide services to private gynaecology lists.
- 7.5 Relevant decisions on healthcare markets more generally are set out below.

Commission's views on market definitions

Medical insurance

- 7.6 *Commerce Commission v Southern Cross Medical Care Society*⁶⁶ was a Court of Appeal case following 3 clearance applications (Decision No.'s 399, 404, 407) and a High Court appeal in relation to the same acquisition.

⁶³ Consistent with previous Commission and Court of Appeal treatment of a medical insurance as a separate market with a broader New Zealand geographic scope.

⁶⁴ Noting previous Commission decisions distinguished downstream markets for private hospital facilities and **related non-specialist services** for elective secondary surgery across geographic (regional) and short-stay vs in-patient (product) segments. Importantly, hospital facilities and **non-specialist** services were considered 'fungible' which implies a separate and distinct market(s) for specialist services which are 'non-fungible'. See also [Connor Healthcare Limited and Acurity Health Group Limited \[2014\] NZCC 43](#) at [117] where the Commission considered separating hospital facilities under specialty procedure product markets (including gynaecology). Accordingly, this could equally apply in the context of providing medical services split by specialties.

⁶⁵ These labour (sub) markets may be disproportionately affected in further geographical delineations for provincial / rural regions. Indeed, the [O&G Workforce in Aotearoa New Zealand Report \(2022\)](#) acknowledges that "Provincial hospitals face particular challenges in recruiting and retaining staff and tend to be more reliant on SIMGs for staffing."

⁶⁶ [Commerce Commission v Southern Cross Medical Care Society, CA89/01, 21 December 2001.](#)

- 7.7 The CA and Commission both saw no reason to depart from the relevant market definition in Decision 399 which was “*the market for the provision of medical insurance in New Zealand*”.⁶⁷
- 7.8 In *Central Healthcare Operations Limited and Aorangi Hospital Limited*, consistent with the applicant’s submissions and previous decisions, the Commission analysed markets for:⁶⁸
- 22.1 the provision of private **short-stay** (less than 24 hours) hospital facilities and related non-specialist services for elective surgery in the Health NZ – MidCentral District region;
 - 22.2 the provision of private **in-patient** hospital facilities and related non-specialist services for elective secondary surgery in the Health NZ – MidCentral District region.

Market definitions split by funder

- 7.9 In *Pacific 2021 BidCo NZ Limited / Pulse Health NZ Limited*, the Commission adopted its previous approaches and concluded that relevant markets were the provision of groups of elective secondary surgical procedures for:⁶⁹
- 18.1 patients funded by the Accident Compensation Corporation (ACC) wider than the Wellington region;
 - 18.2 patients funded by a District Health Board (DHB) in the Wellington region;
 - 18.3 patients funded by health insurance companies in the Wellington region; and
 - 18.4 self-funded patients in the Wellington region.
- 7.10 In considering its previous cases, the Commission considered that:
- 19 In these cases [...] different patient groups (defined by how the elective surgery was funded) were likely to have different options available to them. For example, ACC funded patients could receive surgery outside of the Wellington Region and the DHB could increase its own provision of services by hiring locums or transferring patients to another public hospital in the region
- 7.11 The same approach to market definition was taken in *Connor Healthcare Limited and Acurity Health Group Limited* [2014] NZCC 43.⁷⁰

⁶⁷ [Decision No 399: Southern Cross Medical Care Society; Aetna Health \(NZ\) Inc \(Aetna Inc\)](#)
[Decision No 404: Southern Cross Medical Care Society; Aetna Health \(NZ\) Inc \(Aetna Inc\)](#)
[Decision No 407: Southern Cross Medical Care Society; Aetna Health \(NZ\) Inc \(Aetna Inc\)](#)

⁶⁸ [Central Healthcare Operations Limited and Aorangi Hospital Limited \[2022\]](#) NZCC 40.

⁶⁹ [Pacific 2021 BidCo NZ Limited / Pulse Health NZ Limited \[2021\]](#) NZCC 23. We note this link is now no longer available on the Commission’s website.

⁷⁰ [Connor Healthcare Limited and Acurity Health Group Limited \[2014\]](#) NZCC 43.

8. THE COMMISSION HAS JURISDICTION TO GRANT AUTHORISATION

- 8.1 The Commission has jurisdiction to grant authorisation for:
- a. A person who wishes to enter into (section 58(1)) or give effect to (section 58(2)) a contract, arrangement or understanding (**CAU**) to which that person considers section 27 would or *might* apply; and
 - b. A person who wishes to enter into a CAU that contains a provision (section 58(6B)) or give effect to a provision of a CAU (section 58(6D)) that is or *might* be a cartel provision.
- 8.2 The Applicant considers section 27 *might* apply to the Proposed Arrangements (and separately the Standstill Agreement). This is because:
- a. The “competition threshold” in sections 58(1) and (2) is low, and only requires a lessening of competition, not one that is substantial. This is explicitly recognised under section 61(6A).⁷¹ That lessening need only be *likely*, which amounts to a ‘real chance’ of occurring rather than ‘more likely than not’;⁷²
 - b. In the counterfactual(s) (without the Proposed Arrangements) there may be more diverse price and non-price terms negotiated in individual bilateral agreements (as one or more gynaecologists could compete to supply hospitals). The Proposed Arrangements may harmonise price and non-price terms and to that extent may lessen competition;⁷³
 - c. A standstill may defer implementation of SCHI’s Proposal;⁷⁴ and
 - d. Both the Proposed Arrangements and the Standstill Agreement could impact rivalry or otherwise independent action.
- 8.3 There *might* be a cartel provision under the Proposed Arrangements (and separately the Standstill Agreement) as:
- a. The cartel prohibition under section 30 is per se broad and any contract, arrangement or understanding (**CAU**) between competitors or potential competitors may be captured. Cartel conduct does not require a nexus to an SLC (or any anti-competitive effects) nor it seems a counterfactual.⁷⁵
 - b. One or more gynaecologists might be in competition to be included as a supplier of surgical services to hospitals under SCHI’s Proposal (ie if current arrangements were reversed and hospitals no longer competed to attract gynaecologists and / or their patients); and
 - c. Under that proposal, gynaecologists would be reaching a commitment (as to supply, output or price) in relation to the supply of gynaecological services.

⁷¹ [Commerce Commission NZBA CIT Authorisation Draft Determination \(24 March 2026\) \(NZBA\)](#) at [46]. See also [s 61\(6A\) of the Act](#) which explicitly states that “a lessening in competition includes a lessening in competition that is not substantial” for the Commission’s jurisdiction.

⁷² See *NZME Ltd v Commerce Commission* [2018] NZCA 389; *Commerce Commission v Woolworths Ltd* [2008] NZCA 276.

⁷³ The NZGA represents the significant majority (over 90%) of all private gynaecologists in New Zealand.

⁷⁴ But if the Proposed Arrangements proceed, this may also provide greater efficiency and successful implementation at a national scale where most private gynaecologists agree to a set of reference terms as a starting point.

⁷⁵ See *Lodge Real Estate Ltd v Commerce Commission* [2020] NZSC 25; see also [John Land Clarifying New Zealand Competition Law: Establishing “Arrangements” between Competitors, the “Controlling” of Price, and Anti-Competitive “Purpose” after Lodge \(2019\) 25 NZBLQ 255](#).

- i. The Proposed Arrangements (excluding the standstill) could be caught as this involves agreeing common terms upon which supply is made; and
 - ii. Separately for the Standstill Agreement, this would be to agree, for a limited period, not to supply services under any new contract.
- d. The Proposed Arrangements, particularly the Standstill Agreement, might risk becoming a cartel (restricting output). However, it is not clear that that would be the counterfactual.
- 8.4 The Applicant notes that such a cartel provision would *assume* that SCHI's Proposal was legal (as SCHI's Proposal may reduce competition in hospital and insurance related markets).⁷⁶
- 8.5 However, for the purposes of sections 58(6B) and (6D), it is not necessary for the Commission to determine whether a particular provision is in fact a cartel provision, provided there are "reasonable grounds" for believing that it might be.⁷⁷
- 8.6 Therefore, the Applicant considers that the threshold for the Commission's jurisdiction in this case has been met.

⁷⁶ Whether SCHI's Proposal is indeed legal may be something the Commission wishes to assess separately outside of this authorisation application (ie that it does not breach the Commerce Act due to anticompetitive contracts or conduct, or a direct/indirect commitment by hospitals (eg with SCHI acting as a 'hub') to stop competing and impose common terms). But such an assessment may inform the Commission's decision to grant authorisation (and interim authorisation) in this instance.

⁷⁷ See [s 61\(9\)](#) of the Act.

9. FRAMEWORK FOR ASSESSING NET PUBLIC BENEFITS OF COLLECTIVE BARGAINING

Introduction

9.1 The Commission must authorise an agreement where it is satisfied that the agreement will be likely to result in a benefit to the public that would outweigh the lessening in competition.⁷⁸

9.2 New Zealand's courts have defined a public benefit as:⁷⁹

anything of value to the community generally, any contribution to the aims pursued by the society including as one of its principal elements (in the context of trade practices legislation) the achievement of the economic goals of efficiency and progress

9.3 There is a well-established approach to assessing net public benefits in New Zealand. Both Australia and New Zealand also have a well-established approach for assessing net public benefits of collective bargaining.

9.4 These applications usually appear to have been granted when there is an imbalance in bargaining power, and often for long periods. As the Commission recently noted "*authorisations for a period of approximately 10 years are not unusual*".⁸⁰

9.5 Recognised benefits in trans-Tasman collective bargaining authorisations have included:⁸¹

- a. Reduced / avoided transaction costs (over the short and long term).⁸²
- b. More efficient contract terms.
- c. Positive impacts on allocative, productive and dynamic efficiency from alleviating an imbalance in bargaining power.

9.6 In *Catholic Health Australia* the ACCC stated that sometimes "*collective bargaining may be insufficient and a collective boycott (or the credible threat of a boycott) may result in benefits*".⁸³

9.7 We briefly expand on applying the test below.

The efficiency aspect of public benefit test

9.8 As noted, public benefit has a broad meaning and means anything of benefit to the public, as most recently confirmed in *NZME*.⁸⁴

9.9 On the *economic efficiency* aspect of public benefits, the Commission most recently stated:⁸⁵

127. Benefits can arise if a market experiences gains in allocative, productive, or dynamic efficiency:

⁷⁸ Commerce Commission's [Authorisation Guidelines](#) at [18.2].

⁷⁹ *Telecom Corporation of New Zealand Ltd v Commerce Commission* (1991) 4 TCLR 473 (HC) at 527-530 citing *Re Rural Traders Co-operative (WA) Ltd* (1979) ATPR 40-110 at 18,123, as cited in the [Authorisation Guidelines](#), at footnote 36. See also [Godfrey Hirst NZ Ltd v Commerce Commission \[2016\] NZCA 560 \(Godfrey Hirst \(No 2\) \(CA\)\)](#) and [NZME Ltd v Commerce Commission \[2018\] 3 NZLR 715 \(CA\) \(NZME\)](#) at [80]–[81].

⁸⁰ [NZBA Draft Determination](#) at [73].

⁸¹ See for example [TGA \[2022\] NZCC 30](#) at [109].

⁸² [TGA \[2022\] NZCC 30](#) at [111].

⁸³ [ACCC Determination Authorisation number: AA1000677](#) at [4.56].

⁸⁴ [NZME \[2018\] 3 NZLR 715](#) at [80]–[81].

⁸⁵ [NZBA Draft Determination](#).

- 127.1 Allocative efficiency is gained when efficient prices result in more preferred alternatives for consumers or the purchase of larger quantities by consumers.
 - 127.2 Productive efficiency is improved when resources are more effectively employed in production, manifesting in lower fixed or unit costs.
 - 127.3 Dynamic efficiency is gained when parties' incentive or ability to innovate/invest is increased.
128. On the other hand, detriments can arise if a market experiences loss in allocative, productive or dynamic efficiency:
- 128.1 Allocative efficiency is lost when inefficient (higher) prices result in less preferred alternatives for consumers or to the purchase of smaller quantities by consumers.
 - 128.2 Productive efficiency is lost when resources are inefficiently employed in production, typically increasing costs above efficient levels. This could manifest in higher fixed or unit costs.
 - 128.3 Dynamic efficiency is lost when the incentive or the ability to efficiently innovate/invest is reduced.

Collective bargaining benefits recognised by the ACCC and the Commission

Addressing an imbalance in bargaining power

- 9.10 Collective bargaining shifts the imbalance of bargaining power to some extent by enabling the Participants to pool resources. As noted in academic literature:⁸⁶

By exploiting economies of scale in negotiation, collective bargaining may allow individual businesses to bargain more effectively, resulting in better contracts. Thus, when considering the WABGA application the ACCC noted that 'the WABGA member growers are, in general, small primary producers with often limited resources and expertise to engage in effective negotiation with businesses with the size and negotiating experience of the processors

- 9.11 In *Catholic Health Australia* the ACCC noted:⁸⁷

... **transaction cost savings are likely to arise from...collectively bargaining** ...by reducing resources which would have otherwise been incurred in individual negotiations. In particular, the ACCC considers that these savings are likely to arise through a streamlined negotiation process ... likely to reduce the number of negotiations taking place and allow the parties to engage common professionals (such as **lawyers** and accountants) to advise on a fewer number of transactions, reducing the administrative burden which may otherwise arise through individual negotiations

[emphasis added]

- 9.12 Further:⁸⁸

The ACCC considers that in some circumstances, **collective bargaining may be** insufficient to address market failures **and a collective boycott** (or the credible threat of a boycott) **may result in benefits by facilitating negotiation of more efficient contracts**. A collective boycott may achieve this by making the target commit to the collective bargaining process.

[emphasis added]

⁸⁶ King, SP (2013). *Collective Bargaining by Business: Economic and Legal Implications*. UNSW Law Journal, volume 36(1), 107–138.

⁸⁷ [ACCC Determination Authorisation number: AA1000677](#) at [4.26].

⁸⁸ [ACCC Determination Authorisation number: AA1000677](#) at [4.56].

Avoided transaction costs

- 9.13 The Commission has observed that "*there are likely to be benefits from collective bargaining (compared to individual bargaining) as a result of the reduction in transaction costs.*"⁸⁹ Indeed, the Commission has recognised that:⁹⁰

Parties involved in collective bargaining can **share negotiating costs and achieve economies of scale in transacting**. If there are several parties seeking to negotiate with a single counterparty, those parties can save on transaction costs by sharing the cost of a single, collective negotiation, as opposed to multiple, bilateral negotiations.

[emphasis added]

- 9.14 The ACCC also aligns with this view:⁹¹

The ACCC considers there are transaction costs (including time related costs) associated with contracting. These transaction costs can be lower where a single negotiating process is employed, such as in collective bargaining arrangements, relative to a situation where a series of individual negotiation processes are necessary. The ACCC considers that to the extent these transaction cost savings do arise they are likely to constitute a public benefit.

More efficient contracts / more sophisticated agreements

- 9.15 Collective negotiation will **likely result in more sophisticated agreements** that are likely to have efficiency benefits. As has been noted in academic literature:⁹²

bargaining groups allow buyers and sellers to exploit economies of scale in negotiation to improve contractual outcomes. The gains from these negotiations can then be shared by the buyers and the sellers, so that each party gains from the more economically efficient contracts....

In the absence of collective negotiation, individual firms will reach economically inefficient contracts due to bargaining costs...

In many cases, the ACCC has identified that individually, businesses have a limited degree of input into their contracts being offered take it or leave it terms and conditions. These circumstances do not always lead to the most efficient contract. The ACCC has often accepted that collective bargaining arrangements can provide participants with an opportunity for greater input into contracts and accordingly deliver the opportunity for more efficient contracts

- 9.16 The Commission has also recognised this:⁹³

Allowing negotiation and transaction costs to be shared across parties can make collective bargaining relatively less expensive for parties to effectively negotiate and resolve marginal issues. This is likely to enable **more sophisticated, efficient, and mutually beneficial contracts** to be reached.

⁸⁹ [Waikato - Bay of Plenty Chicken Growers Association Incorporated \[2017\] NZCC 37](#) at [69].

⁹⁰ [News Publishers' Association of New Zealand Incorporated \[2022\] NZCC 35 \(NPA\)](#) at [96]. We note that while there are caveats, collective negotiations here are likely to be less complex and the needs heterogenous (cf at [97]).

⁹¹ ACCC A91275: *Abbot Point Coal Export Terminal Producers* (16 February 2012) at [4.19]. As noted in King, SP (2013): *The relevant cost savings identified by the applicants included a decrease in the number of hours spent negotiating; a decrease in the cost of legal and expert advisors; and efficiencies in the pooling of the limited resources of the smaller applicants* at [4.17]. See also ACCC Determination: Application for Authorisation A91347, 24 January 2013, at [12] regarding collective bargaining by Queensland chicken growers.

⁹² King, SP (2013). *Collective Bargaining by Business: Economic and Legal Implications*. UNSW Law Journal, volume 36(1), at 107–138.

⁹³ [NPA \[2022\] NZCC 35](#) at [107].

Improved investment incentives

9.17 The Commission has noted:

.... improving the bargaining power ... through collective bargaining could also have efficiency enhancing impacts. For instance, **collective bargaining could potentially redress a bargaining power imbalance that might otherwise enable...reduce[d] fees or other supply terms to ... below competitive levels** and create the risk of ‘hold up’ problems. In so doing, collective bargaining **can improve overall economic efficiency if it helps ensure ... appropriate incentives to invest** ... and the certainty that they will be able to recover sunk costs, such that there is a greater level of output that ultimately benefits end consumers.⁹⁴

[emphasis added]

9.18 In *Catholic Health Australia*, the ACCC also recognised that collective bargaining “*can enhance efficiency through investment to increase production or the provision of services (which in this case are hospital and health services and charitable works) to a more socially desirable level.*”⁹⁵

Improvements in clinical and corporate learning

9.19 In *Catholic Health Australia*, the ACCC recognised **improvements in clinical and corporate learning**.

Smaller players authorised facing much larger counterparts / unavoidable trading partners

9.20 The Proposed Arrangements follows other similar Commission decisions authorising collective bargaining, eg:

*News Publishers Association (NPA)*⁹⁶

9.21 NPA was authorised to engage in collective negotiations with Google and Meta regarding display of media content. The Commission emphasised **transaction-cost efficiencies**.⁹⁷

Allowing negotiation and transaction costs to be shared across parties can make collective bargaining relatively less expensive for parties to effectively negotiate and resolve marginal issues. This is likely to enable more sophisticated, efficient, and mutually beneficial contracts to be reached.¹³⁵

9.22 The Commission observed concerns around the bargaining imbalance / unavoidable counterparty (citing the applicant at paragraph 114):

... submitted that the Proposed Arrangements is likely to improve the balance in bargaining power that exists between media companies and the Digital Platforms. The Digital Platforms are ‘unavoidable trading partners’ for New Zealand news media companies, who rely on the Digital Platforms for audience and referrals

*NZ Tegel Growers Association (TGA)*⁹⁸

9.23 TGA was authorised to collectively bargaining on behalf of members for chicken growing supply to Tegel.

⁹⁴ [NPA \[2022\] NZCC 35](#) at [212].

⁹⁵ [ACCC Determination Authorisation number: AA1000677](#) at [4.42].

⁹⁶ [NPA \[2022\] NZCC 35](#); see also [Commerce Commission authorises News Publishers’ Association to collectively bargain](#).

⁹⁷ [NPA \[2022\] NZCC 35](#). Footnote 135 refers to “Stephen King - Collective Bargaining by Business at page 119.”

⁹⁸ [TGA \[2022\] NZCC 30](#); see also [Commerce Commission authorises New Zealand Tegel Growers Association to engage in collective bargaining](#).

*Waikato & Bay of Plenty Chicken Growers Association Inc*⁹⁹

- 9.24 The Commission recognised that collective negotiation could reduce transaction costs by sharing the costs of negotiation and representation.
- 9.25 Those authorisations were predicated on the benefit in smaller parties negotiating with a larger "purchaser" / funder on efficiency / public benefits grounds. Similar benefits apply here.
- 9.26 Other authorisations have been granted on coordination efficiencies, eg *Payments NZ Limited* (20 August 2024).¹⁰⁰

Assessing the imbalance in market power – the bargaining framework

- 9.27 The Commission has applied a *bargaining framework* to assess likely outcomes following negotiations in the factual (collective bargaining) and counterfactual (SCHI's Proposal under individual bilateral agreements).
- 9.28 This is to enable it to determine if proposals likely yield a net public benefit or detriment:¹⁰¹

137. The outcome of bargaining, bilateral or collective, partly **depends on the balance of bargaining power**^{158 [102]} between the negotiating parties. The relative bargaining power of the negotiating parties and the division of surplus depends on several factors, including:¹⁵⁹
[103]

- 137.1 the quality of each party's outside options – key to bargaining strength;
- 137.2 the bargaining costs and losses each party incurs by delaying agreement;
- 137.3 the payoffs either party derives from walking away from negotiations;
- 137.4 the costs suffered by making small concessions to the other party; and
- 137.5 the extent of information asymmetry, for example on costs or value.

138. Outcomes from bargaining, bilateral or collective, can be efficient/more efficient (beneficial to the public) or inefficient/less efficient (detrimental to the public). **Inefficient/less efficient outcomes can arise if bargaining terms tend strongly towards the position of the party with greater bargaining strength** while more efficient outcomes tend to arise if the parties move towards maximising their joint surplus.^{160 [104]} In the authorisation context, **a collective bargaining arrangement produces a public benefit** (or detriment) if **the outcome is more** (or less) **efficient than the situation without the arrangement**.

139. Several factors can contribute to inefficient/less efficient outcomes of bargaining between buyers and sellers, including:^{161 [105]}

- 139.1 information asymmetry^{162 [106]} and incomplete contracts;

⁹⁹ [Waikato - Bay of Plenty Chicken Growers Association Incorporated \[2017\] NZCC 37](#).

¹⁰⁰ [Payments NZ Limited \[2024\] NZCC 18](#).

¹⁰¹ [NZBA Draft Determination](#) at [136].

¹⁰² [Footnote 158] "*Bargaining power is a key concept referring to the ability of buyer(s) or seller(s) in a negotiation to influence the outcome of bargaining in their favour (eg, extracting lower or higher prices).*"

¹⁰³ [Footnote 159] "*Baker, J. B., Farrell, J., & Shapiro, C. (2008). Merger to monopoly to serve a single buyer: Comment. Antitrust Law Journal, 75(2), 637–646. <http://www.jstor.org/stable/27897589> and O'Brien, D. P. (2014). The welfare effects of third-degree price discrimination in intermediate good markets: the case of bargaining. The RAND Journal of Economics, 45(1), 92–115.*"

¹⁰⁴ [Footnote 160] "*Baker, J. B., Farrell, J., & Shapiro, C. (2008). Merger to monopoly to serve a single buyer: Comment. Antitrust Law Journal, 75(2), 159.*"

¹⁰⁵ [Footnote 161] "*Ibid., at [638], [639] and [640].*"

¹⁰⁶ [Footnote 162] "*information asymmetry is present in any bargaining situation or transaction where at least one party has information that other parties lack. It affects each party's behaviour during bargaining, and consequently, the outcomes of bargaining due to the uncertainty regarding the other party's knowledge. Higher levels of information*

- 139.2 challenges with contracting important aspects of business relationships;
- 139.3 purchase (supply) of inefficiently low volumes because prices are too high (too low);
and
- 139.4 breakdown in negotiations or conclusion of inefficient contracts that lead to commercial disputes, litigation, etc.

Necessity of the standstill

- 9.29 When considering “*the public benefit of reducing an imbalance in bargaining power in the context of the **collective bargaining arrangements and collective boycott arrangements***”, the ACCC recognised:¹⁰⁷

The ACCC considers that in some circumstances, **collective bargaining may be insufficient to address market failures and a collective boycott (or the credible threat of a boycott) may result in benefits by facilitating negotiation of more efficient contracts**. A collective boycott may achieve this by making the target commit to the collective bargaining process.

- 9.30 The Applicant submits that the criteria is met for the proposed standstill, to encourage genuine engagement from SCHI and / or other hospitals.

asymmetry are generally associated with detriments because it gives rise to issues relating to moral hazard and adverse selection which can lead to market failure”.

¹⁰⁷ [ACCC Determination Authorisation number: AA1000677](#) at [4.56].

10. COUNTERFACTUAL(S)

- 10.1 The Applicant reiterates that in the absence of the Proposed Arrangements, outcomes would largely depend on SCHI, which is proposing changes to the current arrangements with private gynaecologists.
- 10.2 The Applicant therefore considers SCHI's Proposal to be the *assumed* counterfactual (and the likely counterfactual) as it assumes for the present purpose that SCHI's Proposal is legal and SCHI would likely continue implementing its proposal absent collective bargaining.¹⁰⁸ (Indeed, SCHI's Proposal is the starting point from which the Applicant is seeking to bargain and what the Proposed Arrangements are in relation to.)
- 10.3 A comparison of the key dimensions under the status quo, SCHI's Proposal and with NZGA's collective bargaining (factual) is set out below.

TABLE 1: COMPARISON OF KEY DIMENSIONS UNDER THE STATUS QUO, COUNTERFACTUAL AND FACTUAL

DIMENSION	STATUS QUO	SCHI'S PROPOSAL 'AS IS'	FACTUAL (NZGA COLLECTIVE BARGAINING AUTHORISED)
Who negotiates / process	Decentralised, bilateral process between patients and insurers for approvals. No structured or collective engagement with clinicians. Clinicians are not directly engaged in insurer approval processes and retain autonomy over whether and how to provide services.	Primarily bilateral engagement by individual clinicians; SCHI/hospitals proceed under compressed timeframes; limited ability to refine scheme-wide settings.	NZGA officers lead structured collective engagement. NZGA consults participants / members; participation voluntary.
Coding / combination rules	No standardised coding or insurer-imposed combination rules. Procedures determined by clinician judgement.	AP coding set implemented largely as-is. Exclusions/combination rules may prevent clinically appropriate combinations (eg anterior and posterior repair. Endometriosis excision with hysterectomy).	Negotiated coding aligned with clinical practice (including combining procedures where clinically appropriate) and aligned with RANZCOG recommendations.
Complexity & exceptions ("risk corridor")	No formal complexity framework. Complexity managed through clinician judgement and pricing.	Unclear criteria. Discretion may be exercised inconsistently. Clinicians may bear unfunded complexity.	Objective criteria and workable process for additional funding where complexity exceeds assumptions.
Pricing signals / fee structure	Fee-for-service model. Fees set independently by each provider. Market-informed, not dictated by SCHI/hospitals.	Common price setting upstream. Limited price signals. Pressure on individual clinicians to submit fees and accept standardised terms.	Maintain Fee-for-Service model OR negotiated common pricing subject to agreed CPI and medical inflation adjustments.

¹⁰⁸ Although, to some extent SCHI's Proposal may be exposed to partial and staged implementation in line with Option 2 (row 3) under Table 2.

Patient pathway and safety	Pathway determined clinically. Hospital choice based on availability and suitability. Approvals do not constrain clinical decisions.	Risk of multiple admissions / procedures to work around exclusions or inadequate reimbursement. Increased anaesthetic exposure and recovery time.	Greater likelihood of single clinically appropriate operative episode and predictable pathways.
Market-wide effects	Decentralised market with independent pricing. No insurer-imposed constraints on scope of services.	Potential exit/reduced willingness to undertake complex work; reduced private capacity; spillover to public system.	Supports sustainability of private services and continued access. Mitigates spillovers.

10.4 The Applicant submits that there is a lack of clarity on information such that it is difficult to predict exact counterfactuals, however, it contemplates that counterfactuals could be grouped into the following categories (depending on changes that SCHI could adopt as part of its proposal):

TABLE 2: POTENTIAL CATEGORIES OF COUNTERFACTUALS

CATEGORY OF COUNTERFACTUAL	EXPLANATION OF MARKET DYNAMICS & EFFECTS	BENEFITS / DETRIMENTS COMPARED TO THE PROPOSAL
0. Status Quo (counterfactual)	<ul style="list-style-type: none"> Gynaecologists continue to charge on a Fee-for-Service basis which promotes market price signals. SCHI can refuse reimbursement and/or prior approval for surgeons it considers set excessive pricing Pricing signals remain stronger, relevant for those deciding whether to practice in New Zealand, whether to continue practising, the type of practice they use, etc Hospitals continue to compete to attract surgeons, preserving upstream competition dynamics. 	<ul style="list-style-type: none"> (-) SCHI may lose out on its efficiency benefits (including structural) from simplifying its operations by dealing with hospitals for fees to be paid to subcontracted gynaecologists. (+) Closer to workable and effective competition, (albeit still noting the influence of powerful funders). (+) Maintains existing patient-clinician contractual structure, supporting continuity of care. (-) Does not address existing inefficiencies in approvals or administrative processes (SCHI's claimed efficiencies not realised).
1. SCHI's Proposal ('as is')	<ul style="list-style-type: none"> SCHI does not consult and potentially imposes non price and price terms that are not fully informed SCHI (via hospitals) appears likely to exclude some suppliers and/or reduce payments. SCHI (via hospitals) imposes common pricing Shift from patient-driven and clinician-driven demand to funder-directed allocation of services. Potential alignment or coordination between hospitals via SCHI (hub-and-spoke risk). 	<ul style="list-style-type: none"> (-) Reduced incentives to supply services (all things being equal reduction in non-price and price terms can be expected to lead to reduced supply). (-) Setting common pricing too low and reducing compensation significantly can be expected to negatively impact incentives to innovate and differentiate through quality of care, better outcomes etc. (-) May restrict outputs and have knock on effects. (-) Coding issues remain (exclusions and combined procedures not permitted).

	<ul style="list-style-type: none"> • Reduced hospital competition to attract surgeons (reversal of current incentives). 	<ul style="list-style-type: none"> • (–) Weakening of patient–clinician relationship as primary contracting framework.
2. Modified proposal with partial / staged implementation	<ul style="list-style-type: none"> • SCHI implements AP model incrementally (eg limited procedures, regions, or opt-in basis initially). • Some gynaecologists participate while others remain on Fee-for-Service (mixed model persists). • Hospitals may face dual systems and selective contracting, creating fragmentation. • Competitive dynamics continue but become distorted or uneven across providers. 	<ul style="list-style-type: none"> • (+) Lower immediate disruption relative to full implementation. • (+) Retains some price and clinical variation in early phases. • (–) Risk of gradual tipping to full standardisation without meaningful renegotiation. • (–) Increased complexity / transaction costs (parallel systems); inefficient and may create long term delays. • (–) Strategic “divide and constrain” dynamics (weakens collective responses, entrenches bargaining asymmetry).
3. Modified proposal eg with limits of cover and co-pay (caps with patient top-ups)	<ul style="list-style-type: none"> • SCHI caps cover, but clinicians remain free to price independently and patients can top up. • Market signals are partly preserved, but cost risk shifts to patients and access may become more dependent on ability to pay (price signalling shifted outside insured component, rather than being eliminated). • Creates two-tier access dynamics, with patients’ ability to top-up influencing treatment pathways. 	<ul style="list-style-type: none"> • (+/–) Preserving some competition on price and quality (maintains market signals) but shifts burden to patients rather than improving negotiation outcomes. • (–) patients ultimately pay for the difference between SCHI’s view on costs vs market signals. • (–) May still be inferior to the Proposed Arrangements because low caps may reduce access and leave bargaining asymmetry largely unresolved. • (–) Equity concerns (access linked more directly to ability to pay). • (–) Potential under-treatment if patients decline top-ups.

11. APPLYING THE NET PUBLIC BENEFIT TEST

SCHI's Proposal (counterfactual) may substantially lessen competition and / or have public detriments

- 11.1 Because this application is in response to SCHI's conduct, and potentially related arrangements with hospitals, it is important to contextualise this application by starting with the counterfactual (where SCHI's Proposal proceeds with no further changes).
- 11.2 NZGA recognises that there can be efficiency and other benefits from SCHI's Proposal for SCHI and its members, such as its easy preapproval claims processes and price certainty through agreed common pricing by Affiliated Providers all via simple online systems. However, it must be sufficient to maintain the sustainability quality and quantity of gynaecological services provided.
- 11.3 As set out below, the Applicant is concerned that SCHI's incentives may not necessarily be aligned with longer term impacts.

Potential adverse impacts of non-price terms

- 11.4 SCHI's Proposal may result in:
- a. **AP coding is deficient more broadly:** RANZCOG has clearly expressed its concerns that SCHI's AP coding is deficient in some areas such as urogynaecology and gynae-oncology and strongly encouraged whether further codes can be established for common procedures:¹⁰⁹

RANZCOG still considers the code set deficient in some areas, in particular urogynaecology and gynae-oncology. We strongly encourage Southern Cross to consider whether further codes can be established for any of the more common procedures, especially in urogynaecology, and we trust that further codes will be established over time as clinical data builds.
 - b. **Clinically appropriate procedures being excluded:** Some patients with multi-compartment prolapse may clinically require multiple procedures to be performed together in one operation, but the proposed AP coding structure would exclude this approach, resulting in repeat surgery and poorer outcomes. For example, if a patient has stage 3 or 4 endometriosis and also requires hysterectomy the patient may be disadvantaged as full excision of endometriosis would not be covered if carried out with a complex hysterectomy.
 - i. These codes suggest that when certain pelvic floor procedures are performed together the surgeon (and other providers) will not be able to claim payment if all the procedures that are clinically appropriate are carried out.
 - ii. Performing these procedures together (when indicated) is considered the standard of care that clinicians are required to provide under the HDC Code of Rights (Right 4).
 - iii. There may be a mechanism for reimbursement in these circumstances but this is not clear.

¹⁰⁹ [].

- c. **Pelvic floor procedure codes:** SCHI had indicated that pelvic floor procedures would remain outside the AP scheme on a Fee-for-Service basis, however the revised AP coding issued on 2 February 2026 included a number of those procedures.¹¹⁰
- d. **Ignoring procedure and patient complexity:** SCHI's Proposal does not appear to adequately account for variation in surgical complexity¹¹¹ or patient factors¹¹² that will extend their post-operation recovery. Instead measures such as operation time are used to weigh complexity. While risk corridors are referenced, there is limited clarity on how these operate in practice. Without this, there is a risk that the procedural and patient complexity of surgeries are not being considered (which factors in all assessments of risk, cover, price etc). This may have flow-on effects to the public system where patients with marked surgical complexity or medical comorbidities may be directed to public gynaecology care if the AP scheme is not able to meet their complex needs.
- e. **Adverse impacts on quality, investment (human capital & technology) and innovation:** Including:
- i. Gynaecologists may be less inclined to compete on innovation (new training, new techniques etc), if compensation is materially reduced and / or below workably competitive pricing.
 - It appears that AP coding does not materially differentiate (or account for) procedures carried out using advanced techniques or new technology and therefore does not factor in any investment in training or innovation to promote advancing gynaecological practices (as compared to performed with less advanced or technological techniques).
 - For example, both current and proposed AP coding do not recognise or incorporate robotic surgery codes and will not fund sacral nerve modulators.
 - ii. **Financial impacts:** As a result, this may financially impact suppliers' margins, profitability and ability and / or incentives to innovate and compete fully. For smaller providers, this could lead to exit. Such an initiative may reduce the ability to pay skilled gynaecologists, leading to the loss of both skills from offshore markets (ie reducing supply in New Zealand to the detriment of consumers).
 - iii. Relatedly there may be less inclination to differentiate (or subspecialise further) if SCHI adopts an inadequate fixed fee model.
 - iv. **Reduction in innovation:** Impacts on innovation can lead to reduced consumer choice and quality. A price reduction creates a risk to clinical quality. Further, gynaecologist's focus on innovation in technology may be hindered by the financial impacts of SCHI's Proposal.
 - v. There could be unintended consequences (eg if some providers sought to increase output speed or quantity by doing 'easier' procedures) which is already

¹¹⁰ [] See **Appendix 2** for further details.

¹¹¹ Surgical complexity may include things such as severe adhesions, repeat surgery, high BMI patients.

¹¹² Patient factors may include things such as patients with chronic pain or post-operation nausea and vomiting, immunosuppressed patients.

compounded by current clinical coding limitations which require some women to undergo multiple operations to achieve a successful outcome.¹¹³

- f. **Reduction in supply or output of gynaecologist services ('labour' markets):** Existing gynaecologists may seek to exit the industry earlier (eg early retirement / offshore exit) or at least exit providing services to SCHI members (the bulk of the private health insurance market).¹¹⁴ Indeed, RANZCOG acknowledges that there are challenges in recruiting and retaining staff and the gynaecology workforce is more reliant on Specialist International Medical Graduates (**SIMGs**)¹¹⁵ for staffing (including disproportionately in provincial hospitals).¹¹⁶
- i. A reduction in the range of services being offered in different gynaecology markets as suppliers may not be able to provide “unfunded” services (particularly if compared to a “counterfactual” of co-pay where there could be better market signals and consumer choice).
 - ii. More drastically, if providers were excluded largely / completely from providing services to SCHI members, this could lead to consumers missing out on the range of options and convenience of one of the main suppliers in New Zealand.
 - iii. Exits from the NZ private sector could also have adverse flow on effects on public sector supply (or overburden the public sector to proportionally service more patients). Anecdotal evidence suggests current wait times for gynaecological surgeries are more than 3 months for private practice and over a year for the public sector.
 - iv. The lack of (or reduction in) supply in turn creates longer wait times which results in adverse health impacts on the public (including disproportionately on rural areas).¹¹⁷
 - v. Further, gynaecologists working abroad would be more inclined to defer returning to New Zealand, or not return at all.
 - vi. Gynaecologists conducting postgraduate qualifications may similarly be less inclined to return to New Zealand. As discussed above, RANZCOG identified deficiencies in urogynaecology and gynae-oncology with AP coding, which are subspecialties that are particularly vulnerable areas of exit risk (with low numbers under these subspecialties).¹¹⁸
 - vii. Potential gynaecologists may be less likely to pursue this career, for example choosing a specialisation which compensates more fairly.

¹¹³ Some clinical coding limitations prevent surgeons from completing all necessary procedures in a single operation. As a result, women may need to undergo multiple general anaesthesia's to achieve results. Although there has been around a 70% improvement since the initial stage, these codes have not yet received full approval from RANZCOG or NZGA.

¹¹⁴ Anecdotally NZGA has received 4 letters confirming that gynaecologists (and a further letter from an anaesthetist) may exit if SCHI's Proposal goes ahead without change. See **Appendix 3**.

¹¹⁵ SIMGs refer to medical professionals that have trained overseas (either trainees or specialists) that move to New Zealand to work as a medical practitioner.

¹¹⁶ See [A looming crisis... or a crisis? The O&G workforce in Aotearoa – Report of the Aotearoa New Zealand O&G Workforce Working Group](#) (July 2022).

¹¹⁷ See for example, The Post article which highlights how some women may have to wait years for a surgery (while others may receive timely care): <https://www.thepost.co.nz/nz-news/360833547/three-years-postcode-lottery-still-rules-scalpel>

¹¹⁸ Anecdotal evidence suggests that some urogynaecologists/ gynaecologists with special interest may not continue doing pelvic floor surgeries.

- g. **Asymmetric contract terms:** For example, the draft [] contract purports to impose one-sided obligations (including obligations to the head-contract without any visibility) for individual gynaecologists. See **Appendix 4** for further analysis of such imbalances.

Potential adverse impacts of pricing terms (uninformed common pricing)

11.5 While SCHI, as a dominant funder, may wish to manage costs, SCHI's Proposal effectively seeks to replace (and potentially distort) market signals with its own price/market controls (by setting its own common pricing under AP coding) without adequate consultation of clinicians. This may, especially if set too low, result in:

- a. **(Inappropriately) categorising surgeries in a quantitative manner:** SCHI's Proposal directly conflicts with and second guesses the appropriate care required as it sets common prices too low and without sufficient clinical input (or context) will not account for the qualitative aspects of surgery.
- i. Gynaecological surgeries are heterogenous, unpredictable and complexities often arise, with large variability in duration and complexity of surgery, based on findings intraoperatively. For example, a patient with normal pre-operation imaging may have Stage 3 endometriosis requiring ureterolysis, but the need for a vaginal hysterectomy for prolapse repair may not be known until patient is examined in the operating theatre.
 - ii. Despite this, the Applicant considers the 'risk corridor'¹¹⁹ provided under SCHI's Proposal does not sufficiently detail objective criteria (noting that SCHI has the sole discretion over this determination which interferes with clinical decisions) upon which a gynaecologist could request further funding when surgeries would / do become more complex than what is funded by SCHI.
 - iii. Therefore, SCHI's Proposal may impact the level of care that a patient receives.
 - iv. Indeed, anecdotal evidence suggests that currently SCHI already refuses to exercise 'risk corridor' discretion even when complex surgeries are performed.¹²⁰ This could be exacerbated under SCHI's Proposal.
 - v. Gynaecologists would likely be forced to second guess the appropriate care required to treat patients due to conflicts with what is permitted under AP coding.
- b. **Limited support for assistant/second surgeons:** There is limited support and guidance from SCHI regarding billing for assistants or second surgeons in complex procedures, as well as limited recognition of the broader work required to deliver safe surgical care (including pre-op prep, multidisciplinary input, and post-op follow-up). SCHI already limits funding for assistant surgeons even where the operating surgeon considers the case to be complex, which risks undermining clinical judgment. There are concerns that this will be exacerbated under the proposed changes.
- c. **Reduced quality of care (including audit/credentialing):** Surgical care is not limited to just the operation and includes pre and post-operation. Currently the proposed AP coding and pricing does not appear to account for this. Surgeons, nursing and administrative staff are involved in work to prepare patients for surgery and provide post-op care (including nurse consults, multidisciplinary team to provide wraparound care, case prep,

¹¹⁹ As discussed in fn 10, 'Risk Corridor' is defined as "a mechanism that provides additional payment when a procedure takes longer than the average expected time, without altering the price for the applicable service."

¹²⁰ For example, see email chain between [] in **Appendix 3**.

attendance and presentations at multidisciplinary team meetings (MDMs) as well as data collection and entry for audit and credentialing requirements).

- d. **Loss of (or significantly impaired) price signals:** Price signals are important for showing consumer preference and where investment should be made (consistent with the above point). Anything that distorts those “messages” must arguably result in consumer harm. That is the foundation of competition law. Prices are currently set independently by gynaecologists in workably competitive markets. If, as suggested, these are determined by SCHI and/or hospitals, significantly reduced, and not differentiated this makes SCHI/hospitals the purchaser/customer (ie all suppliers are compensated with the same “price”, regardless of quality, expertise, efficiency, outcomes). This is orthodox, accepted economic theory.¹²¹
- e. **Increased barriers to entry/expansion in the health insurance market:** There is a growing concern that “powerful purchasers” may gain enduring volume or loyalty discounts (or even ratchet them further). Traditionally volume discounts were seen as efficiency based but there is the possibility that a powerful purchaser may obtain an enduring price advantage which could create barriers to entry/expansion. In the US this has seen a revived focus on the Robinson Patman Act due to concerns this could exclude smaller competitors from markets; and the Chair of the NZCC has identified this as a potential concern as well. The *Winstone Wallboards Limited* proceedings are evidence of this concern.¹²² For example the Commission has acknowledged that the Regulated Grocery Retailers greater scale and power limit wholesale competition,¹²³ similarly here SCHI’s advantages may entrench its existing market power.
- f. **The broader context is important: the “waterbed effect”:** The Commission is aware of the waterbed effect, the possibility that price reductions or competitive pressure applied in one part of a firm’s activities may be offset by price increases or reduced competitive outcomes elsewhere, as suppliers seek to recover lost revenue.¹²⁴ Whether such an effect arises, and its magnitude, depends on the extent of competitive constraints in the affected markets and must be assessed on a net welfare basis. It is conceivable that there could be these effects here, Other factors relevant to this analysis include the relevance of the pressure put on suppliers by the two main funders TWO and ACC: It seems well accepted that these parties place considerable downward pressure on pricing which may be at unsustainable levels and/or at least not consistent with workably competitive markets. The context of the downward pricing pressure by the monopsonies suggests that SCHI’s Proposal will have even more detrimental effects. As a separate related point, there is the possibility that providers under pressure may seek to increase prices for other private patients (patients with other less powerful insurers and/or non-insurance privately funded customers).¹²⁵

¹²¹ See, for example, the [OECD discussion](#) (relating to regulation which has some analogies), which notes at (222): “As with price regulation, it is difficult to determine the “right” rate of return, and regulation at levels ... too low would cause problems. ... the incumbent may find it difficult to raise capital to make further necessary investments. Finally to invest ex ante are artificially reduced and under-investment is likely to result”.

¹²² [Commerce Commission - Winstone Wallboards Limited](#).

¹²³ [Wholesale-Supply-Inquiry-Preliminary-Findings-Paper-5-June-2025.pdf](#)

¹²⁴ Commission staff will be aware of the discussion on mobile termination regulatory proceedings in the context of expressed concerns that regulated outcomes could lead to the “waterbed effect”. See the July 2005 discussion by Frontier economics [here](#). More recently these issues have been discussed by economists in the context of grocery mergers. See: [Houston-Kemp-economic-effects-of-proposed-merger-of-FSNI-and-FSSI-review-of-statement-of-issues-26-April-2024.pdf](#).

¹²⁵ [BUYER POWER AND THE 'WATERBED EFFECT' on JSTOR](#). Abstract “When a buyer is able to obtain lower input prices from a supplier, is it possible that other buyers will have to pay more for the same input as a result? Is this bad for consumers? We present a model that analyzes the conditions under which the asymmetric exercise of buyer power can lead to consumer detriment through raising other buyers’ wholesale prices (the ‘waterbed effect’).”

- 11.6 For completeness, the Applicant notes their understanding that some hospitals may have their own concerns about SCHI's Proposal.
- 11.7 As such, there is considerable scope for public detriments under a counterfactual, which the Proposed Arrangements seek to mitigate.

The Proposed Arrangements (factual)

- 11.8 While SCHI will ultimately decide whether it accepts any changes, NZGA would likely advocate for the following changes part of any collective bargaining:
- a. **Contractual framework:** Maintaining price differentiation as is under the status quo or absent such, that any SCHI-determined common pricing is consistent with the long-term sustainability of private gynaecology practice and determined on a transparent basis (eg objective settings for how price is calculated).
 - b. **Scope of inclusions / exclusions:** Gynaecologists are concerned that SCHI's Proposal requires second guessing of clinical decision making without focus on appropriate patient care (NZGA would seek to align the scope of AP coding with realities of clinical practice).
- 11.9 The Applicant considers an AP coding framework a good starting point but would require necessary changes to allow for certain inclusions and combined surgeries to not be excluded (see examples under SCHI's Proposal).

Public benefits

- 11.10 Any public benefits arising from the Proposed Arrangements would therefore be to address (to the extent accepted by SCHI) the potential detriments or risks identified with SCHI's Proposal (ie the reverse). This includes surgeries being performed in efficient manner (no duplication) and patients receive timely and clinically backed care and cover (eg clear scope of pelvic floor procedures and addressing deficiencies in AP coding, including in urogynaecology and gynaecology).
- 11.11 Authorisation for the Proposed Arrangements would likely provide considerable public benefits (largely avoiding the potential detriments of SCHI's Proposal), including (but not limited to):
- a. **Clarity through upfront and ongoing clinical governance (continuous improvement):** Open and coordinated engagement regarding the Affiliated Provider (**AP**) scheme would ensure patient-centred, clinically informed decisions. In particular, the AP scheme would be informed by clinical expertise and subject to structured review, including in relation to billing code scope, combination rules, eligibility criteria, exclusion rules and related administrative processes. This is likely to result in:
 - i. A clinically workable AP framework, reducing the risk that coding or eligibility settings produce unintended or inappropriate clinical constraints;
 - ii. Greater clarity and consistency in how approvals and coverage are determined and should reduce avoidable administrative disputes (eg rework, contested approvals, repetitive submissions for change);
 - iii. Reduce delays in treatment arising from pre-operation uncertainty / time spent determining patient coverage; and
 - iv. Reducing inefficiencies of repetitive requests for interpretation or clarification of the AP scheme.

- b. **Clinically backed AP coding with beneficial patient and surgical outcomes:** A properly negotiated AP coding framework is likely to ensure that coding and combination rules are aligned with clinically appropriate care pathways, enabling gynaecologists to exercise professional judgment without artificial constraints imposed by coding or eligibility settings. Collective negotiation is likely to:
- i. Enable clinically appropriate combination of procedures within a single operation where safe; and
 - ii. Reduce the likelihood that procedures are excluded or fragmented due to coding limitations rather than clinical considerations.
- In turn, this is expected to result in direct patient and system benefits:
- i. Reduced likelihood of patients requiring multiple staged procedures where a single intervention would otherwise be clinically appropriate;
 - ii. Reduced exposure to multiple anaesthetic events and associated clinical risks;
 - iii. Reduced total recovery time, including fewer cumulative admissions and post-operative periods;
 - iv. Reduced delays in receiving complete treatment, enabling patients to receive timely and holistic care (increasing productivity at a national level and wellbeing as patients and their families face less disruption / downtime);
 - v. Reduced burden on surgical teams and facilities through avoidance of duplicative procedures, thereby freeing up capacity.
- c. **Regulatory oversight:** Bringing the Proposed Arrangements within a formal authorised framework would enable structured oversight of collective bargaining (and reduce uncertainty of Commerce Act compliance) and place appropriate safeguards, including legal oversight, scope and (if required) reporting obligations. This would likely reduce the risk of any unintended consequences from all participants including the risk of coordination outside the scope of the authorisation.
- d. **Mitigates or avoids likely adverse impacts of SCHI's Proposal:** As discussed above, the implementation of SCHI's Proposal may result in material changes to remuneration structures, contracting models and clinical autonomy which may affect the viability and sustainability of private gynaecological practice and therefore, the long-term health of the public (all women in New Zealand). In particular:
- i. Reduced supply of private gynaecological surgery capacity (sessions, lists, theatre days etc);
 - ii. Spillover which overburdens the already public system which is already over capacity (waitlist pressure, loss of dual-practice clinicians, etc); and
 - iii. Reduced investment/innovation (training, equipment, new techniques).
- e. **At the very least, proper engagement may lead to greater certainty for all parties and buy-in.**

11.12 Further, the usual collective bargaining benefits as set out earlier in Section 9 should apply to the Proposed Arrangements.

Application of usual collective bargaining benefits the Proposed Arrangements

11.13 As the largest (by far) health insurer and thus most significant funder of privately funded procedures SCHI has monopoly-like characteristics on the supply side (noting switching barriers) and monopsony-like characteristics on the funding side.

11.14 As such, there is considerable scope for public detriments under a counterfactual, which the Proposed Arrangements seek to mitigate.

11.15 The imbalance in bargaining power is overwhelming. SCHI is arguably an unavoidable trading partner. As such the benefits repeatedly recognised apply here.

11.16 Applying the Commission’s bargaining criteria here, consistent with the past collective bargaining determinations:

Information asymmetry and potential for inefficiencies in the counterfactual

11.17 *“There is a degree of mistrust and information asymmetry between [here, SCHI] and the Participants, which could result in a market failure through inefficient contracts”¹²⁶*

11.18 Incomplete and non-negotiable (partial) contracts are being presented which bear no correlation to current contracting and patient relationships.

11.19 Collective negotiation will:

- a. Enhance allocative efficiency by addressing market failures such as information asymmetry.
- b. Enhance verifiability of information and how it is used to design contracts and contract terms, improving outcomes.¹²⁷

Challenges with contracting important aspects of business relationships

11.20 There is no meaningful engagement. The Applicant does not have sufficient transparency over SCHI’s Proposal.

“Purchase” and / or supply of inefficiently low volumes and quality because prices are too low

11.21 As noted there are fears that SCHI’s Proposal could lead to a reduction in supply / output (quantity) and quality (with alone-price, and downward pricing pressure can be expected to reduce the ability and incentives to engage in innovation, including training, improvement, and differentiation).

11.22 **Appendix 4**, sets out terms in the [] and [] which the Applicant expects to negotiate for a more balanced approach as part of any collective negotiations.

Other effects?

11.23 The Proposed Arrangements are unlikely to have a detrimental impact on SCHI’s objectives in simplifying its insurance processes (eg establishing hospitals as the single point of contact for fee negotiation and creating greater price certainty). SCHI's decision to proceed with or abandon its proposal is a matter for SCHI alone, and it could elect to maintain the status quo

¹²⁶ [NZBA Draft Determination](#) at [142].

¹²⁷ See [NZBA Draft Determination](#) at [140] and footnote 164 citing King, SP (2013). *Collective bargaining by business: Economic and legal implications*. University of New South Wales Law Journal, 36(1), 107–138 at [116].

under a Fee-for-Service model irrespective of any collective bargaining. To the extent the Proposed Arrangements have any bearing on SCHI's implementation, they are more likely to facilitate (rather than hinder) an efficient and orderly implementation.

- 11.24 Alternatively (and more likely), if an AP scheme were to proceed, the Proposed Arrangements would in fact yield a positive effect by enabling negotiated outcomes to be reached more efficiently and transparently with gynaecologists, and facilitating higher rates of adoption at a national level (as opposed to counterfactual(s) involving partial, staged or suboptimal implementation with limited / fragmented uptake of SCHI-imposed arrangements, prolonging the process over an extended period). Accordingly, the Proposed Arrangements are more likely to be beneficial than detrimental (including preserving any benefits of SCHI's Proposal).
- 11.25 Any impact on insurance premiums paid by SCHI members would likely be minimal (if not better under the Proposed Arrangements).¹²⁸ SCHI retains significant countervailing buyer power and could continue to negotiate competitive fee outcomes irrespective of any collective bargaining. To the extent the Proposed Arrangements result in any marginal increase in fees, this would likely be offset by corresponding benefits to SCHI members, including:
- a. Improved standards of care and broader scope of cover (reducing out-of-pocket costs for procedures currently excluded);
 - b. The ability to access combination surgeries, which are more efficient (both on a cost and time basis) and reduce patient risk when performed together; and
 - c. The longer-term sustainability of private gynaecological practice in New Zealand, ensuring continued access for SCHI members.
- 11.26 Regardless, any impact on premiums must be assessed against the counterfactual(s) where the roll out of SCHI's Proposal is inefficient and / or suboptimal with variable uptake. This may create more costs for SCHI that are ultimately reflected in increased premiums. The Proposed Arrangements therefore offer an opportunity for SCHI to manage costs more effectively (as opposed to conducting over a hundred individual negotiations) and to establish efficient, clinically backed codes that support better outcomes for SCHI-insured patients.
- 11.27 The potential detrimental effects of a 6-month standstill (which would maintain the status quo while collective bargaining is pursued) would be minimal. SCHI members would continue to access private gynaecological services under existing arrangements during this period, with no interruption to coverage or service availability. There is no basis to consider that maintaining the status quo for this period would have any material impact on SCHI premiums.
- 11.28 Furthermore, the 6-month period must be assessed against a realistic counterfactual where implementation is in a partial and sequential manner with variable uptake by gynaecologists and potentially hospitals. The NZGA understands that SCHI may already be attempting an incremental approach by seeking to negotiate directly with individual gynaecologists (which is unlikely to work at a national level).¹²⁹ As such, there is no indication that SCHI's Proposal would be fully implemented within 6 months absent the Proposed Arrangements. Therefore, any delay attributable to the standstill would likely be de minimis and even with the standstill, a negotiated outcome would likely be more efficient and timelier in implementation (than under the current piecemeal approach).

¹²⁸ Noting that gynaecology as a specialty would only make up part of the payouts from overall cover (and therefore, a proportion of premiums paid).

¹²⁹ For example, NZGA understands there was a meeting between SCHI and an individual gynaecologist on 14 May 2026 for a potential negotiation.

Flow on effects

11.29 The Applicant considers that the flow on effects from the Proposed Arrangements are likely to be positive as:

- a. Collectively negotiated outcomes are more likely to receive ‘buy-in’ from skilled gynaecologists in private practice, sustaining the supply of specialists available to hospitals over the short and long term; and
- b. Negotiation of transparent and informed price and non-price terms would likely provide hospitals with greater certainty and enable them to plan around a stable supply of gynaecological services.

11.30 The Applicant acknowledges that if collectively negotiated fees for gynaecologists were to increase while bundled fees remained unchanged, this could compress margins for hospitals and anaesthetists. However, this risk is not unique to the Proposed Arrangements and the same outcome could arise if SCHI implemented a bulk-funded model absent any collective bargaining.

11.31 The level and scope of any flow on effects will be dependent on any changes that SCHI accepts.

Summary of benefits

11.32 Collective bargaining will shift the imbalance of bargaining power to some extent by enabling Participants to pool resources.

11.33 Efficiencies resulting from transactional cost savings. These cost savings arise because collective negotiation through the Proposed Arrangements avoids bilateral negotiations between each Participant and SCHI / hospitals. The Commission and ACCC have acknowledged a primary source of benefit from collective bargaining is sharing of negotiation costs.

11.34 Here collective negotiation will likely result in more sophisticated agreements that are likely to have efficiency benefits.

11.35 NZGA notes that while sophisticated in their field of speciality, many gynaecologists “*are not confident negotiating with a large commercial entity such as*” SCHI or the hospitals and that this (far) greater bargaining power would allow SCHI and / or hospitals to obtain (far) more favourable terms to the detriment of gynaecologists and their patients.¹³⁰ SCHI is essentially an “*unavoidable trading partner*”.¹³¹

TABLE 3: SUMMARY OF BENEFITS FROM PROPOSED ARRANGEMENTS

BENEFIT CATEGORY (TYPE OF EFFICIENCY)	NET BENEFITS	VALUE UNDER PROPOSED ARRANGEMENTS
Price/volume effects (<i>allocative</i> [but also goes to public policy])	<ul style="list-style-type: none"> • Addresses the imbalance in bargaining power — SCHI is essentially an unavoidable trading partner representing a material portion of revenues. • Collectively negotiated prices are more likely to be efficient, resulting in more preferred alternatives for consumers and/or greater availability of services. • Preserves (or restores) meaningful price signals, supporting consumer choice and appropriate investment incentives. 	Significantly positive.

¹³⁰ TGA [2022] NZCC 30 at [190].

¹³¹ Much like in NPA [2022] NZCC 35.

	<ul style="list-style-type: none"> • Reduces the risk that suppressed pricing leads to reductions in output, supply or quality in private and public sectors. • Mitigates the risk of broader allocative distortions (including the "waterbed effect" and increased barriers to entry/expansion in the health insurance market) that may arise from uninformed common pricing. 	
Non-price contract terms <i>(allocative, productive and dynamic)</i>	<ul style="list-style-type: none"> • Productive: <i>"Collectively negotiated contracts can more efficiently resolve marginal issues compared to contracts concluded by bilateral negotiations. This is because, absent the transaction cost savings arising from collective negotiations, it may be too costly to resolve such issues through individual negotiations. In contrast, by allowing negotiation and transaction costs to be shared across parties, collective bargaining can make it relatively less expensive for parties to effectively negotiate and resolve marginal issues."</i>¹³² • Productive + dynamic: <i>"Collective bargaining can also facilitate the sharing of information that can enable the more efficient resolution not only of marginal issues, but more substantive matters, such as fee structures or investment incentives. This may enable more sophisticated, efficient, and mutually beneficial contracts to be reached."</i>¹³³ • Allocative: Reduced information asymmetry leads to more efficient and balanced contractual terms. • Productive + allocative (+ dynamic long-term): Structured clinical engagement ensures the AP scheme is informed by clinical expertise and subject to ongoing review (coding scope, combination rules, eligibility criteria, exclusion rules and administrative processes). This addresses identified deficiencies in AP coding (including in urogynaecology and gynaecology, as flagged by RANZCOG) and enables clinically appropriate combination of procedures within a single operation, reducing fragmented treatment. Direct patient and system benefits include: fewer repeat procedures, reduced anaesthetic exposure, shorter recovery times, faster access to complete care, reduced pre-operative uncertainty, and reduced burden on surgical capacity. 	Significantly positive — high public benefit from collective negotiation of non-price terms (particularly clinical governance and AP coding outcomes) compared to fragmented bilateral engagement. This is the primary application-specific benefit.
Operational efficiencies <i>(productive + dynamic)</i>	<ul style="list-style-type: none"> • Information exchange supports more efficient coordination of services and reduces duplication. • Collectively negotiated outcomes are more likely to facilitate higher rates of national adoption (avoiding prolonged, fragmented implementation). • A negotiated outcome is likely to be more efficient and timelier than a piecemeal approach. • Proper engagement leads to greater certainty for all parties and buy-in. 	Positive – immediate short term benefits to operational gaps / inefficiencies. Benefits to efficient national implementation.

¹³² [TGA \[2022\] NZCC 30](#) at [177].

¹³³ [TGA \[2022\] NZCC 30](#) at [178].

Investment (<i>dynamic</i>)	<ul style="list-style-type: none"> • Preserves incentives for gynaecologists to invest in training, subspecialisation, technology/equipment (eg robotic surgery, sacral nerve modulators) and staff development. • Encourages hospitals to differentiate to attract surgeons. • Advocates for sustainable pricing linked to transparent indices (eg CPI, medical cost inflation), supporting long-term investment certainty. • Reduces the risk that inadequate fixed-fee models diminish incentives to subspecialise or innovate. 	Positive – long term this would promote greater diversity of alternatives and overall quality (attracting/retaining talent).
(Avoided) Transaction costs (<i>productive</i>)	<ul style="list-style-type: none"> • It is unclear (and not yet calculated) the extent of likely costs incurred under the counterfactual. But clearly there would be significant costs for each gynaecologist. • There will be considerable costs avoided by collective engagement (as opposed to individual bilateral agreements which would likely also mean ongoing information asymmetries). • Specifically, collective bargaining under the Proposed Arrangements is more likely to reduce the duration and costs of any negotiations by allowing a single negotiation process, and removing the duplication of negotiations and advisory costs for both parties.¹³⁴ • Avoids potential costs of subsequently remedying unintended consequences from uninformed bilateral contracting. • Enables SCHI to manage costs more effectively (one negotiation rather than over a hundred). 	Positive – avoids transactions costs, because of the underlying economies of scale available from collective bargaining. ¹³⁵ Both short and long term.

11.36 **Public Detriments** For the avoidance of doubt, the Applicant considers that there is little, if any, detriment in granting authorisation and interim authorisation (rather the reverse).

11.37 In particular, the Applicant does not consider that the Proposed Arrangements result in any:

- a. **substantial lessening of competition in a market.** It simply seeks to address a significant bargaining imbalance in the context of a radical and potentially contractual clinical relationship and does not in any way lessen how the parties compete in the rest of their respective businesses. In such circumstances, there is no prospect of a substantial lessening of competition in the supply of gynaecological services. For example, the ACCC has dismissed anticompetitive concerns where the counterparty is a monopolist:¹³⁶

[T]he target of the collective bargaining is a monopoly provider, reducing the probability that the collective bargaining group will achieve inefficiently low prices'.¹³⁷

¹³⁴ TGA [2022] NZCC 30 at [142].

¹³⁵ TGA [2022] NZCC 30 at [161]–[162].

¹³⁶ King, SP (2013). Collective Bargaining by Business: Economic and Legal Implications. UNSW Law Journal, volume 36(1), 107 – 138 at footnote 75.

¹³⁷ Australian Competition and Consumer Commission, A91275: *Abbot Point Coal Export Terminal Producers* (16 February 2012) at [4.37].

- b. **allocative efficiency losses** are not credible given that funders will continue to have significant bargaining power and incentives to manage costs, such that it would not be credible for Participants to bargain for prices above competitive levels; and
- c. **productive or dynamic efficiency losses** are also not credible as gynaecologists will remain incentivised to compete (by, for example, being more productive, efficient, or innovative) and would be able to do so.

11.38 Instead, for the reasons discussed above, the Proposed Arrangements would result in significant transactional costs savings and other efficiency benefits.

12. APPLICATION FOR INTERIM AUTHORISATION

Urgency / why interim authorisation is sought:

- 12.1 The Applicant seeks interim authorisation to give effect to the Proposed Arrangements and prepare for collective bargaining. Interim authorisation will enable informed industry engagement with SCHI and relevant counterparties (including hospitals) regarding SCHI's proposed restructure to an entirely new funding and contracting model for the provision of gynaecological services.
- 12.2 There is a genuine urgency. SCHI's Proposal is considered to be a fundamental change in contracting relationships for gynaecological surgery, including a shift to a structure in which hospitals hold the primary arrangements and specialists are required to contract (or "subcontract") in order for insured members to access reimbursement pathways. SCHI is also signalling tight timeframes (deadlines) to pressure providers to respond or provide information, with material consequences if responses are not provided within those timeframes.
- 12.3 Absent interim relief, the Applicant is concerned that the market may move rapidly to a new, effectively permanent contractual structure (also impacting clinical relationships) before there has been any opportunity for meaningful engagement on the scope, rationale, and ramifications of the proposed changes. In practice, once counterparties enter longer-form arrangements, there is a risk the new structure becomes "locked in" as the default "industry position", and later consultation becomes largely academic. (The Applicant notes more generally that real or perceived deadlines can become a focal pressure point in negotiations and can distort decision-making.)
- 12.4 For clarity, the Applicant does not necessarily oppose SCHI's Proposal, the Standstill Agreement is sought to encourage SCHI to engage with the Applicant to avoid irreversible structural change and parties being forced into uninformed bilateral contracting driven by deadline pressure and information asymmetries.
- 12.5 Interim authorisation is also required because SCHI has indicated (including to the Applicant) that it is unwilling or unable to engage meaningfully with NZGA and its members on aspects of the proposal, citing competition law concerns. Interim authorisation would therefore reduce "chilling effects" and permit limited, safeguarded engagement to occur promptly while the Commission considers the substantive authorisation application.
- 12.6 **Conclusion:** As noted, the (self-determined) urgency imposed by SCHI (and potentially in turn hospitals) indicates that interim authorisation should be granted to *maintain the status quo* (and *prevent the potential harm to competitive dynamics*), otherwise there could be broader (*potentially irreversible*) *harm to the public (and women's health)* as outlined in this application, and related *potential harm to the Applicant* (who absent interim authorisation may be forced to enter ill-advised contractual arrangements they are not familiar with and have not had the benefit of seeking legal advice on).

13. CONFIDENTIALITY

- 13.1 Confidentiality is not claimed for the fact of the Proposed Arrangements.
- 13.2 Confidentiality is sought for:
- a. Information contained in **Appendices 1, 2, 3 and 4** of this application; and
 - b. Information that is confidential is identified by information contained in square brackets and highlighted in eg [yellow].
- 13.3 A separate schedule of all confidential information accompanies this application.
- 13.4 Confidentiality is sought until the Applicant confirms in writing to the Commission that the particular information is no longer confidential.
- 13.5 This request is made because the information is commercially sensitive and valuable information which is confidential to the Applicant (or third parties), and disclosure of it would be likely to unreasonably prejudice the commercial position of the relevant party. Therefore, confidentiality is requested under sections 9(2)(a) and 9(2)(b) of the Official Information Act 1982 and / or the Privacy Act 2020.
- 13.6 The Applicant requests that it be notified of any request made to the Commission under the Official Information Act 1982 for the release of confidential information, and that the Commission seeks their views as to whether the information remains confidential and commercially sensitive, at the time a response to such a request is being considered.
- 13.7 Paragraphs 13.1 – 13.6 of this application also apply in respect of any additional information provided, whether orally or in written form, to the Commission where it has been expressed to be confidential or it is implicit by the nature of that information or communication.

DECLARATION

I, [], have prepared, or supervised the preparation of, this notice seeking authorisation.

To the best of my knowledge, I confirm that:

- all information specified by the Commission has been supplied;
- if information has not been supplied, reasons have been included as to why the information has not been supplied;
- all information known to the applicant that is relevant to the consideration of this notice has been supplied; and
- all information supplied is correct as at the date of this notice.

I undertake to advise the Commission immediately of any material change in circumstances relating to the notice.

I understand that it is an offence under the Commerce Act to attempt to deceive or knowingly mislead the Commission in respect of any matter before the Commission, including in these documents.

I am an officer of the Applicant and am duly authorised to submit this notice.

Name and title of person authorised to sign:

[]

19 May 2026

Signature

Date

APPENDIX 1 – Contact details of relevant parties to the Proposed Arrangements

CONTACT DETAILS OF THE CURRENT PARTICIPANTS (NZGA MEMBERS)

PARTY	Location	EMAIL	PHONE
[]	[]	[]	[]
[]	[]	[]	[]

CONTACT DETAILS OF PUBLIC-ONLY GYNAECOLOGISTS

PARTY	LOCATION	EMAIL	PHONE
[]	[]	[]	[]
[]	[]	[]	[]

CONTACT DETAILS OF SCHI

PARTY	LOCATION	EMAIL	PHONE
[]	[]	[]	[]
[]	[]	[]	[]

CONTACT DETAILS OF INTERESTED PARTIES

PARTY	LOCATION	EMAIL	PHONE
Te Whatu Ora []	[]	[]	[]
[]	[]	[]	[]
RANZCOG []	NZ Office: Level 10, SAS House 89 The Terrace, Wellington Central, Wellington 6011 Postal address: PO Box 10611, The Terrace, Wellington 6143 (public address)		04 472 4608 (public number)
[]	[]	[]	[]
Australian Gynaecological Endoscopy and Surgery (AGES) []	[]	[]	[]
Endometriosis New Zealand []	PO Box 1673 Christchurch 8140 New Zealand (public address)	[]	[]
Urogynaecological Society of Australasia (UGSA) []	[]	[]	[]

[]	[]	[]	[]
NIB []	[]	[]	[]
AIA []	[]	[]	[]
[]	[]	[]	[]

APPENDIX 2 – NZGA’S CURRENT CHRONOLOGICAL SUMMARY OF SCHI’S CONDUCT

DATE	PARTIES/TOPIC	WHAT HAPPENED
[]	[]	[]
[]	[]	[]

APPENDIX 3 – LIST OF FURTHER DOCUMENTS PROVIDED WITH APPLICATION

This appendix sets out a list of further documents provided with the application at the time of filing:

A3.1 [] (see **Appendix 4**) — provided as a separate attachment.

A3.2 [] — provided as a separate attachment.

A3.3 [] — provided as a separate attachment.

A3.4 Letters provided from medical professionals regarding SCHI’s Proposal:

- a. [] — provided as a separate attachment;
- b. [] — provided as a separate attachment;
- c. [] — provided as a separate attachment;
- d. [] — provided as a separate attachment; and
- e. 21 April 2026 Letter from [] — provided as a separate attachment.

A3.5 [] — provided as a separate attachment.

A3.6 Email chain between [] regarding the application of risk corridors — provided as a separate attachment.

A3.7 Miscellaneous documents, emails and correspondence regarding **Appendix 2** (NZGA’s Current Chronological Summary of SCHI’s conduct) — provided as separate attachments.

APPENDIX 4 – ANALYSIS OF [] & []

A4.1 The following table identifies issues in:

- a. The draft proposed [] (provided in **Appendix 3**); and
- b. [] (provided in **Appendix 3**).

A4.2 The table provides a balanced position which the Applicant may wish to negotiate for as part of a collective negotiation.

	ISSUE	DESCRIPTION	BALANCED POSITION
1.	[]	[]	[]
2.	[]	[]	[]

APPENDIX 5 – EXAMPLE STANDSTILL DEED

Standstill Deed

This Deed is made on [] 2026

By: Each person executing this Deed (**Participant**) in favour of New Zealand Gynaecology Association Incorporated (**NZGA**).

Background

- A. Each Participant is an independent supplier of gynaecology services and competes, and will continue to compete, with other Participants in respect of price, fees, quality, service, innovation, capacity, investment, and the choice of counterparties.
- B. Southern Cross Health Insurance (**SCHI**) and hospitals have proposed new accredited provider, access or contracting arrangements for gynaecology services (**Proposed AP Arrangements**).
- C. NZGA has applied to the Commerce Commission for authorisation to engage collectively with SCHI and hospitals in relation to the Proposed AP Arrangements.
- D. Pending the Commission's consideration of that application, all Participants wish to record a limited and temporary standstill to preserve existing competitive conditions and avoid pre-emptive commitment to the Proposed AP Arrangements.

Operative Provisions

1. **Standstill Obligation**
During the Standstill Period, the Participant must not enter into, accept, sign, vary, or otherwise commit to the Proposed AP Arrangements.
2. **No Restriction Beyond Standstill**
Except for clause 1, nothing in this Deed restricts or influences how the Participant determines its prices, fees, services, volume, scope of practice, investment decisions, or choice of customers or contracting counterparties.
3. **No Coordination or Collective Commitment**
This Deed does not constitute, and must not be used to facilitate, any agreement or understanding between Participants as to future prices, outputs, allocation of patients or territories, or any other competitively sensitive matter.
4. **Preservation of Competition**
The Participant acknowledges that the sole purpose of this Deed is to maintain existing competitive conditions while proposed arrangements are assessed, and not to delay, soften or replace independent commercial decision-making by Participants.
5. **Member Execution**
NZGA must procure that each of its members becomes a Participant by executing, or otherwise agreeing in writing to be bound by, this Deed.
Any member who does not become a Participant within the timeframe reasonably specified by NZGA is removed as a member of NZGA.

6. Standstill Period

This Deed applies for **6 months** from the date of execution, unless earlier terminated:

- (a) by any Participant on **three months' written notice** to NZGA; or
- (b) by written agreement of all Participants.

7. Nature of Deed

This Deed is intended to be legally binding and is executed as a deed.

8. Governing Law

This Deed is governed by, and must be construed in accordance with, the laws of **New Zealand**, and the New Zealand courts have exclusive jurisdiction.

Execution as a Deed

Executed by the Participant:

Signature: _____

Name:

Date:

Annex A to Deed of Standstill

Competition Guardrails During Standstill Period

This Annex sets out binding **competition compliance guardrails** applicable during the Standstill Period under the Deed of Standstill.

A. Purpose

The purpose of these guardrails is to:

1. preserve existing competitive conditions during the Standstill Period; and
2. ensure that no coordination or alignment of competitive conduct occurs between Participants, other than the temporary standstill itself.

B. Permitted Conduct (Do's)

Participants **may**:

1. **Continue independent competition**
Independently determine pricing, fees, services, quality, innovation, capacity, investment, staffing, and contracting decisions, exactly as they would absent the Deed.
2. **Deal independently with third parties**
Continue to engage individually with patients, insurers, hospitals and other counterparties, including entering into new or varied arrangements unrelated to the Proposed AP Arrangements.
3. **Seek independent advice**
Obtain independent legal, accounting or commercial advice at their own discretion.

C. Prohibited Conduct (Don'ts)

Participants **must not**:

1. **Coordinate competitively sensitive conduct**
Discuss, agree, align or signal with other Participants regarding:
 - (a) prices or fees (including minimums, ranges or methodologies);
 - (b) volumes, capacity, output or service mix;
 - (c) allocation of patients, territories or counterparties; or
 - (d) timing or terms of entry into or exit from arrangements.
 Other than as reasonably necessary in relation to NZGA's engagement with SCHI or hospitals on any separately authorised conduct to engage with SCHI or hospitals; and

 Provided that the discussion, agreement, alignment or signal is not for the purpose, effect or likely effect of substantially lessening competition.
2. **Make collective commitments**
Enter into any agreement or understanding (formal or informal) with other Participants about future commercial conduct, whether during or after the Standstill Period.

3. Pre-commit to Proposed AP Arrangements

Agree, conditionally or otherwise, to accept the Proposed AP Arrangements, including through side letters, expressions of interest, or “in-principle” agreements.

4. Use NZGA as a coordination mechanism

Use NZGA (or information received via NZGA) to influence or align competitive behaviour between Participants:

- (a) other than as reasonably necessary in relation to NZGA’s engagement with SCHI or hospitals on any separately authorised conduct to engage with SCHI or hospitals; and
- (b) provided that the discussion, agreement, alignment or signal is not for the purpose, effect or likely effect of substantially lessening competition.

D. Acknowledgement

Each Participant acknowledges that:

1. compliance with these guardrails is a condition of participation in the standstill; and
2. breach of these guardrails may expose the Participant to competition law risk independently of the Deed.