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Public version

Draft Determination

This is a Draft Determination under the Commerce Act 1986 in the matter of an application for authorisation of a restrictive trade practice. The application is made by:

New Zealand Gynaecology Association Inc

The Commission:	Dr John Small Anne Callinan Tristan Gilbertson
Summary of application:	The New Zealand Gynaecology Association has applied for authorisation for itself and its members to undertake certain activities relating to collective bargaining with Southern Cross Health Insurance and/or hospitals.
Determination:	The Commerce Commission's draft decision is to decline authorisation as it is not satisfied that the Proposed Arrangements requested will, in all the circumstances, result or likely result in such a benefit to the public that the conduct should be permitted.
Date of Draft Determination:	23 September 2026

Note: This is a Draft Determination issued for the purpose of advancing the Commerce Commission's decision on this matter. The conclusions reached in this Draft Determination are preliminary and take into account only the information provided to the Commission to date.

Confidential material in this report has been removed. Its location in the document is denoted by [ ].

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Executive summary

We are considering an application for authorisation of restrictive trade practices from the New Zealand Gynaecologists Association

1. The Commerce Commission (**Commission**) is considering an application for authorisation of restrictive trade practices (**Application**) from the New Zealand Gynaecology Association Incorporated (**NZGA**) (**Applicant**), seeking authorisation, on behalf of itself and its members, to:

    1.1 collectively bargain with Southern Cross Medical Care Society (trading as Southern Cross Health Insurance (**SCHI**)), and/or hospital(s) for the provision of private gynaecology services to SCHI-insured patients; and

    1.2 enter into a Standstill Agreement between NZGA members (as further explained in paragraph 7 below) to defer contracting with SCHI for a period of 6 months

    (the **Proposed Arrangements**).

2. NZGA also sought Interim Authorisation for the same.

3. The Application was made by NZGA in response to SCHI seeking to expand its Affiliated Provider Scheme (**APS**) to gynaecology surgery.[1] NZGA was established in 2026 to act as a "competition-compliant medium" for collective engagement, to allow balanced and informed discussion regarding a proposal by SCHI.[2] The APS has existed for several decades and is the primary means by which SCHI funds healthcare for its members.[3] Under the APS, SCHI and healthcare facilities (typically hospitals) negotiate contracts under which set prices are agreed for certain procedures provided to SCHI members.[4] Those hospitals/facilities in turn contract with relevant clinical professionals (including surgeons and anaesthetists) to deliver the healthcare service. Procedures are billed by the facility to SCHI in accordance with a defined set of billing codes. A small set of gynaecology surgeries (robotic surgeries) as well as all gynaecology consultations and rooms-based services are already exclusively funded under the APS.[5]

4. SCHI currently funds most gynaecology surgery under a different model from the APS. SCHI currently funds most gynaecology surgeries on a fee-for-service (**FFS**) basis.[6] Under the FFS model, surgical procedures are charged by each supplier (surgeon, anaesthetist and facility) to SCHI's members at a rate of their own

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1 NZGA, "Notice by New Zealand Gynaecology Association Inc seeking authorisation under section 58(1), (2), (6B) and (6D) (and interim authorisation under section 65AAA)" (19 May 2026) at [1.1 to 1.6] and [4.1 to 4.9].

2 Interview with NZGA (13 July 2026), Application at [4.3].

3 Interview with SCHI (17 June 2026).

4 SCHI submission on Statement of Preliminary Issues (**SOPI**) (16 June 2026) at [4.4], [4.14(a (ii)] and [6.9(e (ii) to (iii))].

5 Interview with SCHI (17 June 2026), SCHI submission on SOPI (16 June 2026) at [4.11].

6 SCHI submission on SOPI (16 June 2026) at [4.2] and footnote 136.

choosing. SCHI will reimburse its members for those fees in accordance with the member's policy terms and conditions.

5. SCHI is seeking to implement the APS to gynaecology surgery as an extension of the existing APS, as it considers the APS to be the best way to address claims cost escalation and moral hazard issues associated with the FFS model.[7] SCHI's original timeline for expanding the APS has been delayed, potentially until at least the conclusion of this authorisation application.

6. While NZGA generally supports SCHI's objective of maintaining affordability for its members, gynaecologists are concerned about the lack of engagement by SCHI in extending the APS to gynaecology surgery and consider that there is a high risk of inadequately informed decisions if the APS is implemented without engagement.[8] NZGA is also concerned that the fees received by gynaecologists under the APS would be significantly lower than they currently receive under the FFS model and that both the billing codes and reimbursement levels do not adequately reflect the complexity and diagnostic nature of gynaecology surgeries.[9] NZGA's application raises a number of concerns about SCHI's proposed extension of the APS to gynaecology surgery, including that, absent the Proposed Arrangements, it could result in reduced healthcare quality, reduced innovation, a reduced supply of gynaecologists, and increased pressure on the public health system.[10]

7. To address its concerns with the APS, NZGA seeks authorisation to engage in collective bargaining discussions with both SCHI and hospitals for a period of up to 10 years. This is expected to involve exchanging information (including pricing information) and negotiating price and non-price terms. It also seeks authorisation for its members to refuse to sign up to the SCHI APS for a period of up to 6 months (the Standstill Agreement).

We have sought the views of interested parties on the merits of the application and received a range of evidence to assist our analysis

8. In considering the Application, the Commission sought feedback from interested parties on the Proposed Arrangements.

9. Some industry associations, several gynaecologists, and Health NZ considered that the Proposed Arrangements would result in at least some benefits identified by

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7 Ibid at [1.3(c)] and [4.1]. Moral hazard arises when one party to a contract changes behaviour in response to that contract and thus passes on the costs of that behaviour change to the other party. *(Principles of Economics, Twelfth Edition, K. Case, R. Fair, S. Oster page 393).* For example, moral hazard may arise as comprehensive insurance lowers patients' out-of-pocket costs, encouraging greater healthcare utilisation. This can produce allocative inefficiency where the incremental cost of bringing the resources to market (marginal cost) exceeds the valuation in the market to those who buy the resources. *(NERA "Assessment of claims benefits of collective bargaining by gynaecologists: Report for Southern Cross Medical Care Society" (3 August 2026) at paragraphs 9(E) and 43-45).* The FFS model contributes to moral hazard, as neither provider nor end-insurance customers have direct incentives to achieve efficiencies and cost savings in service deliver. *(SCHI submission on SOPI (16 June 2026) at paragraph 4.3)*

8 Application at [1.3].

9 Ibid at [2.19(c)] and [11.5(a)].

10 Application at [2.19(a-e)].

NZGA. Some gynaecologists and industry associations agreed with NZGA's view that there were substantial risks regarding SCHI's proposed extension of the APS to gynaecology surgery and that collective bargaining is necessary to address those risks through reducing information asymmetry and bargaining imbalances. For example, some gynaecologists considered that the proposed reduction in fees by SCHI was significant enough to affect the viability of gynaecologists' businesses and could incentivise gynaecologists to leave New Zealand, exacerbating an existing shortage of trained specialists. Some gynaecologists and industry associations also raised that the Proposed Arrangements would allow for more efficient and/or balanced contractual terms with SCHI. Health NZ recognised that the Proposed Arrangements may support more effective engagement between specialists, hospitals and purchasers, including through more workable contractual arrangements.[11]

10. Some insurers, hospitals, gynaecologists, and industry associations, as well as ACC and Health NZ, raised concerns about the Proposed Arrangements. For example, insurers and ACC raised that collective bargaining could result in higher prices for insurers and other funders of gynaecology surgery, resulting in reduced consumption of healthcare services.[12] Health NZ also raised similar concerns that collective bargaining may contribute to price standardisation and increased costs across the health system, with implications for procurement, capacity and access to care.[13] Some hospitals also raised concerns that hospitals could face increased costs as a result of collective bargaining, causing them to reduce investment or spaces offered to provide gynaecology services. Health NZ raised concerns that increased costs, or reduced flexibility, may affect the speed and scale at which private sector capacity can be accessed, with flow-on implications for system capacity and access to care.[14] Some hospitals and SCHI raised a concern that the Proposed Arrangements would increase transaction costs for gynaecologists, themselves and others.

We apply the legal tests in the Commerce Act to determine authorisation applications

11. At a high level, the legal question the Commission must ask itself is whether the public benefits of the Proposed Arrangements are likely to outweigh any detriments associated with the Proposed Arrangements (including any associated harm to competition). This is called the 'public benefit' test.

12. The Commission must not grant authorisation unless it is satisfied that the public benefits of the arrangements are likely to outweigh the detriments. It can either decline authorisation, grant authorisation, or grant authorisation with conditions.

Our analysis indicates that granting authorisation would likely result in a material increase to the remuneration of gynaecologists (among other things)

13. At a high level, the Commission is required to assess what is likely to happen in the future if the Proposed Arrangements go ahead (what we refer to as the 'factual') and

[11] Health NZ submission on SOPI (10 June 2026) at page 2.
[12] ACC submission on SOPI (2 July 2026) at pages 2-3
[13] Health NZ submission on SOPI (10 June 2026) at page 3
[14] Health NZ submission on SOPI (10 June 2026) at page 3

compare it to what we think is likely to happen if the Proposed Arrangements do not go ahead (what we refer to as the 'counterfactual').

14. We then weigh up the likely public benefits and detriments in the factual compared with the counterfactual to determine whether the Proposed Arrangements are likely to result in a net benefit or a net detriment.

15. When it comes to the counterfactual, on the basis of the evidence received we think that SCHI will proceed with expanding the APS to gynaecology surgery. We expect gynaecologists would agree individually with hospitals regarding the set fees they receive for SCHI-funded surgeries. Hospitals would concurrently negotiate with SCHI on the bundled price of gynaecology surgeries at their facilities, taking account of gynaecologists' fee expectations as a key input to the bundled price. Where APS negotiations for gynaecology surgical services are currently at an impasse because gynaecologists consider the fees to be too low, SCHI has the option of raising the prices it offers until it obtains sufficient expert and geographic coverage of services for its members.

16. In the factual, if the Proposed Arrangements are authorised, the evidence before us indicates that SCHI's APS would continue to be expanded albeit with a 6-month delay attributable to the Standstill Agreement. Importantly, NZGA has stated it is not against the APS, and is in fact willing to proceed with the APS if the Proposed Arrangements are authorised.[15] However, we preliminarily expect that the Proposed Arrangements would result in materially higher costs for gynaecology surgery on an ongoing basis, compared to the counterfactual, and that these negotiations would occur sequentially, between NZGA and hospitals, and hospitals and SCHI. NZGA would also be likely to negotiate more efficient non-price contract terms.[16] We further expect that these materially higher prices and more efficient non-price contractual terms would come at the expense of higher transaction costs as parties negotiate harder and more extensively than they would in the counterfactual.

Our analysis indicates that the likely detriments of the Proposed Arrangements outweigh the likely benefits

17. The Commission will grant authorisation if it is satisfied the proposed conduct will result, or will be likely to result, in a benefit to the public which would outweigh the lessening in competition that would result or be likely to result.[17] In making this assessment, the Commission considers the evidence and makes judgements about how much weight to give to the evidence.

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15 Addendum to NZGA's supplemental submission (9 June 2026) at [3].

16 NZGA has identified a range of non-price terms it would seek to negotiate, including; specifying and clarifying when additional fees would be paid, when open codes will be accepted, how risk is shared amongst the hospital, surgeon and anaesthetists when a surgery is unexpectedly complex and various other terms and conditions NZGA presently considers 'asymmetric'.

17 Section 61(6) of the Act. Authorisation Guidelines at [18.2].

18. The Commission's approach is to quantify benefits and detriments to the extent that it is practicable to do so,[18] although we can give weight to qualitative factors where appropriate.[19] For this assessment, the benefits and detriments we have identified are not possible to reliably quantify on the evidence available. The Applicant has not sought to quantify them. We have therefore undertaken a qualitative weighting of the relevant benefits and detriments.

19. While the Commission has made its own enquiries into these matters, we note that in authorisation matters the applicant bears the practical burden of persuasion.

20. In our analysis below we apply a total welfare standard. Under this standard we have not given independent weight to the materially higher cost of gynaecology surgery paid by funders/purchasers and charged by surgeons. This is because the changes in cost themselves represent a transfer of wealth, where one group gains at the expense of another, but do not involve a change in overall public benefit.[20] Rather, changes in the cost of gynaecology services are considered through their effects on economic efficiencies, such as allocative efficiency, which can affect overall public benefit.

Detriments

21. The evidence before us indicates that the Proposed Arrangements are likely to give rise to two types of detriment: increased transaction costs and a loss of allocative efficiency as consumers may switch to otherwise inferior or less satisfactory or timely products/services. This in turn may lead to poorer health outcomes and/or increase the strain on the public healthcare system.

Transaction costs

22. In some circumstances transaction cost savings can be made through collective bargaining (as envisaged by the Proposed Arrangements). Where the interests of the parties who are permitted to collectively bargain are relatively homogeneous, collective bargaining permits participants to reduce duplication by engaging common professionals such as lawyers and accountants and streamlining the number of negotiations that would take place.

23. We have considered the transaction costs the gynaecologists would incur under the counterfactual where they individually agree the terms of an APS arrangement. The evidence before us is that gynaecologists are unlikely to incur significant transaction costs in the counterfactual. When other specialities have transitioned to APS the specialists do not appear to have engaged in lengthy negotiations or commonly

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18 *Telecom Corporation of New Zealand Ltd v Commerce Commission* [1992] 3 NZLR 429 (CA) at [447]. *Air New Zealand and Qantas Airways Limited v Commerce Commission* (2004) 11 TCLR 347 (HC) at [319]. *Ravensdown Corporation Ltd v Commerce Commission* High Court, Wellington API68/96 (16 December 1996) at [47] to [48].

19 *Godfrey Hirst NZ Ltd v Commerce Commission* [2016] NZCA 560 (CA) at [38].

20 *Air New Zealand and Qantas Airways Limited v Commerce Commission* (2004) 11 TCLR 347 (HC) at [241] and *Telecom Corporation of New Zealand Ltd v Commerce Commission* (1991) 4 TCLR 473 (HC) at [530-531].

incurred the costs of retaining advisors to assist them. Instead, negotiations appear to be resolved through local relationships. We have not received evidence to suggest that a material number of gynaecologists would engage advisors or participate in lengthy negotiations.

24. In contrast to this counterfactual, it appears that the Proposed Arrangements will likely increase transaction costs for gynaecologists, SCHI and hospitals.

25. This is particularly the case for gynaecologists/NZGA because they are likely to incur significantly higher transaction costs in the factual when preparing for, and engaging in, negotiations with SCHI and/or hospitals than individual gynaecologists would incur when negotiating with individual hospitals/hospital groups in the counterfactual.

26. Increased transaction costs arise under the Proposed Arrangements because:

    26.1 the transaction costs from negotiating price terms are likely multiplied across each individual hospital/hospital group in the factual. This is because SCHI maintains that it will not negotiate with NZGA and so NZGA would still need to negotiate terms with each private hospital/hospital group, who in turn would negotiate with SCHI;

    26.2 gynaecologists do not have a uniform set of interests. Instead, they diverge in their preferences and characteristics which may create some internal frictions when trying to collectively bargain. In particular, with respect to price expectations, some gynaecologists currently charge significantly more than others and can be expected to want to maintain this level of income, rather than settle for a lower, collective set of charges; and

    26.3 NZGA's plans for negotiating appear to be of materially greater scope and intensity than we would expect negotiations between individual gynaecologists and hospitals in the counterfactual to be. For example, NZGA intends to include multiple feedback loops to its members during several rounds of negotiations[21]. We consider that individual negotiations would not be as onerous.

27. We also consider that SCHI and private hospitals are likely to experience higher transaction costs in the factual, compared to the counterfactual, although to a smaller extent than NZGA/gynaecologists.

28. We have not been able to quantify this detriment, but consider it to be likely and of medium size relative to the other benefits and detriments we are considering. We have given it greater weight given its high likelihood of eventuating.

Allocative efficiency losses

[21] NZGA response to RFI dated 30 July 2026 (18 August 2026) at [11]

29. The second type of detriment we have considered is the allocative efficiency loss in response to materially higher prices charged by gynaecologists in the factual compared to the counterfactual. Allocative efficiency losses reflect the 'cost' to society of an increase in price which leads to either unsatisfied demand or the purchase of a less preferred substitute.[22] We consider there is a relationship between the prices charged by gynaecologists, insurance premiums, and customers' willingness to maintain their current level of insurance. We note that evidence before us indicates that health insurance consumers may be particularly price sensitive, following a trend of increasing premiums.[23]

30. Furthermore, allocative efficiency losses may extend beyond SCHI customers as the collectively negotiated fees become a reference point. This may increase the cost of gynaecology across other funders and purchasers of gynaecology surgery, such as Health NZ and other private insurers and private individuals, leading to further unsatisfied demand or the purchase of a less preferred substitute.

31. We expect the magnitude of this detriment to be correlated to the size of the increase in gynaecology surgery fees in the factual. We have not come to a view on the size of this increase, but consider it is likely to be material. We also expect the burden of this detriment to largely be experienced by females.[24]

32. We have not been able to quantify these allocative inefficiency detriments, but consider them to be likely and together of medium size relative to the other benefits and detriments we are considering.

Benefits

33. We have also assessed whether the Proposed Arrangements would give rise to benefits compared to a counterfactual in which the APS is implemented without collective bargaining or a Standstill Agreement. Our provisional view on the basis of the evidence received is that two types of benefit may arise: more efficient contract terms, and a greater supply of gynaecologists.

<u>More efficient contract terms</u>

34. Collectively negotiated contracts can more efficiently resolve marginal issues because the process can allow negotiation and transaction costs to be shared across parties and by changing the available information and how it can be used in contract design. Marginal issues can be characterised as relatively minor issues that negotiating parties may be able to reach a mutually beneficial agreement on, but the cost of reaching agreement is too high relative to the benefit of doing so. The benefit of efficient contract terms is likely to arise from gynaecologists sharing the time and resource costs of negotiating non-price contractual terms under the APS. However,

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22 Authorisation Guidelines at [63].

23 SCHI response to RFI dated 1 July 2026 (3 August 2026).

24 This may not be the case, for example, to the extent an insurer spreads the cost of increased gynaecology surgery across all its members.
[
] SCHI response to RFI dated 6 August 2026 (27 August 2026) at page 3.

we note there are some issues that would likely be resolved in both the factual and counterfactual (such as non-price clinical issues), and others that would likely not be resolved in either (such as any changes that give clinicians material influence over SCHI member benefits). Consequently, we consider there are limited marginal issues that will be addressed solely by collectively bargaining. Therefore, we have preliminarily assessed this benefit as likely, but the magnitude to be very small relative to the other benefits and detriments we are considering.

Greater supply of gynaecologists

35. We also consider that a benefit of the Proposed Arrangements is likely to be a greater supply of gynaecologists. All else equal, we would expect the materially higher fees received by gynaecologists in the factual to increase the supply of gynaecologists in New Zealand. This could be through either decreasing the number of gynaecologists leaving practice in New Zealand (for example, through early retirement or relocating to another jurisdiction) or increasing the supply in New Zealand (for example, by increasing immigration of overseas trained specialists to New Zealand or incentivising more doctors to train as specialists). However, the level of fees available in private practice is only one of a number of factors that gynaecologists consider when reaching a decision on whether to offer their services in New Zealand. We have not received strong evidence to support this claimed benefit, although we consider it to be plausible. We have preliminarily assessed this benefit as likely, however given the limited strength of evidence received consider the benefit to be small in magnitude.

Unaffected situations

36. We have also explored several other potential benefits and detriments from the Proposed Arrangements. However, based on the evidence before us we consider that they are unlikely to arise, or would be immaterial compared to the counterfactual:

    36.1 Health benefits in the form of avoided reduction in quality of healthcare services in the factual compared to the counterfactual are unlikely to arise from the Proposed Arrangements. We have come to this provisional view based on a range of factors, including the experience of other specialties within the APS, the incentives of SCHI, and the regulatory framework applying to healthcare providers. For example, to the extent there is any misalignment between the APS billing framework and best clinical practice, we consider this is likely to be resolved in a similar manner in both the factual and counterfactual. This, along with the continued engagement with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), is one of the factors that lead us to conclude that clinically appropriate procedures will not be excluded in the counterfactual;

    36.2 We do not consider it likely that the Proposed Arrangements will avoid a reduction in innovation compared to the counterfactual. This is for several reasons, including because innovation in gynaecology surgery is not driven exclusively by gynaecologists, and we consider that the Proposed

Arrangements may have limited impacts on gynaecologists' willingness to adopt new technologies; and

36.3 We have also considered whether materially increased gynaecology surgery fees in the factual would come at the expense of either private hospitals or anaesthetists. This could result in either or both of private hospitals and anaesthetists reducing their provision of services to gynaecology surgery. However, we do not think either of these is a likely outcome, including because we expect that the higher fees received by gynaecologists will largely be borne by SCHI and not other service providers under the APS.

37. Furthermore, we do not consider that the counterfactual would give rise to further differences in gender equity or reduced competition for surgeons. There is also insufficient evidence to indicate that within the counterfactual the transition to APS would place additional pressure on the public health system, or that through collective bargaining this pressure would be alleviated. In fact, it is possible that the allocative efficiency losses from collective bargaining outlined above place greater pressure on the public health system.

Our draft determination is to decline authorisation for the Proposed Arrangements

38. As noted above, we have necessarily undertaken a qualitative weighting of the relevant benefits and detriments. Our preliminary view of the evidence before us is that the magnitude of the detriments is likely to significantly outweigh the benefits in aggregate. We also consider that the evidence in support of the detriments is stronger and more comprehensive, and we place greater weight on them accordingly.

39. We have also declined the application for interim authorisation because we are not satisfied that the potential benefits of doing so would outweigh the detriments, there was no evidence of urgency, and there was no other compelling reason in the public interest to grant interim authorisation.

40. We now seek submissions on this Draft Determination, following the process set out below, to enable us to reach a final view.

Conditions

41. Where we are not satisfied that the public benefit test would be met, we can nevertheless grant authorisation subject to conditions. We will do this where we consider the conditions will enable the conduct to pass the public benefit test.

42. A number of parties submitted that the Commission should authorise the Proposed Arrangements subject to conditions. Proposed conditions include imposing reporting and information sharing and oversight obligations on the Applicant, limiting authorisation to only discussions on coding and the Standstill Agreement, and conditions that would protect the interests of anaesthetists.

43. None of the proposed conditions appear to materially reduce or eliminate the detriments we have identified, or increase or make more certain the benefits we

have identified. Accordingly, we do not preliminarily consider that the conditions proposed would address our concerns with the Proposed Arrangements such that the public benefit test could be met.

Introduction

44. On 19 May 2026, the Commission received an Application[25] from the NZGA seeking authorisation, on behalf of itself and its members, to:

    44.1 collectively bargain with Southern Cross Medical Care Society (trading as SCHI)[26], and/or hospital(s) for the provision of private gynaecology services[27] to SCHI-insured patients; and

    44.2 enter into a Standstill Agreement between NZGA members to defer contracting with SCHI for a period of 6 months.

45. NZGA applied for authorisation under sections 58(1), (2), (6B) and (6D) of the Act. NZGA is seeking authorisation for a period of 10 years.

46. The Proposed Arrangements are described in more detail below under the section ***Proposed Arrangements***.

47. In its Application, NZGA also requested interim authorisation of the Proposed Arrangements under section 65AAA of the Act. The Commission has published its decision on interim authorisation at the same time as this Draft Determination.[28] For the reasons set out in the Interim Determination and as set out below, the Commission has declined interim authorisation.

Draft Determination

48. The Commission's preliminary view is that it is not satisfied that the expected public benefits from the Proposed Arrangements would outweigh the detriments. Accordingly, we would decline authorisation, as discussed below.

Next steps

49. The Commission now seeks written submissions on the Draft Determination. Submissions should be received by the Commission by close of business on 7 October 2026. This will be followed by an opportunity to cross-submit. The process for making a submission is discussed at the end of this document.

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25 NZGA, "Notice by New Zealand Gynaecology Association Inc seeking authorisation under section 58(1), (2), (6B) and (6D) (and interim authorisation under section 65AAA)" (19 May 2026).

26 NZGA seeks to negotiate with Southern Cross Medical Care Society, all its interconnected bodies corporate and associated persons, and/or hospitals. Application at [2.4(e)].

27 Private gynaecology services for the purposes of the 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.

28 New Zealand Gynaecology Association – Interim Authorisation [2026] NZCC 39 (**Interim Determination**).

Assessment procedure

50. In making this Draft Determination the Commission reviewed submissions, correspondence, and other information, including:

    50.1 the Application;

    50.2 submissions, cross-submissions and expert reports, including those responding to our SOPI;

    50.3 interviews with interested parties; and

    50.4 responses to our voluntary requests for information.

51. The Commission remains open to receiving further information to assist it to make a final determination.

Background

Interested parties

*New Zealand Gynaecology Association (**NZGA**)*

52. NZGA is an industry representative organisation that represents and advocates for the interests of gynaecologists in New Zealand that was registered in 2026.[29] It was explicitly established to act as a "competition-compliant medium" for collective engagement, to allow balanced and informed discussion regarding a proposal by SCHI.[30] NZGA represents 128 of 141 (approximately 92%) private gynaecologists in New Zealand.[31]

53. NZGA's aim is to ensure gynaecology remains a sustainable specialty in New Zealand, to improve the health of women in New Zealand and to advocate for high quality, accessible and equitable gynaecological surgical services for all women.[32] NZGA intends to provide training, education, and conferences to its members.[33]

*Royal Australian and New Zealand College of Obstetricians and Gynaecologists (**RANZCOG**)*

54. RANZCOG is a trans-Tasman professional body that serves as the specialist medical college and training organisation for obstetricians and gynaecologists across Australia and New Zealand.[34] Alongside its advocacy for women's health and the obstetrics and gynaecology profession in New Zealand, RANZCOG supports the professional development of its members.[35] RANZCOG's main interests within New

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29 Interview with NZGA (13 July 2026).
30 Application at [4.3].
31 NZGA "NZGA Q&A" (14 July 2026) at [1], Application at [3.6].
32 NZGA "NZGA Q&A" (14 July 2026) at pages 1-2, NZGA constitution at [4.2].
33 Interview with NZGA (13 July 2026).
34 Interview with RANZCOG (30 June 2026).
35 Ibid.

Zealand are around the future of service provision for women in New Zealand and advocacy.[36]

55. RANZCOG's membership includes all gynaecologists and obstetricians, including those who solely work in the public sector. The specialists focusing on either gynaecology or obstetrics have differing levels of experience with insurers as private obstetrics is relatively small compared to private gynaecology.[37]

56. As a guiding principle, RANZCOG does not get heavily involved in the commercial aspects of its members' work.[38]

*Southern Cross Health Insurance (**SCHI**)*

57. Southern Cross Medical Care Society, trading as Southern Cross Health Insurance (**SCHI**), is the largest provider of health insurance in New Zealand.[39] SCHI operates as a friendly society such that, within its operational rules, it can appropriate its surpluses for the benefit of its members in a number of ways that include, but are not limited to, a reduction in premiums or increase in benefits.[40]

58. SCHI is a separate legal entity to Southern Cross Healthcare Limited (**SC Hospitals**). SC Hospitals is owned by Southern Cross Health Trust and provides hospital facilities throughout New Zealand.[41] This distinction, according to SCHI, means that the two bodies are separate independent entities that deal on an arm's length basis.[42]

59. In terms of coverage, SCHI provides health insurance to approximately 940,000 individuals, or 60% of New Zealanders with health insurance.[43] From a gross written premium perspective, SCHI has a 68% share of the New Zealand health insurance market.[44]

60. Despite SCHI having relatively low operational costs, it nevertheless incurred deficits in the past two financial years.[45] In financial year 2025, SCHI reported a deficit of $56.9 million, down from a $99.1 million deficit incurred in the year prior.[46]
[ ][47]
[ ][48]

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36 Ibid.
37 Ibid.
38 Ibid.
39 SCHI submission on SOPI (16 June 2026) at [2.3(a)].
40 Ibid at [2.2].
41 Ibid at footnote 74 to [6.2(i)].
42 Ibid at [2.3(a)].
43 Ibid.
44 Southern Cross Health Insurance "Why choose us?" https://www.southerncross.co.nz/society/buying-health-insurance/why-choose-us.
45 SCHI submission on SOPI (16 June 2026) at [1.3(b)].
46 Ibid at [1.3(b)].
47 Ibid at [2.4]. APS is described below under the section ***Under the Affiliated Provider Scheme (APS).***
48 Ibid.

Private hospitals

61. Private hospitals play a major role in the provision of healthcare in New Zealand. Currently, there are 77 private hospitals certified by the Ministry of Health.[49] The New Zealand Private Surgical Hospitals Association (**NZPSHA**) represents almost all private surgical hospitals in New Zealand, of which most offer gynaecological services.[50] The term "private hospital" reflects a wide range of operating models, from charities to for-profit entities.[51]

62. Private hospitals have traditionally provided facilities for non-urgent and non-life-threatening procedures which are generally referred to as elective surgery.[52] Their facilities include operating theatres, medical equipment, rooms, consumables, as well as related services such as nursing and administrative staff.[53]

63. While a wide range of surgeries are performed at private hospitals, some private hospitals consider gynaecology to be a core offering[54], with it being greater than [ ] of their revenues.[55] Across all NZPSHA members, gynaecology has represented approximately 6-7% of total discharges from 2021-2025.[56]

Anaesthetists

64. Anaesthetists are specialist doctors who have completed a minimum of five years of anaesthesia specialist training.[57] Anaesthetists are heavily involved in surgical treatment and provide expertise in perioperative care, from pre-operative assessment, to monitoring during surgery, to post-operative pain management.[58] They generally work in a mix of public and private settings and are involved in nearly every surgical procedure, and work across all surgical specialties.[59] Anaesthetists generally only have subspecialties when in major hospitals, nevertheless it is generally considered that all anaesthetists have the skillset to operate in gynaecology.[60] As gynaecology is a surgery-based speciality, most gynaecology procedures could not be done without an anaesthetist.[61]

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49 Ministry of Health "Private hospitals" (6 June 2024) at https://www.health.govt.nz/regulation-legislation/certification-of-health-care-services/certified-providers/private-hospitals

50 Interview with NZPSHA (29 June 2026), Email from NZPSHA to Commerce Commission (25 May 2026).

51 Interviews with Braemar Hospital (1 July 2026) and Allevia Hospitals (18 June 2026).

52 *Connor Healthcare Limited and Acurity Health Group Limited* [2014] NZCC at [40].

53 Interviews with Allevia Hospitals (18 June 2026), Crest Hospital (24 June 2026), Grace Hospital (30 June 2026).

54 Interview with Allevia Hospitals (18 June 2026).

55 Interviews with Boulcott Hospital (23 June 2026), Evolution Healthcare (16 June 2026).

56 Calculated from NZPSHA response to RFI dated 22 July 2026 (24 July 2026) "2025 Statistics".

57 New Zealand Society of Anaesthetists (**NZSA**) submission on SOPI (3 July 2026) at [11].

58 Ibid at [12].

59 Ibid at [13-14].

60 Interviews with NZSA (22 June 2026), [ ] (22 June 2026).

61 Interview with NZSA (22 June 2026).

65. Within the private health setting, anaesthetists generally acquire work through their relationships with surgeons. For example, they will work with a surgeon for that surgeon's entire operating list. Although they can switch surgeons, it does take time to develop those relationships.[62] Accordingly, patients do not choose anaesthetists but can provide feedback via surgeons.[63]

66. The New Zealand Society of Anaesthetists (**NZSA**) represents anaesthetists in New Zealand.[64] NZSA's key roles are advocacy, facilitating and promoting education, and strengthening networks of anaesthetists nationwide.[65] It represents around about 750 members, of whom 450 are full, fee-paying members.[66]

Current interactions in the market

Patient pathway

67. Generally, a patient will consult their General Practitioner (**GP**) before being referred to a surgeon for further consultation.[67] For insured patients, a referral from a GP is generally required by health insurers for reasons including identification of pre-existing conditions.[68, 69] Out-of-pocket or "self-funded" patients, on the other hand, do not necessarily require a GP's referral to see a specialist.[70] However, some surgeons may still require a GP referral before agreeing to see a patient.[71]

68. Patients typically follow their GP's recommendation when choosing a surgeon, although some may base their decision on referrals from friends, family or other trusted members in their personal network.[72, 73] Once a preferred surgeon has been identified, patients do not commonly switch between surgeons (unless, for example, they require a second opinion).[74]

69. As surgeons do not generally advertise their services, GPs determine which surgeon to refer a patient based on factors such as surgeon's expertise in the relevant medical condition, professional reputation, existing relationship with the GP, and geographic location.[75] Information about surgeons is often shared at gynaecology-

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62 Interview with [ ] (22 June 2026).
63 Ibid, Interview with NZSA (22 June 2026)
64 Interview with NZSA (22 June 2026), NZSA submission on SOPI (3 July 2026).
65 NZSA submission on SOPI (3 July 2026) at [8].
66 Interview with NZSA (22 June 2026).
67 Interviews with Allevia Hospitals (18 June 2026) and NZGA (13 July 2026).
68 Interview with NZGA (13 July 2026).
69 Interview with nib NZ (7 July 2026).
70 Interview with NZGA (13 July 2026).
71 Ibid.
72 Some patients may receive a "blank" referral from their GP, which lets them shop around to better identify a gynaecologist with a shorter waiting list. Despite this, patients do not shop around based on price. Interview with NZGA (13 July 2026).
73 Interview with Allevia Hospitals (18 June 2026).
74 Interviews with Allevia Hospitals (18 June 2026) and NZGA (13 July 2026).
75 Interviews with Allevia Hospitals (18 June 2026), [ ] (29 June 2026).

focused conferences and educational evenings for GPs, that are hosted by private hospitals, to increase awareness of facilities and clinicians practicing within them.[76,77]

70. In deciding where to refer patients, we understand that GPs neither have visibility of a surgeon's fees nor metrics on their patients' health outcomes.[78] When a gynaecologist receives a patient outside their scope of specialisation, they may pass the patient on to another colleague, who may be at the same practice.[79]

71. To work at a private hospital clinicians must undergo a credentialling process with that facility to verify their background, qualifications and skillset. Credentialled clinicians can make use of the facilities at a private hospital to complete their operating lists. The credentialing process is separate from determining the usage of the facilities. Once credentialled, surgeons are not guaranteed theatre time by the private hospital.[80] Equally, private hospitals are not guaranteed that a credentialled surgeon will perform surgeries using that hospital's facilities.[81]

72. In some cases, the hospital may still need to further attract the surgeon to complete their lists at the hospital. Where surgeons are credentialled to work at more than one facility, particularly in urban areas, the choice of facility where the procedure will be performed is principally the prerogative of the surgeon. The choice will typically be based on the appropriateness of the facility, considering the quality of facilities, the proximity of the hospital to the surgeon's clinic, and the patient's proximity to the hospital.[82, 83] In situations where the surgeon is credentialled to operate at only one facility, a patient would not have their choice of private hospital unless they are willing to switch surgeons.[84]

*Under Fee for Service (**FFS**)*

73. The default way surgeries are funded at private hospitals is on a FFS basis. This includes self-funded surgeries, surgeries funded by SCHI's competitors (eg, nib NZ, AIA, UniMed, Partner's Life etc),[85] and surgeries funded by SCHI that are not covered by its APS. Currently, [ ] of all SCHI funded surgeries are funded on a FFS basis, of

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76 Interview with NZGA (13 July 2026).

77 Interview with Boulcott Hospital (9 July 2026).

78 Interview with SCHI (18 June 2026).

79 Interview with [ ] (26 June 2026).

80 Interview with [ ] (29 June 2026).

81 Interview with Allevia Hospitals (18 June 2026).

82 Interviews with [ ] (29 June 2026), [ ] (29 July 2026), SC Hospitals (9 July 2026).

83 We note that being credentialled at a hospital does not guarantee a surgeon time in an operating theatre. Surgeons might be offered infrequent and/or short lists at a hospital they are newly credentialled at. As they build their practice (and demonstrate reliability in filling allocated capacity), hospitals will provide longer/reliable list space. Interview with Allevia Hospitals (18 June 2026).

84 Interview with [ ] (29 June 2026).

85 Interviews with nib NZ (7 July 2026), UniMed (28 July 2026).

which gynaecology is [ ].[86] Most gynaecology surgeries are currently funded on a FFS basis by SCHI.[87]

74. Under the FFS model, the patient has separate contracts and receives separate independent invoices from the surgeon, anaesthetist, and hospital.[88,89] Post-surgery, an insured patient receives these invoices and either passes them to the insurer for payment or pays them upfront and then passes them to the insurer for reimbursement.[90]

75. Anaesthetists generally determine their fees independently, often with reference to the NZSA-developed 'relative value guide',[91] but there are instances where the anaesthetist's fees are presented on the same invoice as a percentage of the surgeon's fee.[92] We understand that the surgical portion of gynaecology FFS fees vary substantially across different regions.[93]

76. Patients may seek pre-approval for surgery by their health insurer – this can give comfort and certainty that the procedure will be covered by insurance.[94] The actual procedures (and invoices) may differ from the pre-approved procedure because of unforeseen circumstances that arise during surgery, causing reassessment at the time.[95] Pre-approvals are issued in good faith based on the information provided.[96] One interviewee considered FFS to be a "paperwork nightmare".[97]

77. Under FFS, the insurer funds the cost of treatment, but it is not ordinarily a party to any contractual arrangements with the surgeon. To limit their exposure, insurers can set caps on the amount they will pay for a surgery.[98] For example, SCHI will pay up to 80% of a surgical procedure and up to $100,000 per operation, for members under its KiwiCare and RegularCare plans.[99] They may also offer lower premiums to customers that pay excesses.

78. Despite bearing most or all of the resulting financial cost, insurers have limited *ex ante* contractual mechanisms through which they can constrain the surgeon, hospital and anaesthetist fees before the treatment is provided if the patient is eligible for the services under their policy.[100] For insured patients under FFS, the risk of a

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86 Interview with SCHI (17 June 2026).

87 This excludes a small number of robotic surgeries, rooms-based procedures and 2 pilot programmes. Interview with SCHI (17 June 2026).

88 Interviews with [ ] (22 June 2026), NZSA (22 June 2026).

89 Interview with Crest Hospital (24 June 2026).

90 SCHI submission on SOPI (16 June 2026) at [9.6(q)].

91 Interview with [ ] (22 June 2026).

92 Interview with NZSA (22 June 2026).

93 Interview with nib NZ (7 July 2026).

94 *Connor Healthcare Limited and Acurity Health Group Limited- Determination* [2014] NZCC 39.

95 Interview with SCHI (18 June 2026); Interview with [ ] (29 June 2026).

96 Interview with nib NZ (7 July 2026).

97 Interview with Allevia Hospitals (18 July 2026).

98 Interview with nib NZ (7 July 2026).

99 SCHI "KiwiCare and RegularCare Policy document" (1 April 2026).

100 NERA "Assessment of claimed benefits of collective bargaining by gynaecologists: Report for Southern Cross Medical Care Society" (3 August 2026) at [66-67].

complication is entirely carried by the insurer as any cost overrun by any other party can be passed onto the insurer. While some insurers have reasonable charge requirements which can be implemented *ex post*, this is relatively burdensome to implement.

79. Self-funded patients will pay out of pocket, and insured patients may also be liable to pay excess, copay or other additional payments, subject to their insurance terms and conditions. Sometimes self-funded patients receive discounts on affordability grounds.[101]

*Under the Affiliated Provider Scheme (**APS**)*

80. SCHI's APS is a fixed-fee model that was launched in 1997 to support competitive bilateral negotiations with hospitals/facilities, provide price certainty, moderate healthcare cost inflation, and ensure affordable premiums and healthcare benefits for members.[102] SCHI has also raised that its APS addresses a moral hazard under FFS, noting there is no tension in fee for service to drive efficient prices. [103] In pursuit of these objectives, SCHI targets to achieve an agreed increase in fees for specialists and facilities in line with [ ].[104]

81. Under its APS, SCHI contracts with providers, typically hospitals, to become "Affiliated Providers" that hold and administer a "bundle of fees" for all the participants to a surgical procedure. Affiliated Providers then sub-contract with the surgeons and the anaesthetists and pay those parties out of the bundle of fees.[105]

82. SCHI's APS is similar to contracting arrangements by the Accident Compensation Corporation (**ACC**) and Health New Zealand Te Whatu Ora (**Health NZ**), which also operate bundled and fixed fee models for work outsourced to private hospitals.[106]

83. Over the years, the number of medical specialties under the APS has grown to cover more than 30 clinical specialties and 2,500 healthcare providers across New Zealand.[107] There has not been any previous authorisation applications by medical specialists in those other specialties.

84. More recently, SCHI is seeking to move gynaecology surgery from FFS to its APS.[108] SCHI's APS already applies to 2 robotic gynaecology procedures, room-based gynaecology procedures, and gynaecology consultations. We understand that SCHI is

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101 Interviews with [ ] (26 June 2026), [ ] (30 July 2026).

102 Interview with SCHI (17 June 2026).

103 Interview with SCHI (17 June 2026).

104 SCHI submission on SOPI (16 June 2026) at [1.3(c)]. In contrast, services funded under FFS are not subject to escalation constraints and have increased more sharply over time. For example, gynaecological surgeon fees have increased by more than [ ] cumulatively since 2013 compared to cumulative CPI growth of approximately 40% and cost increases of AP [ ] surgeries of approximately [ ] over the same period.

105 Interview with SCHI (17 June 2026).

106 Interviews with NZSA (22 June 2026), Health NZ (9 July 2026)

107 SCHI submission on SOPI (16 June 2026) at [1.3(c)], Interview with SCHI (17 June 2026).

108 Application at [2.3].

not targeting a fixed implementation date for its transition of gynaecology surgery and discarded its original indicative timeline of approximately seven months for the transition of gynaecological surgical services to its APS.[109]

85. Whether a facility is willing to sign the head contract will depend on the number of gynaecologists who are willing to become subcontractors under the APS and the volume of work they bring in.[110]

86. Hospitals undertake the administrative work associated with applying for funding from SCHI using their coding set, including amending any claims where necessary.[111] Hospitals can either choose a primary fixed procedure code that covers all applicable procedures included in the service description, or for secondary procedures[112] not covered under a primary fixed procedure code, they can choose either an applicable add-on code, another applicable separate procedure code or an open code.[113]

87. Under the APS, SCHI will only allow its members to seek treatment at an Affiliated Provider, unless they self-fund.[114] The exception to this requirement is SCHI members on the UltraCare plan (currently [ ] of members)[115] who are free to choose a provider of their choice, with SCHI funding their entire medical bill.[116]

88. SCHI believes its APS to be more efficient than FFS from a patient's viewpoint. The system is set up in such a way that the APS contract holder enters the member's insurance number and sees whether the patient requires prior approval for a procedure or is required to make a co-payment beforehand.[117] After the procedure, invoices are sent to SCHI by the APS contract holder and settled promptly with minimal paperwork on the part of the patient.[118]

89. SCHI negotiates the total bundled price with the hospital and does not specify how it should be split between specialists. That split is at the discretion of the hospital.[119] However, SCHI has provided an indicative breakdown of its bundled fee to hospitals to facilitate discussions between facilities and gynaecology surgeons. SCHI's indicative methodology is [ ] to the facility, [ ] to the surgeon, and [ ] to the anaesthetist.[120] Under the APS, the hospital, anaesthetist and surgeon are not permitted to charge patients additional fees for the procedure, except for permitted

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109 SCHI submission on SOPI (16 June 2026) at [6.7].
110 Interviews with Allevia Hospitals (18 June 2026), St George's Hospital (6 July 2026).
111 SCHI submission on SOPI (16 June 2026) at [4.14 (d (ii))].
112 A secondary procedure is an additional surgical or diagnostic service performed during the same operative session as the main (primary) procedure. SCHI submission on SOPI (16 June 2026) at footnote 98 to [6.9(e (iii))].
113 Interview with SCHI (18 June 2026).
114 Southern Cross Health Insurance Wellbeing One and Two – Policy document (1 April 2026) https://www.southerncross.co.nz/society/-/media/southern-cross-health-society/health-insurance/member-collateral/plan-documents/current-plan-documents/pd_wellbeing_plan.pdf.
115 Interview with SCHI (17 June 2026).
116 SCHI submission on SOPI (16 June 2026 at [7.4(b)].
117 Interview with [ ] (3 August 2026).
118 Interview with [ ] (3 August 2026).
119 Interview with SCHI (17 June 2026), SCHI submission on SOPI (16 June 2026) at[4.6].
120 Interview with [ ].

member contributions or items such as prescription charges and ambulance transfers.[121]

90. The APS also has the following mechanisms for additional funding:[122, 123]

90.1 risk corridors – mechanisms allowing for additional funding when theatre time exceeds agreed durations built into standard procedural codes;[124]

90.2 top up – mechanisms that allow for additional funding to be considered where case complexity falls outside the expected scope of what is already covered under the AP agreement. Top ups are reviewed by SCHI and considered on a case-by-case basis via an application;[125] and

90.3 add-on codes – a general set of codes providing access to additional funding for commonly performed additional procedures that are performed in the same surgical episode and are not included in the primary procedure.[126] Multiple primary procedures can be claimed together with additional add-on codes.

91. SCHI's AP code framework does not specify fixed prices for all procedures under each specialty. For those procedures that do not have an agreed fixed contracted price, "open codes" are the billing codes used.[127] The surgeon fee component of open code reimbursement is calculated on an agreed rate per minute basis.[128] Open codes are intended to prevent clinical decision-making being constrained by coding limitations – surgeons can perform whatever procedure is clinically appropriate, and if the procedure is covered by SCHI's policy terms and conditions, they can claim funding through the open code mechanism.[129]

92. It is not uncommon for a gynaecologist to find additional issues requiring secondary procedures while conducting a surgery (eg, endometriosis).[130] Where secondary procedures are not foreseeable, the surgeon decides whether to carry out the second procedure while the surgery is being carried out. Under the APS, the hospital, as lead contractor, bears the primary risk of non-payment if the patient is not eligible

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121 Interview with SCHI (18 June 2026).

122 SCHI submission on SOPI (16 June 2026) at [6.9 (e (iii))], SCHI supplemental submission (11 August 2026).

123 ACC and Health NZ also have mechanisms to address uncertainties arising in surgery. ACC has "non-core" prices that apply when there is no specific code that relates to a surgery or if there is a complex procedure. In that case, a series of factors would be used to build a price. Interview with Boulcott Hospital (23 June 2026). Health NZ also allows for post-operative adjustments for complex procedures, which are pre-determined and outlined in contracts. Interview with Health NZ (9 July 2026).

124 SCHI submission on SOPI (16 June 2026) at footnote 96 to 6.9(e (iii)), Interview with Crest Hospital (24 June 2026).

125 SCHI submission on SOPI (16 June 2026) at footnote 97 to [6.9(e (iii))].

126 SCHI supplemental submission (11 August 2026).

127 SCHI submission on SOPI (16 June 2026) at footnote 94 page 38. ACC also has open codes to allow for instances where a second procedure occurs in the same operation as the primary procedure.

128 Interviews with SCHI (18 June 2026) and [ ].

129 Interview with SCHI (17 June 2026).

130 Interviews with NZGA (13 July 2026), [ ] (29 June 2026), Application at [11.5(a)(i)].

for any part of the procedure including any secondary procedure.[131] How hospitals share, or pass on, that risk may vary according to arrangements in place with specialists at each hospital.

Proposed Arrangements

93. NZGA seeks authorisation to:[132]

93.1 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);

93.2 enter into a limited Standstill Agreement between the Participants to defer any contracting with SCHI for a period of 6 months;

93.3 engage in discussions and exchange information to the extent relevant and reasonably necessary for those collective negotiations;

93.4 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

93.5 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).

94. NZGA has requested authorisation for a period of 10 years to permit time to negotiate and give effect to new service contracts, as well as engage in a Standstill Agreement for a period of up to 6 months.[133] NZGA indicates it understands that SCHI may wish to renegotiate and change terms every 3 years.[134]

Content of the application

95. SCHI characterised the NZGA's application as seeking authorisation for separate forms of conduct (labelling these as collective bargaining and a collective boycott) and queried whether this could be sought under a single application.[135] The Commission does not consider there is any such limit on combining multiple, related elements of conduct into a single application. It is the applicant who chooses for what authorisation is sought.[136] Applications for authorisation frequently involve multiple arrangements, contracts, or types of conduct, which are assessed together.

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131 Interview with Mercy Hospital (25 June 2026).
132 Application at [6.2].
133 Application at [6.5-6.6].
134 Application at [6.6].
135 SCHI submission on SOPI (16 June 2026) at [1.3(h)].
136 *New Zealand Tegel Growers Association Incorporated* [2022] NZCC 30 at [55].

How we assess authorisations

Statutory framework

96. The Commission's power to authorise certain restrictive trade practices is set out in section 58 of the Act. Relevant to the Application, the Commission may authorise conduct potentially breaching section 27 (prohibition of contracts, arrangements or understandings that substantially lessen competition) or section 30 (prohibition of contracts, arrangements, understandings or covenants containing cartel provisions) of the Act.

97. The Commission undertakes a two-stage assessment when considering an authorisation application under section 58 of the Act.

    97.1 We first confirm whether the Commission has jurisdiction to assess the application, including whether:

        97.1.1 for applications pursuant to sections 58(1) and (2), the applicant considers that section 27 of the Act would apply, or might apply to the proposed arrangement(s); and

        97.1.2 for applications pursuant to sections 58(6B) and (6D), the proposed arrangement(s) contains a provision that is, or might be, a cartel provision.

    97.2 Second, we establish whether the public benefit test is satisfied under:

        97.2.1 section 61(6) of the Act (for applications under sections 58(1) and (2); and/or

        97.2.2 section 61(8) of the Act (for applications under sections 58(6B) and (6D).

98. The public benefit test is discussed in greater detail below under the section ***Public benefit test***.

Jurisdictional threshold

99. The Applicant has applied for authorisation under:[137]

    99.1 sections 58(1) and (2), which set out that a person who wishes to:

        99.1.1 enter into a contract, arrangement or understanding (section 58(1)); or

        99.1.2 give effect to a provision in a contract, arrangement or understanding (section 58(2)),

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[137] Application at [6.1].

to which that person considers section 27 would apply, or might apply, may apply to the Commission for an authorisation to do so; and

99.2 sections 58(6B) and (6D) which set out that a person who wishes to:

99.2.1 enter into a contract, arrangement or understanding that contains a provision that is, or might be, a cartel provision (section 58(6B)); or

99.2.2 give effect to a provision of a contract, arrangement, understanding or covenant that is, or might be, a cartel provision (section 58(6D)),

may apply to the Commission for an authorisation to do so.

100. The Commission has jurisdiction to assess applications under sections 58(1) and (2) only for arrangements to which the applicant considers section 27 of the Act would, or might, apply. In addition to this, the application must also meet the 'competition threshold', which requires us to consider whether the arrangement is likely to lessen competition.[138] The competition threshold arises from the wording in section 61(6) which requires a "…lessening in competition that would result, or would be likely to result…" from the arrangement.

101. For the purposes of applications under sections 58(6B) and (6D), the Commission has jurisdiction to grant authorisation if it has reasonable grounds to believe the arrangement might contain a cartel provision. However, it is not necessary for the Commission to determine whether a particular provision is in fact a cartel provision.[139]

Public benefit test

102. The Commission can authorise an arrangement if it is satisfied that a proposed arrangement will, in all the circumstances:

102.1 in relation to sections 58(1) and (2), be likely to result in a benefit to the public which would outweigh the lessening of competition;[140] and

102.2 in relation to sections 58(6B) and (6D), be likely to result in such a benefit to the public that the matter should be permitted.[141]

103. Despite differences in wording, the substantive public benefit test and assessment is materially the same for authorisations under sections 58(1), 58(2), 58(6B) and 58(6D) of the Act.[142]

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138 The lessening in competition need not be substantial: s 61(6A) of the Act.

139 Section 61(9) of the Act.

140 Section 61(6) of the Act.

141 Section 61(8) of the Act.

142 See *Air New Zealand and Qantas Airways Limited v Commerce Commission* (2004) 11 TCLR 347 (HC) at [33] and also *Godfrey Hirst NZ Ltd v Commerce Commission* (2011) 9 NZBLC 103,396 (HC) (Godfrey Hirst (No 1)) at [88]-[90].

104. Courts have taken a consistent approach to the assessment of public benefits in authorisation decisions and have applied a fact-based assessment of the benefits and detriments, adopting a quantitative approach where possible.[143] Courts have also permitted the use of a qualitative assessment of all the benefits and detriments from a proposed arrangement, including those that cannot be quantified in monetary terms.[144]

105. In each case, the Commission needs to investigate and assess the nature, likelihood, and magnitude of any benefits and detriments that might arise from the proposed arrangements.

106. The benefits and detriments balanced in the public benefit test must arise from the proposed arrangements for which authorisation is sought.[145] To determine whether the benefits and detriments are specific to the proposed arrangements, we assess:

    106.1 what is likely to occur in the future with the arrangement (the factual); and

    106.2 what is likely to occur in the future without the arrangement (the counterfactual).

107. Once we have identified likely benefits and detriments, we then assess their relative value. When making that assessment, factors we may consider include how the conduct could affect:

    107.1 allocative efficiency – whether the conduct would raise or lower margins, and whether it would reduce or improve quality, choice or other elements of value to consumers;

    107.2 productive efficiency – whether the conduct would improve or worsen the cost of production processes; and

    107.3 dynamic efficiency – whether the conduct would assist or hinder efficient innovation in products or processes.

108. The Courts have recognised that efficiencies are not the only benefits and detriments relevant to the Commission's assessment.[146] As such, the Commission is not limited to considering only these efficiencies. Rather, the Commission assesses what benefits accrue to the public in the circumstances of any given case.[147]

109. If we are satisfied that the benefits of a proposed arrangement likely outweigh the detriments, we will grant authorisation. If we are not satisfied of this, we will not grant authorisation.[148]

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143 Authorisation Guidelines at [51].
144 Authorisation Guidelines at [7].
145 Authorisation Guidelines at [43].
146 *NZME Ltd v Commerce Commission* [2018] NZCA 389 at [80]-[81].
147 Authorisation Guidelines at [42].
148 Authorisation Guidelines at [49].

Conditions and time period of authorisation

110. We can authorise agreements subject to conditions and for a period we consider appropriate.[149]

111. If we decide to impose conditions on an authorisation, they must be consistent with the Act.[150] We may include conditions that remove or lessen the detriments arising from an agreement or unilateral conduct, or conditions that create or enhance the benefits.[151]

112. When considering whether to impose behavioural conditions, we are mindful they can carry costs. In assessing potential behavioural conditions, we have regard to:[152]

    112.1 how well they achieve their objectives, while minimising the risk of unintended negative consequences;

    112.2 the likely cost of monitoring and enforcement; and

    112.3 the likely compliance costs for the firms involved.

Relevant markets

113. The term "market" refers to a market in New Zealand for goods or services as well as other goods or services that, as a matter of fact and commercial common sense, are substitutable for them.[153]

114. The Applicant submitted that the relevant markets impacted under the Proposed Arrangements include (at least):[154]

    114.1 a national market for the provision of health insurance in New Zealand;

    114.2 regional markets for the provision of hospital facilities to private gynaecologists. Within these regional markets, there would likely be separate markets for the provision of day-stay and in-patient hospital facilities to private gynaecologists; and

    114.3 local markets for the provision of private gynaecology services. Under which or separately, there are likely to be labour (sub) markets for the supply of gynaecologist services.

115. The Applicant also considers there is likely to be a range of potentially impacted markets the Commission may wish to consider:[155]

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149 Section 61(2) of the Act.
150 Ibid.
151 Authorisation Guidelines at [32].
152 Ibid at [34].
153 Commerce Act 1986, s 3(1A).
154 Application at [7.1].
155 Application at [7.3].

115.1 markets for the provision of private anaesthetist services for private gynaecology procedures; and

115.2 national and regional public sector markets for the provision of gynaecology services.

116. Furthermore, the Applicant submitted that the "Proposed Arrangements would not have, nor be likely to have, the purpose, effect or likely effect of *substantially* lessening competition in any relevant market (possibly the reverse)…."[156]

117. We have received mixed submissions on the proposed markets. These include broader markets for privately funded healthcare services, encompassing insurer-funded and self-funded services,[157] and broader markets for specialist or private specialist healthcare services.[158] Other submissions suggest narrower markets focusing on those services for which gynaecologists will be remunerated under the contractual framework with SCHI.[159] Submissions have also identified that anaesthetist services used in private gynaecology procedures as an adjacent area that may be affected by the Proposed Arrangements.[160]

118. When considering an authorisation application, the Commission assesses the competitive effects of proposed arrangements in relevant markets in New Zealand. We define markets in the way that best isolates the key competition issues arising from the proposed arrangements.

119. We have not undertaken a detailed market definition assessment in this case, which, following our usual approach, would involve us applying the hypothetical monopolist (or 'SSNIP') test.[161] However, we do consider that there are several interconnected markets, identified by the Applicant and other parties, that may be potentially impacted by the proposed arrangements. As indicated by the Applicant and other parties, the boundaries of these markets may depend on the surgical speciality, funder of the surgery, type of hospital, and location.

120. For the purpose of assessing the Proposed Arrangements, we do not consider it necessary to conclude on the exact boundaries of the relevant market(s) because we ultimately do not consider that it would change our assessment of whether the benefits of the Proposed Arrangement are likely to outweigh the detriments. Without precisely defining markets, we consider the effect of the Proposed Arrangements on private gynaecologists, SCHI and its members, other insurers and self-funded patients, anaesthetists, private hospitals, and the public healthcare system.

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156 Ibid at [2.23].

157 nib NZ submission on SOPI (19 June 2026) at [12].

158 ACC submission on SOPI (1 July 2026), ONZ submission on SOPI (12 June 2026), Intus submission on SOPI (16 June 2026).

159 SC Hospitals submission on SOPI (23 June 2026) at Appendix A.

160 Dr David Pirotta submission on SOPI (4 June 2026) at [5].

161 As set out in more detail in Commerce Commission, *Mergers and Acquisitions Guidelines* (May 2022) at [3.15-3.24].

Our assessment of jurisdiction

Sections 58(1) and (2) and the section 61(1) competition threshold

121. We consider we have jurisdiction to assess the Application under sections 58(1) and (2) of the Act. NZGA acknowledges section 27 of the Act might apply to the Proposed Arrangements.[162]

122. In addition, we consider that there is at least a real chance that the Proposed Arrangements would lessen competition between NZGA members. In particular:

    122.1 absent the Proposed Arrangements, some NZGA members would likely individually negotiate with hospitals (or SCHI) regarding the terms on which they provide private gynaecological services. Those negotiations could result in differences in price and non-price terms between individual gynaecologists who would otherwise compete (absent the Proposed Arrangements);[163] and

    122.2 in contrast, the Proposed Arrangements envisage coordination between NZGA members, including individual competing gynaecologists, in relation to those terms and collective negotiation with hospitals (or SCHI).

Sections 58(6B) and (6D)

123. We also consider that we have jurisdiction to assess the Application under sections 58(6B) and (6D) of the Act. In our view, the Proposed Arrangements may contain at least one provision that is, or might be, a cartel provision. In particular, the Proposed Arrangements may contain provisions that have the purpose, effect, or likely effect of:

    123.1 fixing, controlling or maintaining the prices at which NZGA members supply private gynaecological services funded by SCHI; and/or

    123.2 co-ordinating whether and if so, on what terms, NZGA members will contract with hospitals (or SCHI).

124. The Application also seeks authorisation for a Standstill Agreement under which NZGA members would refrain from entering individual contractual arrangements while collective negotiations are occurring. We consider that there is at least a real chance that such an arrangement could constitute, or form part of, a cartel provision.[164]

125. Given that the Proposed Arrangements involve collective negotiations beyond price, we do not consider it necessary for the purposes of jurisdiction to reach a view on whether conduct may be exempt under section 33 of the Act.

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162 Application at [8.2].

163 SCHI has submitted that pricing forms part of individual negotiations between a hospital and a surgeon, and each hospital could agree different prices with different gynaecology surgeons: SCHI submission on SOPI (16 June 2026) at [6.9(a)].

164 For example, an output restriction under section 30A(3)(c) of the Act.

Arguments raised by SCHI on Application and Jurisdiction

126. SCHI has not challenged the Commission's jurisdiction to consider the Application. SCHI submitted that the Proposed Arrangements would remove competitive constraints between NZGA members by allowing them to coordinate on price and engage in a collective boycott.[165] However, SCHI considers authorisation is not necessary for consultation between SCHI and gynaecologists on clinical matters.[166]

With and without the Proposed Arrangements

127. As noted above, to determine whether the benefits and detriments identified by an applicant are specific to the proposed arrangement(s), we assess:

    127.1 what is likely to occur in the future with the proposed arrangement(s) (the factual); and

    127.2 what is likely to occur in the future without the proposed arrangement(s) (the counterfactual).

128. This analysis also allows us to determine both the existence and magnitude of potential benefits and detriments so we can assess whether there are public benefits.

129. We have considered all submissions and evidence we have received to date on what is likely to occur in the future with (factual) and without (counterfactual) the Proposed Arrangements.

130. In this context the Commission is necessarily engaging in a future-focussed assessment. As such, there is scope for a range of potential factual and counterfactual scenarios.

131. The Commission must consider all "likely" factual and counterfactual scenarios to identify all likely benefits and detriments relevant to its authorisation assessment.[167]

132. For the "likely" threshold to be met, Courts have held that there must be a real and substantial chance of the factual or counterfactual arising.[168] It must be more than a mere possibility but it need not be more likely than not.[169] The Courts have observed that, inherently, the factual and counterfactual are "necessarily incapable of accurate assessment".[170] As such, there is no legal burden or evidential standard of proof for the Commission to be satisfied that the factual or counterfactual scenarios

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165 SCHI submission on SOPI (16 June 2026) at [1.3(e)].

166 Ibid at [1.3(i (i))].

167 Authorisation Guidelines at [44 and 45].

168 *NZME Ltd v Commerce Commission* at [86(a)], citing *Port Nelson v Commerce Commission* [1996] 3 NZLR 554 (CA) at [562-563].

169 Ibid.

170 *NZME Ltd v Commerce Commission* at [85], citing *Woolworths Ltd v Commerce Commission* (2008) 8 NZBLC 102,128 at [113].

and the benefits and detriments arising from them are likely.[171] For the Commission to be satisfied, it simply needs to have made up its mind on all of the material before it.[172]

133. Benefits and detriments must be specific to the authorisation sought. If there are outcomes that would occur in a roughly equivalent manner both with and without authorisation, such that the difference would be immaterial, they are not relevant to our assessment.

The situation without the Proposed Arrangements (counterfactual)

134. The counterfactual in the assessment of an authorisation application is the future without the conduct for which authorisation is sought. Here, that involves SCHI seeking to apply its APS to all gynaecological surgery without the NZGA being authorised to collectively bargain or to enter into a Standstill Agreement.

Applicant's view

135. The Application states that, in the absence of the Proposed Arrangements, outcomes would largely be determined by SCHI,[173] and identifies SCHI's proposed roll out of its APS to gynaecology surgery as the likely counterfactual.[174] NZGA also submitted that SCHI has to date refused to meaningfully engage or negotiate with clinicians, RANZCOG or NZGA.[175] By implication, NZGA does not expect SCHI to do so in the counterfactual either.

136. The Applicant acknowledges SCHI's APS may bring benefits to SCHI's members, such as an efficient claims process and price certainty.[176] However, the Applicant raises a number of concerns with SCHI's APS proposal, including that gynaecology surgery would be under-remunerated, that gynaecologists would unfairly bear risk under non-transparent contract terms, that the proposal would result in poor health outcomes for affected patients, and poor outcomes for the New Zealand health system generally. These issues are addressed in more detail below in ***Our assessment of benefits and detriments***.

137. The Application identified three other possible counterfactuals:[177]

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171 *NZME Ltd v Commerce Commission* at [86(c)], citing *Z v Dental Complaints Assessment Committee* [2008] NZSC 55 at [96] per Elias CJ and [96] per Blanchard, Tipping and McGrath JJ.

172 *NZME Ltd v Commerce Commission* at [86](c)], citing *Z v Dental Complaints Assessment Committee* [2008] NZSC 55 at [26] per Elias CJ and [96] per Blanchard, Tipping and McGrath JJ.

173 Application at [10.1].

174 Ibid at [10.2].

175 NZGA "NZGA Q&A" (14 July 2026) at paragraph 51. NZGA submitted that SCHI would not engage with clinicians or NZGA representatives, with SCHI citing Commerce Act concerns. NZGA also stated that RANZCOG was largely disregarded.

176 Application at [2.17].

177 Ibid at Table 2.

137.1 SCHI implements the APS incrementally, with partial or staged implementation. Some gynaecologists sign up to the APS while others remain compensated on a FFS basis;

137.2 continuation of the status quo whereby gynaecological surgeries are compensated on a FFS basis; and

137.3 SCHI caps the cover for gynaecology surgery available under its policies but clinicians remain free to price independently.

Interested parties' views

138. SCHI opposes the application for authorisation.[178] We understand that, absent authorisation, SCHI intends to continue with its proposed application of APS to the entirety of gynaecological surgery.

139. SCHI has identified a range of benefits of its APS,[179] including for:

139.1 SCHI itself: addressing healthcare cost escalation (saving approximately [ ] a year compared to the status quo), [180] administrative efficiencies, driving innovation, and collecting better data;

139.2 SCHI members: mitigating premium increases, supporting accessibility of insurance, driving innovation, an easier claims process, and greater certainty of costs (for members on copay plans);

139.3 AP providers (eg, hospitals): certainty of prices, improved cash flows, administrative efficiencies, dedicated support at SCHI and promotion by SCHI; and

139.4 Listed providers (eg, surgeons): improved cash flows, administrative efficiencies, and certainty of prices.

140. SCHI further submitted that, as seen in other specialties, its APS will not result in a standardised or single fixed surgical fee across the country, and that the APS contractual framework allows for hospitals to negotiate fees with individual surgeons.[181]

141. The estimated savings that SCHI looks to achieve in the counterfactual by implementing APS for gynaecology are [ ]. SCHI expects hospitals and anaesthetists to receive [

178 SCHI submission on SOPI (16 June 2026) at [1.1].
179 Ibid at [4.14].
180 Ibid at [5.3(a)].
181 SCHI submission on SOPI (16 June 2026) at [6.9(a)].

][182]

Our assessment

142. Our preliminary view is that the only likely counterfactual is one in which, in the absence of collective negotiation, SCHI proceeds with the planned expansion of its APS to all gynaecology surgery.

143. In the counterfactual, we expect that gynaecologists would agree individually with hospitals regarding the fixed fees they would receive from a hospital for SCHI-funded surgeries. Concurrently, hospitals would each negotiate with SCHI on the bundled price of gynaecology surgeries at their facilities, taking account of gynaecologists' fee expectations as a key input to the bundled price. This matches the approach taken in other specialities that have procedures under APS.

144. Gynaecologists with fee expectations that are at least somewhat aligned with SCHI's offers under APS may be more likely to sign up (we have heard from several such gynaecologists to date). SCHI has submitted that its proposed pricing [ ] is based on the [ ],[183] suggesting that some gynaecologists will be financially better off under SCHI's current APS proposal. SCHI's modelling suggests that its proposed APS pricing will result in it paying *more* in total gynaecology surgeon fees in [ ] out of 15 identified regions in New Zealand, and making only relatively small savings in a further [ ] regions.[184] In the [ ] regions where SCHI has modelled it will make its biggest savings, [ ] of surgeons within those regions will on average be financially better off or unaffected under its proposed APS pricing than under the status quo.[185]

145. Currently, there are 2 providers that have implemented the APS for gynaecological surgical services (Mercy Hospital Dunedin and a single surgeon in Wellington who

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182 SCHI response to RFI dated 1 July 2026 (3 August 2026) at [1.2] and [1.4].

183 Ibid at [1.1].

184 Ibid.

185 Ibid at [10.1]. As discussed below at paragraph 178, SCHI has provided a high-level indication of the fees that it is targeting in each region of New Zealand. The fee target is expressed in relation to where SCHI expects it to sit compared to the current fees charged by gynaecologists under FFS. For most regions, the estimated fee is at the [ ] of fees charged under FFS in that region. That is, if you line up all the fees charged under FFS, SCHI is expected to pay the [ ] fee. In [ ]. What this means is that compared to the fees charged under FFS, [ ] of gynaecologists will be better off as their fee moves up to the [ ] and [ ] of gynaecologists will be worse off as their fee decreases down to the [ ]. This is a high-level expectation, and the 'actual' fees proposed will not match this exactly as there will likely be some unders and overs.

holds the head AP contract with SCHI),[186] and 8 private hospitals that have implemented the APS for robotic gynaecological surgical services.[187] SCHI indicated that it may be close to reaching an AP agreement for gynaecological services for [ ].[188] However, although negotiations have continued between SCHI and hospitals, they have been unable to be finalised while this authorisation application process has been underway, as they need gynaecologists to agree.[189]

146. Hospitals interviewed that were further away from reaching a negotiated outcome with SCHI suggested that the reluctance was due to SCHI offering fees that were below hospitals' expectations and also the expectations of their clinicians.[190] Where AP negotiations for gynaecology surgical services are currently at an impasse because gynaecologists consider fees to be too low, SCHI has the option of raising the prices it offers until it obtains sufficient expert and geographic coverage of services for its members.

147. As a member-focused friendly society, SCHI is incentivised to agree terms that attract broad gynaecology surgeon participation to cover each region in New Zealand.[191] Therefore, SCHI may not have the option of simply "walking away" if it considers surgeon fees to be too high.[192] In previous AP transitions (eg, for ophthalmology), we understand SCHI eventually raised the bundled prices it was willing to offer to a level acceptable to hospitals and clinicians when they received feedback that the prices were unacceptably low for clinicians.[193] However, we also note that it may not be necessary for all gynaecologists to accept APS for SCHI to implement it.[194]

148. Once a hospital is comfortable that the bundled fees being offered by SCHI are sufficient to attract a critical mass of gynaecologists it will sign up as an APS lead contractor for gynaecology surgery. We expect that SCHI will be able to secure sufficient APS lead contractors to provide all its members access to gynaecology surgical benefits under the APS. Key features of the APS in the counterfactual include:

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186 SCHI submission on SOPI, (17 June 2026) at Appendix 1, item 3 (Confidential version). Although there is a single surgeon holding an APS head contract in Wellington, we note that this appears to be a fairly unusual arrangement, and is not how SCHI typically structures its APS contracts for surgery or intends to expand its APS to gynaecology surgery.

187 Interview with SCHI (18 June 2026).

188 SCHI submission on SOPI (16 June 2026) at footnote 74 to [6.2(i)].

189 Interviews with Allevia Hospitals (18 June 2026), Boulcott Hospital (23 June 2026), SCHI (18 June 2026).

190 Interview with [ ].

191 SCHI submission on SOPI, (17 June 2026) at [7.6(b)].

192 SCHI cross-submission on SOPI (3 August 2026) at [3.20(c)].

193 Interview with Crest Hospital (24 June 2026). Ophthalmologists in the Manawatu refused to do cataract surgery because the prices offered through the APS were too low. Eventually, SCHI raised the prices it was willing to offer and ophthalmologists resumed offering cataract surgery services to SCHI patients.

194 Interview with SCHI (17 June 2026). While SCHI want more coverage for its members, it submitted that not all surgeons may be willing to accept what SCHI considers a 'fair market price', and they have every right to do so.

148.1 hospitals/facilities would be lead contractors, and receive a single, bundled fee for each agreed type of surgery, out of which they would pay surgeons and anaesthetists as subcontractors;[195]

148.2 there will likely be some variation in the bundled fee paid to different hospital/facilities as the bundle that a hospital receives is the result of negotiations. Some of the difference in the bundled fee between hospitals may be because of market conditions in different regions.[196] However, SCHI would seek to minimise variability, likely in-line with current fee variation of [ ] for other types of surgery;[197] and

148.3 non-price terms of the contractual arrangements would largely remain as is, and concerns raised by the NZGA would likely not be addressed. These include concerns regarding uncertainty of risk sharing amongst facilities, surgeons, and anaesthetists[198] and what has been characterised as potentially unfair contract terms placed on surgeons.[199]

149. We do not consider there are any other likely counterfactuals, including those identified by the Applicant as potential counterfactuals. This is because of SCHI's strong preference for implementing its APS, the Applicant's acceptance of it, and because the other potential counterfactuals identified in the application would erode the benefits to SCHI and its members identified above. In addition:

149.1 retaining FFS charging, even in part, would likely undermine SCHI's ability to move any gynaecologists under the APS;

149.2 [ ].[200] Although capped policies help the insurer to manage its insurance risk so it has a known maximum sum it would pay in respect to a particular claim, it does not help the member or customer to manage his or her risk, nor incentivise the specialist to meet the insurer's price. Likewise, co-payments prevent members from over-claiming healthcare but still does not cause specialists to compete on (or moderate their) price. As a member-owned organisation, SCHI would likely want to provide certainty for its members about what they have to pay and what they are covered for – particularly under its flagship

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195 Interview with SCHI (18 June 2026). Other surgery types may be charged using open codes.

196 The bundled fees paid to hospitals will differ, with ranges across the country. There are a number of factors including different staffing costs, transport and freight costs, and how efficient their surgeons might be. Interview with SCHI (18 June 2026).

197 Interview with SCHI (17 June 2026).

198 The primary risk of concern is the inability to be compensated adequately for unexpected complications or procedures that must be completed during a planned surgery. Interview with NZGA (13 July 2026).

199 Interview with NZGA (13 July 2026).

200 Interview with SCHI (17 June 2026). Capped policies provide a monetary limit on the maximum amount an insurer will pay out. Co-pay policies require insured patients to pay either a flat out-of-pocket fee or percentage of the overall cost. Under both capped policies and co-pay policies, the insured patient would be required to self-fund any additional costs charged by the surgeon.

policies Wellbeing One and Wellbeing Two, which cover the entire cost of a surgery.[201]

150. Taking into account all of the above, we consider that implementation of SCHI's APS to gynaecology surgeries – but without the Proposed Arrangements involving gynaecologists – to be the only likely counterfactual.

151. The benefits and detriments identified by the Applicant and SCHI are discussed in detail as part of our assessment of benefits and detriments.

The situation with the Proposed Arrangements (factual)

152. The factual in the assessment of an authorisation application is a future which includes the conduct for which authorisation is sought. In this case, that involves Participants collectively negotiating with SCHI and/or hospitals regarding the provision of private gynaecological services to SCHI-insured patients and entering into a 6-month Standstill Agreement to defer any contracting with SCHI and/or hospitals (ie, the Proposed Arrangements).

Applicant's view

153. NZGA submitted that in the factual:[202]

153.1 NZGA officers would lead structured collective engagement, involving consulting members whose participation is voluntary;

153.2 negotiated coding would be aligned with clinical practice (including combining procedures where clinically appropriate) and aligned with RANZCOG recommendations;

153.3 NZGA and SCHI would negotiate objective criteria and workable processes for additional funding where the complexity exceeds assumptions;

153.4 either the FFS model would be maintained or SCHI and NZGA would negotiate common pricing subject to CPI and medical inflation adjustments;

153.5 there would be a greater likelihood of single clinically appropriate operative episode and predictable pathways; and

153.6 private gynaecology services would be more sustainable and accessible, with mitigated spillovers.

154. NZGA also submitted that "*SCHI could reject what it considers are uneconomic proposals and ultimately walk away (at the end of the standstill). SCHI continues to enjoy the discretion to do as it chooses and authorisation would not compel any outcome*."[203]

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201 Wellbeing One and Two policy documents. Subject to any excess agreed by the policy holder.

202 Application at Table 1.

203 NZGA cross-submission on SOPI (4 August 2026) at [7].

Interested parties' views

155. SCHI submitted:

155.1 SCHI has invested significant time and effort to date in transitioning gynaecological surgeries to its AP programme, and sees its APS as the best solution to moderating rapidly increasing gynaecologist fees.[204]
[ ].[205]

155.2 The transition of gynaecology surgeries to APS has been delayed due to [ ],[206] (which are likely to be addressed by conclusion of the authorisation application
[ ])
[ ].[207]

155.3 Because SCHI is contractually bound to its members to fund eligible gynaecology surgical treatment, SCHI may not have the option of simply "walking away" if it considers surgeons' prices to be too high.[208] SCHI is obliged to achieve adequate provider coverage for its members.

156. We have heard from several stakeholders that APS-type arrangements in private healthcare (ie, bundled, fixed price surgeries) are well accepted in New Zealand and overseas, and are expected to become even more prevalent in the future.[209]

Our assessment

157. What the Commission considers is likely to occur in any factual(s) is dependent upon the facts before it. For a collective bargaining authorisation application, this includes amongst other factors an assessment of how the change in relative bargaining power would impact negotiations, and each party's intentions.

158. Based on our discussions with SCHI, further refinements provided by the NZGA and information from other stakeholders, we consider that there is one likely factual scenario. In this factual scenario, SCHI will bring gynaecological surgery under its APS and NZGA will be able to negotiate higher fees for its members relative to the counterfactual.

<u>We think it is likely that SCHI will bring gynaecological surgery into its APS in the factual</u>

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204 Interview with SCHI (17 June 2026); SCHI submission on SOPI (16 June 2026) at [1.3 (c)].

205 Interviews with SCHI (17 June 2026) and (18 June 2026).
[ ]

206 SCHI submission on SOPI (16 June 2026) at [6.5(a)].

207 Ibid at [6.2(i)].

208 SCHI cross-submission on SOPI (3 August 2026) at [3.20(c)].

209 Forté Health submission on SOPI (9 June 2026), SCHI submission on SOPI (16 June 2026) and Interview with [ ] (14 July 2026).

159. SCHI submitted that the APS is its best and primary solution for driving down its claims costs and has already invested time and resource to transitioning gynaecological surgeries to the APS.[210]

160. Despite the wide range of topics NZGA has signalled it would like to collectively bargain with SCHI in its application (including whether SCHI applies APS to gynaecology at all), NZGA submitted it is not against an APS, and is in fact willing to proceed with an APS if the Proposed Arrangements are authorised.[211]

161. Accordingly, we consider that, SCHI will likely bring gynaecology surgery under the APS, if the Proposed Arrangements are authorised.

<u>We think it is unlikely that SCHI will materially alter the APS contractual framework in the factual</u>

162. Although we consider it likely that SCHI will bring gynaecology surgery under the APS, the application and other submissions raise the possibility of variations within the APS contractual framework. These include, for example, gynaecologists becoming the lead contractor (in lieu of hospital/facilities) and hospitals remaining lead contractors but NZGA negotiating the gynaecology surgery portion of the bundled fee directly with SCHI.

163. We do not think SCHI will agree to materially alter the APS contractual framework in the factual, including because SCHI is unlikely to directly negotiate with NZGA on price.

164. NZGA has stated an intention to directly negotiate with SCHI. However, [ ] also stated:[212]

> we would not be at any point looking to negotiate price with NZGA because that wouldn't be our place, we don't interfere with the relationship between the provider hospital and the specialist the best place to understand what is required for a particular surgery to take place in an appropriate environment to give appropriate care for the member or customer, so we would continue to look to negotiate with the providers and hospitals. We would be very happy to continue to provide information to the gynaecologists (or to the association and the gynaecologists) to the extent that they would want it just as we have to date being really transparent about what we're envisaging in terms of the transition, what they could expect in that way and keeping that open door and having those conversations there.

165. SCHI's APS allows SCHI to limit negotiations to individual private hospitals (or hospital groups), who in turn negotiate with surgeons and anaesthetists who are active in each hospitals' region. SCHI does not generally directly negotiate with surgeons or anaesthetists.

166. If authorisation were granted, we expect SCHI would continue to resist direct discussions with NZGA on matters that would undermine the benefits of the APS

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210 SCHI submission on SOPI (16 June 2026) at [9.6(q)].

211 Addendum to NZGA's supplemental submission (9 June 2026) at [3].

212 Interview with SCHI (17 June 2026).

structure, for the reasons stated above as well as the precedent effect it may have. SCHI currently funds procedures across more than 30 clinical specialties through its APS, which we understand are typically renegotiated every two to three years.[213, 214] SCHI has also stated it intends to expand its APS to other healthcare services it purchases.[215]

167. Regarding gynaecologists "holding the contract", we have heard that this contracting model may not be widely applicable, as gynaecologists may not be willing to carry the risks of being the contract holder.[216] Nor do gynaecologists/NZGA presently have the same internal infrastructure to support administration of this nature as some hospitals do (eg, in-house legal counsel, finance staff, administrative team, computer systems). Hospitals also bear significantly larger costs than surgeons and anaesthetists,[217] and are better equipped to know when it can receive more or less across any particular procedure (for example if they cross-subsidise procedures), which makes hospital facilities better candidates for administrators of the APS. Moreover, NZGA expressly disregarded the possibility of NZGA or gynaecologists "holding the contract" because they are disinterested in managing what hospitals/anaesthetists receive from SCHI, only in what they themselves receive.[218]

<u>The rollout of APS to gynaecological surgery will likely be delayed in the factual</u>

168. NZGA has requested authorisation for a 'Standstill Agreement between the Participants to defer any contracting with SCHI for a period of 6 months'.[219] Under the Standstill Agreement, NZGA's members would agree with one another to decline to sign up to the APS for 6 months (the **standstill period**) in order to retain the status quo (ie, FFS) while NZGA seeks to collectively bargain with SCHI. The NZGA considers a Standstill Agreement would encourage meaningful engagement by SCHI in collective negotiations.[220]

169. The NZGA considers in its application that a Standstill Agreement would not materially alter its bargaining power.[221] Participation by NZGA members is voluntary and participants may opt out of the Proposed Arrangements at any time following notice under the Standstill Agreement (after a 3 month notice period).[222] NZGA states its members would continue to provide services to SCHI members on a FFS basis (ie, the status quo) for the standstill period.[223]

170. We consider that, if authorised, the NZGA is likely to invoke its right to impose a Standstill Agreement on its members, which covers over 90% of privately practicing

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213 SCHI submission on SOPI (16 June 2026) at [4.10].
214 Ibid at [4.8].
215 Ibid at [2.4].
216 Interview with [ ]
217 Interview with SCHI (18 June 2026).
218 Interview with NZGA (13 July 2026).
219 Application at [2.3].
220 Ibid at [2.12].
221 Ibid at [6.11].
222 Ibid at [6.3(b)] and Appendix 5 – Example Standstill Deed.
223 Application at [11.27].

gynaecologists,[224]and that this would likely have the effect of delaying implementation of SCHI's APS for at least the standstill period.

171. We understand that, in most circumstances, the majority of gynaecologists are likely to receive a lower fee per procedure under SCHI's proposed APS without the Proposed Arrangements than they do currently on a FFS basis.[225] Accordingly, we expect the majority of gynaecologists will be financially better off by maintaining FFS for as long as possible, and hence incentivised, to delay the implementation of APS to gynaecology for at least the standstill period.

<u>We expect that any negotiation on fees will largely impact SCHI and gynaecologists</u>

172. Under the APS contractual framework there are four types of participants who have a stake in the fee bundle for gynaecological surgery: SCHI as funder, hospitals as lead contractors and facility providers, and gynaecologists and anaesthetists as service providers to hospitals.

173. While we note that the high level of interdependency between all four parties in order to provide gynaecology surgery to a SCHI member, hospitals (generally speaking) and anaesthetists have the greatest ability to walk away if their portion of the bundled fee is unacceptably low and are therefore least likely to bear financial impacts in response to change in gynaecologist fees.
[
]226 [ ]

174. Whether a hospital may bear some of the costs associated with higher gynaecologist fees negotiated by NZGA will depend on the market conditions that particular hospital operates in and the utilisation rate of its operating theatres. These features may indicate a hospital's ability and willingness to 'walk away' in response to a reduction in their portion of fees. While there may be some shifting of margins between hospitals and surgeons, we consider in general NZGA and hospitals are unlikely to reach an agreement within their current funding envelope as NZGA looks to achieve prices significantly different from those estimated in the counterfactual, therefore likely requiring SCHI to increase its bundle to hospitals if it wishes to implement APS for gynaecology. This is discussed in more detail below when we consider the ***Reduction in the private hospital provision of facilities for gynaecology.***

175. Similarly, it is unclear that anaesthetists will be affected if NZGA is able to increase the fees received by gynaecologists, as they do not appear to be captive to gynaecology but also provide an essential service to complete gynaecology surgeries.

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224 Application at [1.5].

225 In estimating its gynaecological cost claim savings, SCHI benchmarked surgeon fees across [ ] across all regions except [ ], where maintenance of adequate coverage at [ ] prices was considered less likely given the number of surgeons charging well in excess of [ ] in those [ ] regions. [ ] were used for those [ ] outlier regions instead. See SCHI response to RFI 1 July 2026 (3 August 2026) at pages 1 and 18.

226 SCHI submission on SOPI (16 June 2026) at footnote 65.

We understand that anaesthetists are trained to work across all surgical specialties, and their training does not limit their practice to one surgical specialty eg, gynaecology.[227] Anaesthetists who work in the public and private systems also have the option of increasing their hours in the public system. This is discussed in more detail below when we consider the ***Reduction in anaesthetist provision of services for gynaecology.***

176. In support of this understanding, SCHI has submitted that SCHI's negotiations parameters are that
[
].[228]
[
].[229]

177. By contrast, private gynaecologists and SCHI are much more dependent on each other. SCHI offers gynaecology surgery benefits on almost all of its plans,[230] and estimates it funds approximately [ ] of gynaecology surgery in New Zealand across the public and private sectors or approximately [ ] across the private sector.[231] As previously discussed, SCHI is not able to simply "walk away" if it does not agree with prices sought.[232] Accordingly, in the context of APS negotiations, we expect that any material increase in the bundled fee for gynaecology surgical procedures will largely be borne by SCHI and its members, and conversely, any decrease in that funded fee will be borne by surgeons.

<u>We expect bargaining power in the factual will lead to materially higher surgical fees</u>

178. Our preliminary view is that it is likely that authorisation of the Proposed Arrangements will result in materially higher costs for bundled gynaecology surgery on an ongoing basis.

179. We have established above that, in the factual, it is likely that SCHI will bring gynaecology surgery within its APS, largely as it has for other surgical specialties,

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227 Interview with [ ] (22 June 2026), NZSA submission on SOPI (3 July 2026) at [14].

228 SCHI submission on SOPI (16 June 2026) at footnote 65.

229 SCHI cross-submission on SOPI (3 August 2026) at [6.2(c)].

230 The exception is SCHI's HealthEssentials plan, which is its shared day-to-day health cover plan, which has no surgical cover under any specialty. SCHI response to request for information (3 August 2026) at page 6; Interview with SCHI (17 June 2026).

231 By its own estimate, SCHI funds [ ] of all gynaecology surgeries in New Zealand across both the private and public health systems. The remaining [ ] is broken down as such:

- Other private insurers: [ ]
- Health New Zealand: [ ]
- Self-funded patients: [ ]
- ACC: [ ]

SCHI submission on SOPI (16 June 2026) at Figure 16 and at [7.3].
Because this includes gynaecology surgeries performed in the public health system, this likely understates SCHI's true position. Using the above data from SCHI, if Health NZ and ACC are excluded from the calculation, SCHI's share would sit closer to [ ].

232 SCHI cross-submission on SOPI (3 August 2026) at [11.1(b)].

with some delay relative to the counterfactual, and that it will resist attempts by NZGA to engage with it directly on price.

180. Negotiations on price between SCHI and NZGA will instead likely occur via hospitals. Hospitals are likely to seek a higher overall bundle from SCHI when faced with higher surgeon fee expectations. As noted above, hospitals and anaesthetists may experience some margin shifting to gynaecologist, however, it is likely that the cost will be more directly felt by SCHI. For example, if all hospitals experience higher fee expectations from gynaecologists, and are unable to reach an agreement within their funding envelope, SCHI may be more inclined to meet these expectations and offer larger bundles that would allow hospitals to continue to feasibly offer services for gynaecology. Hospitals bear no material additional costs if FFS-based charging continues and gynaecologists decline to sign up to the APS.

181. Once the standstill period has ended, a key difference between the factual and counterfactual is that the experience of NZGA and its members entering into a Standstill Agreement and collective bargaining discussions within the NZGA would have facilitated a greater understanding of price differences and expectations between members, both nationally and regionally.

182. In this context, an unwillingness on the part of NZGA to agree to proposed APS fees would manifest in hospitals being unable to sign up a critical mass of gynaecology surgeons such that the hospital would be unwilling/unable to sign a SCHI APS contract for gynaecology surgery within the current funding envelope.

183. As noted above, it is likely that the Standstill Agreement and any further delay to implement SCHI's APS proposal will be to the financial benefit of gynaecologists. Given these incentives, and the recent experience of the Standstill Agreement, it may be that NZGA members individually decide to decline to sign an APS contract unless it is materially similar to the NZGA's bargaining position. This may extend the effect of the Standstill Agreement, on an informal basis, after it has expired.

184. This may have a more pronounced effect in some regions, particularly if there is a concentration of surgeons who have higher than average fees under FFS (and therefore have more to lose from SCHI's APS).
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185. SCHI could seek to force a resolution by setting a hard date by which it will transition gynaecology surgery to APS. This could be done nationally, regionally or on a hospital-by-hospital basis. For this to be an effective tactic, SCHI would have to credibly signal an unwillingness to fund further gynaecology surgery outside of the APS framework once the transition date had been reached.

186. Gynaecologists would face a significant financial risk by not signing up to an APS agreement by any transition date set by SCHI. Although the impact will vary for

233 Interview with SCHI (18 June 2026).

individual surgeons,[234] SCHI appears to currently fund [ ] of all private gynaecology surgeries.[235] However, such a tactic would also pose significant risks to SCHI. We expect SCHI would have potentially significant financial and legal risk, as well as significant reputational damage, if it significantly reduced its gynaecological cover for any amount of time or in any geographical region. In particular, it would run the risk of breaching contractual obligations to its members to cover gynaecological surgical services.[236] SCHI has not imposed an ultimatum of this nature so far and has instead opted to extend the transition period several times.[237]

187. What SCHI may do to contain its costs instead is seek to target gynaecologists who charge at the lower end of the spectrum and/or may be less aligned with NZGA until it has sufficient coverage for its members. FFS pricing is highly variable and we understand that SCHI to date has proposed fees charged at [ ] in [ ] out of 15 regions in New Zealand, and for those remaining [ ] regions [ ] SCHI expects that offers may fall between the [ ].[238] This means that at least [ ] gynaecologists (out of [ ] gynaecologists in New Zealand) would earn more under AP than under FFS and [ ] would earn less. In support of this claim, SCHI provided the following chart.

Figure 1: [

]

188. However, those gynaecologists would likely have raised their fee expectations, potentially to the rate that NZGA is negotiating at. Those raised fee expectations may also influence what gynaecologist charge under FFS in the meantime, placing upward pressure on their fees to the extent that they are below the rate NZGA is seeking to negotiate. This would reduce any financial benefit they might otherwise receive from accepting the currently offered APS prices. They may also be slower to sign up to the APS prior to a collectively negotiated outcome being reached to the extent that there is pressure not to erode the bargaining power of NZGA.[239] Furthermore, as NZGA represents 128 out of 144 gynaecologists in New Zealand, [240] SCHI would be unable to target non-NZGA members for sufficient coverage to implement its APS for gynaecological surgeries absent NZGA members.

189. While we have not reached a view on what negotiated fees may be agreed (and are not required to as part of our analysis), we do consider it likely that SCHI would pay a

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234 For example, whether they work full time or part time, the extent to which they also work in the public system, and their private patient mix.

235 See discussion above at footnote 231.

236 SCHI cross-submission on SOPI (3 August 2026) at [3.20(c)].

237 SCHI submission on SOPI (16 June 2026) at [6.7].

238 SCHI response to RFI 1 July 2026 (3 August 2026) at pages 1 and 18.

239 Interviews with [ ], [ ] (14 July 2026).

240 Interview with NZGA (13 July 2026).

materially higher amount in the factual compared to a counterfactual without the Proposed Arrangements.

190. Although NZGA has expressed an intention to support SCHI's financial position by reducing private healthcare costs compared to the status quo, NZGA may face some difficulty achieving this through a position that reconciles SCHI's desire for structured pricing under its APS with the significantly varied fees charged by gynaecologists under FFS. Structured / standard pricing is a core feature of the APS that SCHI is unwilling to depart from. This means that despite NZGA's intentions, the overall cost of claims may yet increase in the factual compared even to the status quo.

191. The eventual rate that is collectively negotiated will reflect fee expectations of gynaecologists, as informed by the fees and fee structure NZGA offers hospitals. We expect that NZGA would not be prepared to bargain at a rate where any gynaecologists may face concerns about their ability to maintain their existing fee levels, particularly given NZGA's concern that those gynaecologists would otherwise cease practicing gynaecology in New Zealand or offer a lower quality of care. However, the wide range of fees gynaecologists charge under FFS may mean that NZGA proposes to negotiate a set of fees that are significantly higher than what the majority of gynaecologists charge under FFS.[241] On the other hand, NZGA submitted that it accepts gynaecological surgery fees may need to be lower than what is charged under FFS to some degree to support SCHI managing its costs.[242] Ultimately, whether NZGA can offer a set of fees acceptable to SCHI will depend on whether NZGA can reconcile or take into account the significant variation in what gynaecologists charge in a way that meets SCHI's expectation that the APS for gynaecological surgeries will not depart from the fee structures established in respect of other specialties.

192. We also note there may be ongoing pressure on SCHI to raise gynaecological surgery fees over the duration of the authorisation period of 10 years. For example, NZGA may negotiate for fee increases to be pegged to metrics that increase at a higher rate than those that may be used in the counterfactual, and any percentage increase would be compounded by the fact that the base price would be higher to begin with.

193. For its part, SCHI considers that the Proposed Arrangements would result in significantly higher gynaecological surgery costs than in the counterfactual.[243] It has not suggested that it would be possible for SCHI to refuse to engage with NZGA's price demands (via hospitals). Rather SCHI considers with collective bargaining a conservative assumption would be that average prices would increase to

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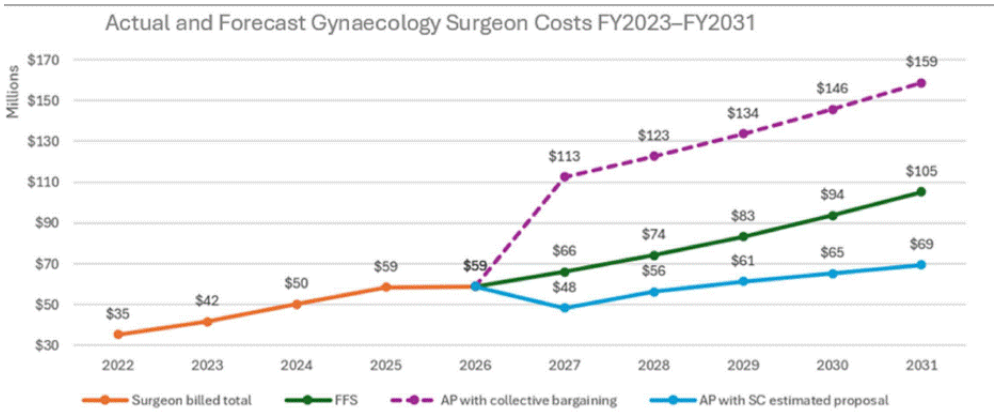
241 Based on NZGA's submissions to date, we expect that NZGA materially underestimates the variability of fees charged under FFS and will likely find it challenging to reconcile these without causing low charging gynaecologists to receive an increase in the factual. In particular [ ]. SCHI submission on SOPI (16 June 2026) at [8.1(d)(ii)]. Furthermore, data from nib NZ supports the view that there is significant variation in the minimum and maximum average fees charged by gynaecologists across New Zealand. nib NZ response to RFI dated 22 July 2026 (27 August 2026) at page 5.

242 NZGA cross-submission on SOPI (4 August 2026) at [2], NZGA addendum to supplemental submission (26 June 2026) at [7].

243 SCHI submission on SOPI at [9.6(a)].

[ ] of gynaecological surgical fees charged under FFS, implying that [ ] of surgeons would earn more and [ ] would earn less.[244] SCHI suggests that this is conservative as collective bargaining gives rise to a significant risk that no higher-charging surgeons are willing to reduce their prices and that the highest prices become the "price floor". SCHI provided the following chart, which highlights their estimates of the cost of providing gynaecology under FFS (the status quo), APS with SCHI's proposal (counterfactual) and APS with collective bargaining (factual).[245]

Figure 2: Actual gynaecology surgeon costs to SCHI FY2023 to FY2026, and forecast gynaecology surgeon costs with and without Competitor Coordination FY2027 to FY2031



194. Figure 2 has a number of underpinning assumptions regarding price and volume growth.
[
][246] Additionally under the "AP with collective bargaining" scenario, it is unclear that the shift of fees to [ ] is a conservative assumption as SCHI has not provided evidence to support this assumption.

195. Despite this, we understand that
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196. Professor Jaime King gave examples of physicians in other jurisdictions leveraging collective market power to extract higher rents from insurance companies, which resulted in supranormal profits by those medical practitioners.[248] However, we find those examples to be of limited assistance as those cases involved instances where medical professionals withdrew or threatened to withdraw services from more than

244 SCHI response to RFI dated 1 July 2026 (3 August 2026).
245 SCHI cross-submission on SOPI (3 August 2026) at Figure 1.
246 SCHI response to RFI dated 1 July 2026 (3 August 2026).
247 SCHI submission on SOPI (3 August 2026) at footnote 32.
248 Professor Jaime King report (on behalf of NZPSHA) (10 August 2026).

one insurer. NZGA has not requested authorisation to withdraw services, and its Proposed Arrangements do not extend to bargaining with insurers other than SCHI.

197. For completeness, we note that we have not considered a factual in which other specialties are permitted to collectively bargain with SCHI. This would potentially predetermine the outcome of any future authorisation applications and is therefore not a matter the Commission can consider.

198. Taken together, our preliminary view is that the likely factual scenario would involve gynaecological surgery fees paid by SCHI under its APS being, on average, higher than the fees paid in the counterfactual. While the precise magnitude of the increase is uncertain, we consider it is likely to be sufficient to give rise to the benefits and detriments discussed below.

SCHI has several options to respond to higher gynaecology surgery fees

199. If faced with higher costs relative to the counterfactual there are several options SCHI may consider to manage these higher costs. SCHI may consider using these options if either the transition to APS is delayed and the status quo of FFS charging remains, ie, for at least the standstill period and/or if NZGA were able to successfully negotiate a material increase in gynaecology surgery fees.

200. As noted above, SCHI has made losses in the last two financial years [ ]. Given SCHI's status as a friendly society and its current financial position, we think it unlikely that SCHI would simply absorb any increased costs itself.

201. Firstly, we expect SCHI will respond to any material increase in bundled gynaecology surgery fees relative to the counterfactual by increasing its member premiums, decreasing its member benefits, or some combination of both. Decreases in member benefits may be focused on gynaecology or more broadly across the various benefits it offers to members. Because of the way that SCHI calculates its member fees [ ], any increase in fees will likely have a broad impact across its member base.[249]

202. Secondly, in the case of a temporary or transitory increase in gynaecology surgery fees relative to the counterfactual (ie, if the transition is delayed and FFS remains in place for a limited time) SCHI has contractual mechanisms it can use to limit its exposure to increased costs. [ ][250]
[
]][251]

[249] Interview with SCHI (18 June 2026), SCHI response to RFI dated 1 July 2026 (3 August 2026).
[250] SCHI submission on SOPI (16 June 2026) at footnote 32.
[251] Interview with SCHI (17 June 2026).

203. These options will have different efficiency impacts, discussed further below in the benefits and detriments section.

The Proposed Arrangements may result in more efficient non-price APS contract terms

204. The Applicant has identified a range of non-price issues it would seek to negotiate if the Proposed Arrangements are authorised. For example:

204.1 NZGA raises as a concern in its application that members would be required to sign up to asymmetric contract terms', effectively being bound by terms and conditions in the agreement between SCHI and hospitals, which gynaecologists have no visibility of.[252]

204.2 NZGA has raised concerns about how risk is shared amongst the hospital, surgeon and anaesthetist when a surgery is unexpectedly complex. An example NZGA raised was if a surgeon finds an additional problem during a procedure that leads to additional time when it is not necessarily clear at the time whether SCHI would fund the additional theatre time.[253] NZGA also raised the example of surgeons being subject to fees clawback if a patient is subsequently found to be ineligible for an operation already performed.[254]

204.3 NZGA has raised concern that SCHI's proposal will not allow clinically appropriate procedures to be performed together.[255] In describing the issue, the Application states '*There may be a mechanism for reimbursement in these circumstances but this is not clear*'.[256]

205. We have heard from a number of stakeholders that these concerns are either addressed in the SCHI APS contractual framework or do not arise in practice.[257] Clarifying and resolving these issues may be mutually beneficial to SCHI and NZGA, but the transaction costs may mean that they are unresolved absent the Proposed Arrangements. This is discussed in more detail in the benefits and detriments section below.

Exchange of information in collective bargaining may affect other funders of gynaecological services

206. To prepare a collective position for bargaining, the NZGA will need to gather information about its members' pricing and preferences on price and non-price terms. Sharing this information, even if only at an aggregate level, risks affecting the price gynaecologists seek to charge other funders of private gynaecological surgery.

207. This is discussed in more detail in the benefits and detriments section below.

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252 Application at [2.19(f)] and Appendix 4, item 1.
253 Interview with NZGA (13 July 2026).
254 Application at [2.19(f)] and Appendix 4, item 7.
255 Application at [11.4(b)].
256 Application at [11.4(b)(iii)].
257 Interviews with St George's Hospital (6 July 2026) and [ ].

Transaction costs will likely increase in the factual

208. SCHI's APS contractual framework, as described above, appears to be a streamlined arrangement for a funder to contract the provision of surgical services.

209. The Proposed Arrangements, if authorised, seem to have scope to add transaction costs relative to the counterfactual, including because:

209.1 NZGA members would have to agree positions on price and non-price terms on which they would be willing to sign up to APS agreements. This would require NZGA to overcome internal heterogeneity;

209.2 NZGA would be seeking to insert itself into several different layers of the contractual framework, including direct discussions with SCHI (which are likely to be rebuffed at least with respect to pricing but may have some traction regarding non-price terms), hospitals (regarding price and potentially non-price terms, which would likely require engagement with individual hospitals), and with its members (if it is acting on their behalf in individual discussions);

209.3 following collective negotiations, it would still be incumbent on individual surgeons to decide independently whether to contract on the negotiated reference terms, which NZGA would not take part in;[258] and

209.4 it is not clear there are material transaction costs that would be avoided by including NZGA in negotiations.

210. Transaction costs are discussed in more detail in the benefits and detriments section below.

Summary of the factual and counterfactual

211. The following table summarises our preliminary view on the key features of the likely factual and counterfactual.

Key features	Factual (future with Proposed Arrangements)	Counterfactual (future without Proposed Arrangements)
Overall fee structure	APS for all gynaecology surgery	APS for all gynaecology surgery
Contractual framework	Hospitals to be the lead contractors SCHI is unlikely to materially alter the framework	Hospitals to be the lead contractors SCHI is unlikely to materially alter the framework

[258] NZGA response to RFI dated 30 July 2026 (18 August 2026).

Timing of APS rollout	Likely to be delayed by at least the 6-month term of the Standstill Agreement	Work towards APS rollout to continue
Level of fees	Higher costs for bundled gynaecology surgery (including surgeons' and other fees)	Lower costs for bundled gynaecology surgery relative to the factual
Non-price terms	More efficient terms, with more marginal issues agreed between the parties	Marginal issues remain unresolved between the parties
Transactions costs	Greater transactions costs, because NZGA members will have to agree on the terms on which they would sign up to APS agreements and owing to NZGA engaging with hospitals and SCHI on price and non-price terms	Lower transactions costs relative to the factual, as NZGA members would negotiate individually with counterparties and not directly engage with SCHI

Our assessment of benefits and detriments

212. The Commission will grant authorisation if it is satisfied that the proposed conduct will result, or will be likely to result, in a benefit to the public which would outweigh the lessening in competition that would result or be likely to result.[259] In making this assessment, the Commission considers the evidence and makes judgements about how much weight to give to the evidence.

213. In *Godfrey Hirst*, the Court of Appeal observed that the Commission must consider a broad range of benefits and detriments in applications for authorisation. This may include efficiencies and non-economic factors.[260]

214. The Court of Appeal said the Commission must have regard to efficiencies when weighed together with long-term benefits to consumers, the promotion of competition, and any economic and non-economic public benefits. The Court stated that "[w]here possible these elements should be quantified; but the Commission and the courts cannot be compelled to perform quantitative analysis of qualitative variables."[261]

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259 Section 61(6) of the Act. Authorisation Guidelines at [18.2].

260 *Godfrey Hirst NZ Ltd v Commerce Commission* [2016] NZCA 560 (CA) at [24] and [31].

261 *Godfrey Hirst NZ Ltd v Commerce Commission* [2016] NZCA 560 (CA) at [36].

215. The Commission's approach is to quantify benefits and detriments to the extent that it is practicable to do so.[262] Regarding the weight that can be given to qualitative factors, the Court of Appeal said in *Godfrey Hirst* that "[q]ualitative factors can be given independent and, where appropriate, decisive weight."[263]

216. In general, collective bargaining has the potential to cause both public benefits and detriments. Collective bargaining can reduce the costs of negotiating contracts by reducing the number of negotiations and by allowing advisory costs to be shared.[264] Collective bargaining may also enable access to higher quality advice through the pooling of member's resources. However, collective bargaining could also increase transaction costs by introducing negotiations that would not otherwise occur.

217. Collective bargaining can also change incentives to obtain mutually beneficial gains from trade by allowing information to be shared and by rebalancing bargaining power. Consequently, collectively negotiated contracts may be more efficient in the sense that they are more nuanced and take account of more contingencies than might be the case if negotiated individually.

218. Detriments generally arise if a market experiences a loss in allocative, productive or dynamic efficiency. Allocative efficiency is lost when inefficient (higher) prices result in substitution to less preferred alternatives or to the purchase of smaller quantities. Productive efficiency is lost when resources are inefficiently employed in production, typically increasing costs above efficient levels. Consequently, costs or unit costs may increase, and capacity may be sub-optimally used. Dynamic efficiency is typically lost when the incentive or the ability to innovate/invest is reduced. These potential impacts are discussed in further detail below.

219. Unless we are applying a modified total welfare approach, changes in the distribution of wealth, where one group gains at the expense of another, are generally not relevant to our analysis because they do not usually involve a change in overall public benefit.[265]

220. The Court of Appeal in *NZME* confirmed that the Act allows the Commission to apply a 'modified total welfare' approach but does not require us to do so. A modified total welfare approach can take into account the distributional effects of benefits and detriments within a community, allowing us to adjust the weight given to benefits and detriments to reflect their distribution.[266]

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262 *Telecom Corporation of New Zealand Ltd v Commerce Commission* [1992] 3 NZLR 429 (CA) at 447. *Air New Zealand and Qantas Airways Limited v Commerce Commission* (2004) 11 TCLR 347 (HC) at [319]. *Ravensdown Corporation Ltd v Commerce Commission* High Court, Wellington API68/96 (16 December 1996) at [47] to [48].

263 *Godfrey Hirst NZ Ltd v Commerce Commission* [2016] NZCA 560 (CA) at [38].

264 Stephen King (2013) Collective Bargaining by Business: Economic and Legal Implications. UNSW Law Journal, 36(1), [107] – [138].

265 *Air New Zealand and Qantas Airways Limited v Commerce Commission* (2004) 11 TCLR 347 (HC) at [241] and *Telecom Corporation of New Zealand Ltd v Commerce Commission* (1991) 4 TCLR 473 (HC) at [530-531].

266 *NZME Ltd v Commerce Commission* at [75]; and see Authorisation Guidelines at [85].

221. SCHI has raised the modified total welfare approach, though has not expressly requested the Commission adopt such an approach here. SCHI submitted that that detriments would largely accrue to 940,000 SCHI members whilst benefits would accrue to approximately 130 members of the NZGA.[267] NGZA's position is that benefits would also accrue to SCHI members and the wider health system.[268]

222. Ultimately, we have adopted a total welfare approach. However, we consider that even if we had adopted a modified total welfare approach, that would be unlikely to have changed our preliminary view to decline authorisation, whether we accepted the arguments made by either SCHI or NZGA.

223. Under the total welfare standard approach we have not given independent weight to the materially higher cost of gynaecology surgery paid by funders/purchasers and charged by surgeons. This is because the changes in cost themselves represent a transfer of wealth, where one group gains at the expense of another, but do not involve a change in overall public benefit.[269] Rather, changes in the cost of gynaecology services are considered through their effects on economic efficiencies, such as allocative efficiency, which can affect overall public benefit.

224. For the reasons set out below, on the evidence before us, our preliminary evaluative judgement is that the Proposed Arrangements would likely result in detriments that materially outweigh any benefits to the public.

225. While the Commission has made its own enquiries into these matters, we note that in authorisation matters the applicant bears the practical burden of persuasion.

Potential benefits

226. There are three main categories of potential benefits from the Proposed Arrangements that we have considered:

    226.1 health benefits;

    226.2 more efficient contracts; and

    226.3 allocative efficiency gains from maintaining the supply of gynaecologists.

227. We consider the likelihood and magnitude of these potential benefits in more detail throughout the rest of this section.

Health benefits

228. The Commission is not limited to taking account of efficiency benefits in the public benefit test and can consider anything of value to the community generally that

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267 SCHI submission on SOPI (16 June 2026) at [9.6(k)].

268 NZGA cross-submission on SOPI (3 August 2026) at page 7.

269 *Air New Zealand and Qantas Airways Limited v Commerce Commission* (2004) 11 TCLR 347 (HC) at [241] and *Telecom Corporation of New Zealand Ltd v Commerce Commission* (1991) 4 TCLR 473 (HC) at [530-531].

results from a proposed arrangement. For example, the Commission has previously recognised health benefits from breastfeeding.[270]

229. In this case the Commission would consider health outcomes a benefit of the Proposed Arrangements if we considered that they are likely to be better in the factual than in the counterfactual. The Applicant and some interested parties consider that the Proposed Arrangements will avoid a reduction of quality in healthcare services that may otherwise arise in the counterfactual.[271] However, based on the evidence we have received we provisionally consider that this is not likely to be the case.

Applicant's view

230. The Applicant has submitted that the APS currently proposed by SCHI is deficient and not clinically appropriate, and that there is a misalignment in the incentives of surgeons, hospitals and SCHI such that these issues will not be resolved absent the Proposed Arrangements.[272] In particular, NZGA submitted that:[273]

    230.1 The APS coding is deficient. NZGA submitted that RANZCOG has clearly expressed its concerns that SCHI's APS coding is deficient in some areas such as urogynaecology[274] and gynae-oncology[275] and strongly encouraged establishing further codes for common procedures.

    230.2 Clinically appropriate procedures are excluded. For example, some patients with multicompartment prolapse may clinically require multiple procedures to be performed together in one operation, but the proposed APS coding structure would exclude this approach, resulting in repeat surgery and poorer outcomes. NZGA has further submitted that its primary objective is to establish an appropriate coding set so that women can avoid unnecessary multiple operations.[276]

    230.3 It ignores procedure and patient complexity. NZGA submitted that SCHI's APS does not appear to adequately account for variation in surgical complexity or patient factors that will extend their post-operation recovery. Instead, measures such as operation time are used to weigh complexity. While risk corridors are referenced in materials provided by SCHI to gynaecologists, there is limited clarity on how these operate in practice.

231. NZGA has indicated that the APS model does not accurately reflect the quality of medical care provided and can obscure the realities of clinical complexity and the

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270 *Infant Nutrition Council Limited* [2023] NZCC 42.

271 Application at Page 43

272 NZGA response to RFI (18 August 2026) at pages 2-3.

273 Application at [11.4].

274 Urogynaecology is a subspecialty of gynaecology that is focused on the diagnosing and treating women with pelvic floor disorders.

275 Gynae-oncology is a subspecialty of gynaecology that is focused on diagnosing and treating cancers of the female reproductive system.

276 NZGA addendum to supplemental submission (26 June 2026) at [4].

need for flexibility in patient management. Its view is that APS does not include built-in complexity modifiers. Instead, reimbursement depends on meeting a detailed set of insurer-defined criteria before a claim can be submitted.[277] NZGA considers there is "*no flexibility during the surgery in case of unexpected findings, during surgery with additional pathology or additional surgery required, or additional equipment required*".[278] Even if such flexibility mechanisms did exist, NZGA submitted that these should be contractually guaranteed rather than dependent on unilateral discretion by SCHI. Otherwise, the risk of non-payment is borne wholly by the surgeon.

232. As a result, NZGA considers that the AP coding as proposed is fundamentally unsuitable for many gynaecology procedures because the coding assumes a standard episode of care whereas clinical complexity varies considerably between patients.[279] Therefore, NZGA considers that through the Proposed Arrangements they may be able to address some of these concerns and as a result the SCHI APS will be more clinically informed leading to better patient outcomes.

SCHI's view

233. SCHI submitted that it is not seeking to reduce access to care or reduce quality,[280] and that it is not making any changes to its coverage for gynaecology surgery through the transition to APS. Instead, it seeks a funding mechanism that provides better clarity, consistency and sustainability of funding for members who seek gynaecology surgery under their policies.[281]

234. SCHI submitted that its funding codes do not place restrictions on clinical care. The codes do not determine whether treatment is clinically required, what procedure should be undertaken, or how a clinician should treat a patient. SCHI's procedure funding code set is simply the mechanism through which covered surgical procedures are categorised and funded for SCHI's insurance purposes.[282]

235. SCHI submitted that in developing its APS coding it has engaged with both RANZCOG and NZGA, is continuing to engage with RANZCOG and the Aotearoa New Zealand Society of Urologists (**ANZSU**) on clinical matters, and to the extent further consultation on clinical governance matters is considered beneficial, that can be achieved through legitimate advocacy channels.[283]

236. SCHI further submitted with respect to issues raised regarding clinical outcomes that:[284]

    236.1 SCHI's proposed procedure funding code set is deliberately designed to accommodate varying complexity or intraoperative findings (via risk corridors

277 NZGA "NZGA Q&A" (14 July 2026) at [41].
278 Ibid at [81(b)].
279 Ibid at [13] page 12.
280 SCHI cross-submission on SOPI (3 August 2026) at [2.7].
281 Ibid at [2.6].
282 Ibid at [2.5(b)].
283 SCHI submission on SOPI (16 June 2026) at [9.6(p)], email from SCHI (4 September 2026).
284 SCHI cross-submission on SOPI (3 August 2026) at [2.6].

and open codes) and surgery requiring multiple procedures concurrently (via add-on codes or combining codes);

236.2 the proposed AP model would not interfere with clinical decision-making. No change would be made regarding clinical decision-making as treatment decisions remain with the treating clinician and patient;

236.3 SCHI has engaged in consultation with RANZCOG and gynaecologists over many months;

236.4 introducing a procedure funding code set for gynaecology is neither unique nor unusually complex compared to other surgical specialties; and

236.5 APS arrangements do not lead to poorer access, lower quality or worse patient outcomes, as evidenced by the transition of other specialties to APS.

Interested parties' views

237. Interested parties had a range of views on whether the Proposed Arrangements would lead to better health outcomes.

238. Several parties raised concerns about the financial incentives created by SCHI's APS. For example, that SCHI's APS proposal does not adequately account for clinical practice, and risks placing inappropriate incentives on surgeons and hospitals.[285] NZSA submitted that the Proposed Arrangements would encourage quality negotiation and integration of clinical expertise, without which financial incentives may not align with optimal clinical decision-making.[286]

239. Several submitters raised concerns that a reduction in fees paid to surgeons in the counterfactual relative to the factual would decrease the quality of clinical care:

239.1 One hospital submitted that the APS funding could effectively cap prices, creating a risk that SCHI members experience a reduction in the quality of care below the best and latest services and materials.[287]

239.2 Intus submitted that SCHI's approach to pricing is driving wrap around support towards the minimum. For example, it is difficult to sustain patient convenience and compliance supports if they are not funded and cannot be charged to the patient.[288]
[
].[289] Intus also submitted that SCHI's approach to pricing is

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285 Anglesea Gynaecology submission on SOPI (29 June 2026) at [3] and [4.2], Interview with [ ] (2 July 2026).

286 NZSA submission on SoPI (3 July 2026) at [29].

287 [ ] submission on SOPI (29 June 2026) at page 4.

288 Intus submission on SOPI (16 June 2026) at [7.1].

289 Intus submission on SOPI (16 June 2026) pages 6-7 (Confidential version).

already encouraging practices to restrict availability of after-hours and weekend services.[290]

239.3 Anglesea Gynaecology submitted that the APS framework creates a bias towards lower-cost and lower-expertise provision of care, that will negatively affect clinical outcomes, complication rates, and patient satisfaction.[291] One gynaecologist noted that he currently pays for psychologist and health coach consultations to assist his patients before and after surgery.[292]

240. Some submitters also raised concerns about SCHI's ability to decide member benefits and eligibility criteria potentially affecting the quality of care. NZSA raised concern with SCHI's approach to changing eligibility criteria for some members despite clinicians raising significant concerns about adherence to established clinical standards and patient outcomes.[293] Intus raised concerns regarding SCHI's contractual ability to unilaterally determine member benefits affecting the quality of care provided to patients.[294]

241. RANZCOG, and a gynaecologist [ ], told us the AP code set is 'close' to being acceptable,[295] and we understand SCHI is continuing to engage with RANZCOG to refine the code set.[296] RANZCOG's engagement on the code set has been focussed on clinical aspects, with RANZCOG seeking to ensure its members would be comfortable it was clinically sound.[297]

242. Some of the hospitals we have spoken to appeared comfortable with implementing APS using the existing code set,[298] potentially with the knowledge that it would continue to be refined over time.

243. Finally, there were several submitters that considered health benefits would not arise under the Proposed Arrangements because poor health outcomes had not materialised in other specialties to which the APS applies and collective bargaining is not required to resolve the issues being raised:

243.1 Allevia Hospitals submitted that the APS has been in place for more than 20 years covering most surgical specialities, and that [ ][299] Mercy Hospital noted that AP contracts can accommodate recognised risk

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290 Intus submission on SOPI (16 June 2026) at [7.4].
291 Anglesea Gynaecology submission on SOPI (29 June 2026) at [4.1].
292 Interview with [ ] (28 July 2026).
293 NZSA submission on SOPI (3 July 2026) at [28].
294 Intus submission on SOPI (16 June 2026) at [7.6].
295 Interviews with RANZCOG (30 June 2026) and [ ] (14 July 2026).
296 Interview with RANZCOG (30 June 2026).
297 RANZCOG's primary purpose for being is to be a medical college. They are accredited by the Australian Medical Council and the New Zealand Medical Council. While their primary role is in education and training for trainees, and for ongoing professional development for members they also play a role in supporting their membership and advocacy for women's health and for obstetrics and gynaecology in New Zealand. Interview with RANZCOG (30 June 2026).
298 Interviews with [ ] and [ ].
299 Allevia Hospitals submission on SOPI (17 June 2026) at [11].

corridors, and that it collaborates with specialists at times of patient specific complexity.[300]

243.2 Others noted that advocacy regarding appropriate treatment does not require authorisation and is not inherently linked to collective bargaining regarding commercial terms.[301]

Our preliminary view

244. Our preliminary view is that no material health benefits or detriments arise from the Proposed Arrangements because we have not identified any material difference in the quality of health outcomes between the factual and counterfactual.

245. To date the Applicant has not provided any quantitative evidence supporting its claim of better quality health outcomes in factual compared to the counterfactual, either as to the magnitude or likelihood of harm. We have made our assessment on the evidence available.

246. To the extent there is any misalignment between the APS billing framework (including the code set) and best clinical practice, we consider this is likely to be resolved in a similar manner in both the factual and counterfactual, such that there is not a significant difference that can be attributed to Proposed Arrangements. In particular:

246.1 SCHI advised the Commission in September that, following engagement with individual gynaecologists and RANZCOG, its gynaecology code set is now largely settled.[302] SCHI is continuing discussions with RANZCOG and ANZSU on several discrete matters including in the areas of gynaecological oncology and urogynaecology and where a second surgeon/surgical assistant is appropriate.[303] We understand that it is common for SCHI to engage with industry bodies to improve its AP code sets.[304] SCHI also has an internal medical team who regularly review AP code sets to ensure that SCHI keeps up to date with developments in medical practice.[305]

246.2 Some of the issues identified in the Application appear to have been caused by differences in understanding and perspectives between the NZGA and SCHI, and may already have been addressed, for example with respect to the operation of certain aspects of the billing codes.[306]

246.3 We also acknowledge that the code set is not intended to perfectly capture every clinical eventuality. It is primarily intended to support billing of services,

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300 Mercy Hospital submission on SOPI (10 June 2026) at page 2.
301 Allevia Hospitals submission on SOPI (17 June 2026) at [18], and nib NZ submission on SOPI (19 June 2026) at [21].
302 Email from SCHI (4 September 2026).
303 Ibid, interview with RANZCOG (30 June 2026).
304 Interview with SCHI (17 June 2026).
305 Interview with SCHI (17 June 2026).
306 Interview with RANZCOG (30 June 2026).

has built-in flexibility for complex and unexpected clinical situations, and will evolve over time as SCHI acquires more data.

246.4 We further place some weight on the apparent alignment of interested parties on many important clinical issues. It is in the interest of both SCHI and patients to combine procedures into a single surgery, where clinically appropriate. This both reduces costs for SCHI and avoids unnecessary health risks from multiple surgical procedures for its members.

246.5 To the extent there is any residual misalignment between the financial incentives facing surgeons under the APS and clinical best practice, we place significant weight on the professional obligations and duty of care of surgeons. There is a regulatory framework in place, including the Health Practitioners Competence Assurance Act 2003, the Medical Council of New Zealand, and the Health and Disability Commissioner that ensures a minimum standard of care provided by gynaecologists. None of the interested parties we spoke to raised concerns about the effectiveness of the regulatory regime in ensuring quality of healthcare.[307]

247. We acknowledge the concern raised by some interested parties that a reduction in SCHI fees in the counterfactual, and restrictions on optional quality enhancements, may reduce the level of ancillary services some SCHI members receive. To some extent this [ ]. SCHI has stated that ancillary services that are covered under policy and correctly billed will continue to be funded.[308]

248. However, the extent to which surgeons may use any higher fees received in the factual to voluntarily provide a higher level of service than what SCHI is willing to fund is unclear and uncertain. Our provisional view is that there will not be a material health benefit from this potential outcome in the factual.

249. Finally, with respect to member benefits and eligibility criteria, we do not consider that there will be a material difference in the process by which SCHI determines these settings between the factual and counterfactual scenarios. Where SCHI makes adjustments to its benefits and eligibility criteria, this likely reflects a balancing exercise undertaken with respect to member benefits and claims costs. We do not think it is likely that the Proposed Arrangements would lead to a material difference in SCHI's approach to these matters that could result in better health outcomes in the factual. Determining member benefits and eligibility criteria goes to the core of SCHI's business as an insurer, and SCHI is unlikely to agree to greater involvement of a professional body as this would undermine its ability to manage claim costs.

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307 Interviews with Health NZ (9 July 2026) and SC Hospitals (9 July 2026).

308 SCHI cross-submission on SOPI (3 August 2026) at [3.4].

More efficient contracts

250. Generally speaking, collectively negotiated contracts can more efficiently resolve marginal issues because the process can allow negotiation and transaction costs to be shared across parties, making it relatively less expensive for parties to effectively negotiate and resolve marginal issues.[309] Collective bargaining may also improve contracting by changing the available information and how it can be used in contract design, to enable the efficient resolution of both marginal and some more substantive issues.[310]

251. We consider that, consistent with the economic theory outlined above, the evidence gathered to date indicates that the efficient resolution of marginal contractual issues is more likely with the Proposed Arrangements. Accordingly, we provisionally consider there is a very small benefit to the Proposed Arrangements because they will provide a limited scope for more efficient contract terms between the parties.

Applicant's view

252. The Applicant submitted that the Proposed Arrangements would reduce transaction costs and provide greater transparency,[311] and that the benefits of the Proposed Arrangements include more sophisticated contracts between the parties that are likely to have efficiency benefits.[312] The commercial advisors to NZGA have submitted that the Proposed Arrangements would allow common issues to be worked through once, while individual negotiations would be unlikely to resolve overarching issues.[313]

253. NZGA identified a range of non-price terms it would seek to negotiate, including:

    253.1 improvements to the gynaecological surgical AP code set (including which procedures are excluded and when certain procedures can be performed together);[314]

    253.2 contract terms specifying and clarifying when additional fees would be paid (particularly top-ups, add-ons, and risk corridors), when open codes will be accepted, and ensuring these terms are clearly documented and contractually agreed;[315]

    253.3 how risk is shared amongst the hospital, surgeon and anaesthetist when a surgery is unexpectedly complex. An example NZGA raised was if a surgeon finds an additional problem during a procedure that leads to additional time

309 *New Zealand Tegel Growers Association Incorporated* (2022) NZCC 30 at [177].
310 Stephen King – Collective Bargaining by Business.
311 NZGA response to RFI dated 30 July 2026 (18 August 2026) at pages 1, 2.
312 Application at [9.15].
313 NZGA response to RFI dated 30 July 2026 (18 August 2026) at [6].
314 Interview with NZGA (13 July 2026).
315 Interview with NZGA (13 July 2026), NZGA response to clinical assertions by SCHI (4 August 2026) at [49].

and surgeons needed when it is not necessarily clear at the time whether SCHI would fund the additional theatre time;[316]

253.4 various terms and conditions [ ] NZGA presently considers 'asymmetric', such as:[317]

253.4.1 [ ];

253.4.2 [ ]; and

253.4.3 [ ].

254. NZGA has also more generally raised concerns regarding a lack of visibility over potential contractual arrangements including between hospitals and SCHI (which surgeons would not be a party to, but which may have a bearing on agreements between hospitals and surgeons),[318] and arrangements between hospitals and surgeons (which we understand will be bespoke to each hospital/hospital group and which may not have been provided to NZGA members for review to-date).[319]

255. NZGA submitted that, because of SCHI's refusal to engage with it on competition grounds, it would not be possible to resolve issues with the APS absent the Proposed Arrangements, including the proposed Standstill Agreement.[320]

SCHI's view

256. SCHI's position is that the Proposed Arrangements are not required for clinical matters to be addressed. SCHI's submission outlined that SCHI has continued to engage on non-price (clinical) matters, including:[321]

256.1 clarifying that pelvic floor procedures are included within the APS and funded through open codes;

256.2 amending the photographic evidence requirement for endometriosis procedures so that detailed clinical documentation may be provided in lieu of photographs where consent is not given;

316 Interview with NZGA (13 July 2026).

317 Application.

318 For example, we have been provided a copy of a SCHI APS contract with a facility with a confidentiality clause that would appear to prevent the facility disclosing the terms and conditions of the agreement to subcontracted surgeons [ ].

319 NZGA response to RFI dated 30 July 2026 (18 August 2026) at pages 4-5. NZGA supplemental submission on SOPI (26 June 2026) at page 2.

320 NZGA response to RFI dated 30 July 2026 (18 August 2026) at page 1.

321 SCHI submission on SOPI (16 June 2026) at [6.2(f) and (g)].

256.3 inviting NZGA to submit a detailed proposal on clinical documentation standards;

256.4 preparing and distributing an AP Training Guide for Surgeons and an AP Training Guide for Facilities to assist providers with understanding how the codes and agreements were proposed to work in practice; and

256.5 preparing and distributing a Provider Matrix showing which AP codes can be claimed together, and a Detailed Pelvic Floor Code Principles guide.

257. SCHI has further submitted that it is not a party to and does not have visibility over the contractual arrangements between hospitals and surgeons. SCHI has stated it is ultimately for the hospital and each surgeon to determine the terms on which specialist services are provided, including pricing and other commercial terms. However, it does require that hospitals have written agreements with surgeons, including minimum requirements relating to the APS such as correctly applying the notified policy terms, maintaining confidentiality, and reporting obligations.[322]

Interested parties' views

258. We have heard from a number of stakeholders that negotiating these issues, particularly clinical issues, does not require the Proposed Arrangements.[323]

259. We have also heard from a number of stakeholders that some of NZGA's concerns are either addressed in the SCHI APS contractual framework or do not arise in practice.[324] For example, that hospitals as lead contractors hold most of the risk for unexpectedly complex surgeries,[325] and that they do negotiate with SCHI regarding unexpectedly complex surgeries after the fact.[326]

260. ACC submitted that authorisation is not necessary to achieve some of the benefits identified by the Applicant, including information flows and more effective engagement.[327]

261. It appears that some hospitals do not currently have formal service level agreements with surgeons who operate at their facilitates. For example, Forté Health submitted that '*There is no formal agreement as such between the lead provider and individual surgeons. Surgeons are advised that if they are prepared to undertake surgery under the fixed price arrangement, the fee for the surgery is as listed. Undertaking the procedure constitutes acceptance of the surgeon fee for that procedure*'.[328] In interview, [ ] stated that while they require specialists to comply with the funder contracts in their credentialling guide, their focus is on delivering quality

322 SCHI response to RFI dated 1 July 2026 (3 August 2026).
323 For example, nib NZ submission on SOPI (19 June 2026) at [21] and ACC submission on SOPI (2 July 2026) pages 3-4.
324 Interviews with St George's Hospital (6 July 2026) and Allevia Hospitals (18 June 2026).
325 Interview with St George's Hospital (6 July 2026).
326 Interview with St George's Hospital (6 July 2026).
327 ACC submission on SOPI (2 July 2026) at pages 2-3.
328 Forté Health Limited submission on SOPI (9 June 2026) at page 2.

healthcare and not contractual arrangements.[329] This is because the quality of service provided by surgeons is heavily regulated by Health and Disability Commissioner standards and clinical governance standards.[330] [ ] also stated that clinicians using their facilities do not agree to written contracts, and they manage the clinical risk through the clinical governance framework that clinicians are expected to meet.[331]

262. On the other hand, one party supports interim authorisation and the Standstill Agreement if necessary for the purpose of allowing NZGA to negotiate the clinical code set and some non-price aspects with SCHI.[332]

Our preliminary view

263. Our provisional view is that there may be a very small efficiency benefit to gynaecologists sharing the time and resource costs of negotiating non-price contractual terms under the APS.

264. We have previously recognised that, absent the transaction cost savings arising from collective negotiations, it may be too costly to resolve marginal issues through individual negotiations.[333] 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 that are unlikely to be resolved in individual negotiations.

265. 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.[334] This may enable more sophisticated, efficient, and mutually beneficial contracts to be reached.[335]

266. NZGA has identified a range of non-price issues it would like to negotiate on as part of the move to the APS contractual framework. Negotiating these issues may require bilateral discussions between NZGA and SCHI, NZGA and hospitals, as well as discussions between all of SCHI, NZGA, hospitals, and potentially anaesthetists.

267. In addition to the issues identified by NZGA, there may be others that arise in the course of implementing the APS, particularly as hospitals may take different approaches to contracting with gynaecologists [ ],[336] and we have heard evidence that

329 [ ].
330 Ibid.
331 Ibid.
332 [ ], [ ].

333 *New Zealand Tegel Growers Association Incorporated* (2022) NZCC 30 at [177].
334 Stephen King - Collective Bargaining by Business at [116-117].
335 Stephen King - Collective Bargaining by Business at [119].
336 NZGA response to RFI dated 30 July 2026 (18 August 2026).

hospitals take different approaches to some issues, for example how payment risk is shared amongst the hospital, gynaecologist and anaesthetist.[337]

268. We acknowledge that SCHI has recently addressed some of the non-price (clinical) issues identified by NZGA. However, there are still outstanding issues, not all of which SCHI can address itself. In any event economic theory suggests that, absent collective bargaining, there will likely be marginal issues that remain unaddressed.

269. Some parties have submitted that non-price issues could be negotiated without breaching the Commerce Act and, therefore, without the need for authorisation. We agree that is the case for some, and potentially many, of the non-price issues including, in particular, clinical issues. We have not individually assessed or reached a view on each of the matters we understand may be in issue between the parties, including because those issues are not definitively specified. For present purposes, we note that collective negotiation of some issues, including some non-price commercial issues, would raise potential Commerce Act compliance risk. We also recognise that SCHI has expressly raised Commerce Act risk as a reason for not engaging in some discussions with NZGA to date and NZGA have subsequently sought authorisation to provide comfort for those discussions to occur.

270. The nature of the APS contractual framework means that negotiating non-price contract terms may require participation of at least SCHI, hospitals, and gynaecologists (and potentially anaesthetists). This will add to the cost and complexity of negotiations (relative to bilateral negotiations) and may decrease the likelihood that marginal issues would otherwise be resolved.

271. The Applicant describes many of its members as not being confident negotiating with a large commercial entity.[338] They may be unable or unwilling to engage in sophisticated contractual negotiations on their own, and the cost of obtaining professional advice on an individual basis may outweigh any perceived benefit to the individual gynaecologist.

272. There appears to be differences in understanding and perspectives between SCHI and NZGA, decreasing the likelihood of credible information exchange and the resolution of marginal issues absent formal collective bargaining as would occur with the Proposed Arrangements.

273. Based on the evidence we think that the following outcomes are likely regarding non-price terms:

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337 For example, we heard examples where each of the hospital, anaesthetist and surgeon may be out of pocket for additional, unfunded complexity (Interview with [ ] (30 July 2026)). We also heard of instances where hospitals hold most of the risk for unexpectedly complex surgeries (Interview with St George's Hospital (6 July 2026)).

338 Application at [11.35].

273.1 It appears likely that non-price (clinical) issues will continue to be discussed and addressed in both the factual and counterfactual. This is discussed in more detail above.

273.2 Some non-price terms may not be addressed in either the factual or counterfactual. For example, SCHI may be unlikely to agree to any changes that would undermine the benefits of the APS to itself or its members, or that give clinicians material influence over SCHI member benefits.

273.3 We think there is likely some scope for the Proposed Arrangements to reduce transaction costs such that small number of marginal issues will be resolved that otherwise would not in the counterfactual, and allow for discussion on some items which may otherwise be likely to raise potential Commerce Act compliance risk.

274. In conclusion, we provisionally consider it likely that there are some limited marginal issues that may only be resolved with collective bargaining under the Proposed Arrangements. Accordingly, we expect there would be a likely, but very small benefit associated with more efficient contract terms that better reflect the overall preferences of parties to the APS.

Greater supply of gynaecologists

275. As part of our assessment, we have considered the potential for an allocative efficiency benefit resulting from a greater supply of gynaecologists in New Zealand due to the Proposed Arrangements, compared to the counterfactual. We assessed whether this allocative efficiency benefit would arise from the Proposed Arrangements resulting in higher fees for treating SCHI insured patients. As previously discussed, we consider that through the Proposed Arrangements, NZGA members will achieve prices materially higher than without the Proposed Arrangements, although we have not reached a definitive conclusion on what those prices will be.

Applicant's view

276. The Applicant submitted that, in the counterfactual, gynaecologists would receive significantly lower remuneration compared to FFS prices.[339] Absent the Proposed Arrangements, NZGA submitted that there will be a reduction in supply or output of gynaecologist services:[340]

276.1 existing gynaecologists may seek to exit the industry earlier (eg, retirement or offshore exit) or at least exit providing services to SCHI members;

276.2 gynaecologists practicing overseas may defer or decide against returning to New Zealand:

339 Application at [2.14].

340 Ibid at paragraph 2.19(e).

276.3 gynaecologists undertaking postgraduate qualifications may be less likely to return to New Zealand; and

276.4 prospective gynaecologists may choose other specialties offering higher remuneration.

276.5 NZGA provided letters from four individual gynaecologists describing the potential for early retirement, closure of private practices and relocation overseas if private practice becomes financially unsustainable.[341]

277. In addition to the effects of reduced gynaecologist supply for private patients, NZGA has also identified that there could be adverse flow on effects on public sector supply or overburden the public sector to proportionally service more patients.[342] NZGA submitted that there is already a shortage of gynaecologists and critically low numbers within some subspecialities.[343] These shortages have been exacerbated by gynaecologists leaving for Australia, where positions are available and the same specialist college operates.[344]

SCHI's view

278. At the currently proposed AP remuneration rates SCHI submitted that there is no evidence of a material risk of workforce exit arising.[345] SCHI submitted that:

278.1 SCHI has a structural incentive to ensure that fees are set at levels that maintain an adequate supply of high-quality gynaecological services for its members.[346] This is reflected in SCHI's estimated savings from transitioning to AP, where it proposes
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278.2 [

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341 Application at Appendix 3 – letters from clinicians: Letter from [ ] (27 March 2026), Letter from [ ] (25 March 2026), Letter from [ ] (21 March 2026), Letter from [ ] (12 April 2026). We note that [ ] has already closed their practice.

342 Application at [2.19(e)].

343 NZGA "NZGA Q&A" (14 July 2026) at [2].

344 Interview with NZGA (13 July 2026).

345 SCHI submission on SOPI (16 June 2026) at [9.6(r)].

346 Ibid.

347 SCHI response to RFI dated 1 July 2026 (3 August 2026) at [1.1].

348 SCHI submission on SOPI at [6.2(i)].

278.3 [
].[349]
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].[350]

Figure 3:

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][351]
[ ]

278.4 Evidence from other specialties shows the transition to SCHI's APS does not result in a reduction of services being performed. SCHI submitted that to the contrary, the evidence demonstrates that when specialties transition to SCHI's APS, procedure volumes continue to grow.[352]

Interested parties' views

279. Individual gynaecologists have expressed a range of views on whether the transition to AP would result in a reduction in the supply of gynaecologists in New Zealand.

279.1 One gynaecologist considered that current private remuneration in New Zealand compared very favourably to other jurisdictions and stated that a reduction in the fee paid by SCHI would not cause them to practice overseas.[353] Another considered that New Zealand remained a generally attractive place to practise and that Australia was not currently particularly attractive for gynaecological surgery.[354] However, that gynaecologist considered that Australia could become more attractive if SCHI implemented its proposed APS fee levels, potentially leading practitioners to spend less time practising in New Zealand.[355]

279.2 Some interviewed gynaecologists acknowledged that fees for gynaecological surgery vary substantially and may, in some cases, be unacceptably high. One gynaecologist attributed some of the observed variation in procedure costs to differences in surgeon's skill and experience, which can also affect theatre time.[356] However, that gynaecologist considered that a twofold difference between the fees charged by different surgeons for the same procedure was

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349 Ibid, SCHI response to RFI dated 1 July 2026 (3 August 2026) at [12.3].
350 AMA, "Setting medical fees and billing practices 2024 Position Statement" (4 April 2024), at [1.1] and [1.9] https://www.ama.com.au/articles/setting-medical-fees-and-billing-practices-2024
351 SCHI's indicative allowances in Figure 3 exclude GST. SCHI response to RFI dated 6 August 2026 (27 August 2026) at page 2.
352 SCHI submission on SOPI (16 June 2026) at [9.6].
353 Interview with [ ] (14 July 2026).
354 Interview with [ ] (29 June 2026).
355 Ibid.
356 Interview with [ ] (14 July 2026).

unsustainable for SCHI.[357] Another gynaecologist considered that gynaecologists' fees had increased to unacceptably high levels and that some reduction was warranted.[358] That gynaecologist also considered that a submission suggesting that private gynaecology fees are currently approximately 25% higher in New Zealand than in Australia was likely to be correct.[359]

279.3 Other gynaecologists raised concerns that operating a practice under SCHI's proposed fee levels would not be financially viable. They considered that SCHI should instead target practitioners charging unusually high fees. By way of example, one gynaecologist described a patient who sought competing quotes for a self-funded procedure and was offered the same procedure by that gynaecologist for half the fee quoted by another provider.[360]

280. RANZCOG notes that there is already competition from Australia for gynaecologists and existing workforce shortages in New Zealand which they expect to worsen over time.[361] RANZCOG qualifications are trans-Tasman and there is significantly higher income potential in Australia.[362] The appeal of Australia is very real for its consultants/fellows.[363] More than 50% of their New Zealand trained gynae-oncologists have not come back after rotating to Australia for the last of their training.[364] While incomes at public hospitals in New Zealand are lower than in the public system in Australia, it is RANZCOG's view that private practice is a very good 'top up' to make things at least a little bit more even, [365] including for those surgeons that only work in the private sector part time.[366]

281. Health NZ similarly notes that remuneration for medical officers in New Zealand's public healthcare system is significantly lower than in Australia, and private practice is an important feature of the New Zealand healthcare system because it enables practitioners to supplement their public-sector income.[367] Most gynaecologists work in both public and private hospitals with the division of a practitioner's time negotiated individually.[368] In regard to the frictions a gynaecologist may face when

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357 Ibid.
358 Interview with [ ] (29 June 2026).
359 Ibid.
360 Interview with [ ] (29 July 2026).
361 Interview with RANZCOG (30 June 2026).
362 Ibid.
363 Ibid.
364 Ibid.
365 RANZCOG stated they are not aware of any formal benchmarking of O&G salaries between Australia and New Zealand but received a lot of anecdotal evidence on the higher income levels offered in Australia. RANZCOG also provided some job advertisements and the salaries received by gynaecologists in the public sector. This showed that in the public sector, specialists could expect to receive between NZ$198,386 – NZ$282,645 per year based on experience. The job advertisements for work in Australia were offering AU$350,000 – AU$679,000 plus extra benefits. The job advertisement offering AU$679,000 was for a position in an "outback community". Email from RANZCOG to Commerce Commission (7 July 2026).
366 Interview with RANZCOG (30 June 2026).
367 Interview with Health NZ (9 July 2026).
368 Ibid.

moving overseas, Health NZ notes that the shared specialist colleges between New Zealand and Australia (like RANZCOG) generally facilitate movement between New Zealand and Australia without additional training requirements and while other jurisdictions may impose additional requirements, Health NZ considers that New Zealand qualifications are well regarded internationally.[369]

282. Australasian Gynaecological Endoscopy & Surgery Society (**AGES**) submitted that without collective representation, smaller centres[370] across New Zealand relying on gynaecological services offered by one or two clinicians would be at risk of potential service withdrawal. It submitted that practitioners in smaller centres have diminished bargaining power and limited ability to spread administrative and compliance costs, absorb reductions in procedural reimbursement, negotiate through larger provider organisations, or withstand prolonged uncertainty regarding contractual arrangements.[371]

Our preliminary view

283. Our preliminary view, based on the evidence before us, is that there is likely a small benefit from a greater supply of gynaecologists in the factual compared to the counterfactual. In particular, the higher fees negotiated by NZGA in the factual will impact the incentives of some gynaecologists to enter and exit the speciality, as well as their incentives to migrate to and from New Zealand. However, the evidence in support of this benefit is not strong:

    283.1 while fees may be higher in the factual, it is not clear whether this would be a sufficient incentive to drive materially different decisions by gynaecologists to enter or exit the profession or leave/migrate to New Zealand compared to the counterfactual;

    283.2 individuals choose to relocate for a variety of reasons, and so the relationship between increased remuneration and supply is non-linear; and

    283.3 there will likely be gynaecologists that leave New Zealand in both the factual and counterfactual and to that extent, net migration cannot be counted towards a public benefit.

284. We have primarily considered the likelihood that gynaecologists currently practising in New Zealand would leave for Australia, as we consider Australia the most likely and viable outside option for private gynaecologists. We acknowledge there is mixed evidence as to whether privately practising gynaecologists could earn more in Australia than in the counterfactual. It appears that the remuneration within public hospitals is typically higher in Australia than in New Zealand.[372] In regard to private gynaecology remuneration the evidence before us does not signal a clear difference in the AP fees indicated by SCHI and private remuneration in Australia.

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369 Ibid.

370 Including Whangarei, Rotorua, New Plymouth, Palmerston North, Whanganui, Timaru and Invercargill.

371 AGES response to RFI dated 25 June 2026 (3 July 2026) at pages 2-3.

372 Interviews with [ ] (28 July 2026) and RANZCOG (30 June 2026).

285. Regarding Figure 3 above, we note that
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286. Overall, we have not found evidence comparing remuneration in Australia to be particularly relevant to the question of whether fewer gynaecologists will leave New Zealand in the factual compared to the counterfactual.

287. While lower fees in the counterfactual may make practising gynaecology in New Zealand relatively less attractive than in the factual, it is unclear whether this would make a significant difference to the actual choices made by surgeons on whether to stay in New Zealand or practise in Australia. This is because individual surgeons will consider a wider range of factors than just relative pay potential between Australia and New Zealand when making such a decision. In particular, when faced with lower prices in the counterfactual it is not clear that this will lead to higher exits from New Zealand compared to the factual:

    287.1 As discussed under the section ***Patient pathway***, GP referral relationships and a gynaecologist's reputation are important to a gynaecologist's workflow.[373] Additionally, gynaecologists who have been working for a long time may have treated a woman through different stages of life, who may refer their own family to the gynaecologist.[374] By exiting New Zealand, a gynaecologist would have to rebuild these referral relationships and their local reputation.

    287.2 Secondly, it does not appear uncommon for gynaecologists in New Zealand to establish their own clinics.[375] For these gynaecologists, leaving New Zealand could mean incurring the financial downsides of disestablishing their clinic in New Zealand.

    287.3 Thirdly, there may be non-financial factors that impact a gynaecologist's choice to stay in the market or not. There is further indication that despite the existing perception of higher remuneration in Australia by some gynaecologists, they have nonetheless chosen to continue practising in New Zealand.[376, 377]

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373 Interview with NZGA (13 July 2026).

374 Ibid.

375 Other gynaecologists may complete their private work at a clinic under an income sharing arrangement, or at hospitals with consult rooms. Interviews with NZGA (13 July 2026), [ ] (26 June 2026) and Allevia Hospital (18 June 2026).

376 RANZCOG provided an example of a consultant that turned down a high salary in Australia as they have family in New Zealand. Interview with RANZCOG (30 June 2026).

377 One gynaecologist was of the view that gynaecologists may stay in New Zealand due to "family or whatever reasons". Interview with NZGA (13 July 2026).

287.4 Based on SCHI's estimates we understand that some gynaecologists will be financially unaffected by the transition to APS or even better off, making them unlikely to leave in the counterfactual. SCHI estimates approximately [ ] of gynaecologists may in fact be better off in the counterfactual than under the existing funding model.[378] Furthermore, despite AGES' submission that regional communities are more likely to be impacted by potential service withdrawal, evidence from SCHI indicates
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288. Additionally, if faced with higher fees in the factual it is not clear that this will lead to lower exits from New Zealand. We understand some gynaecologists, in particular younger gynaecologists, may be likely to leave New Zealand in both the factual and counterfactual. These gynaecologists may choose to leave New Zealand for reasons other than remuneration such as the availability of innovative technologies overseas earlier than in New Zealand, and bias towards staying where they undertook training.[380] We also understand that younger gynaecologists tend to work primarily in public hospitals and may consider the higher likely remuneration in Australia's public hospitals to be more a bigger drawcard than higher future remuneration in New Zealand's private hospitals. To the extent that gynaecologists exit New Zealand in both factual and counterfactual, that cannot be counted as a public benefit within our assessment framework.

289. It has also been raised that in response to the proposed APS fees, gynaecologists may recoup lost revenue by increasing the volume of surgeries they complete.[381] Therefore, in the instance that there is a reduction in supply from gynaecologists leaving New Zealand (which is unclear), this may be partial offset by increased procedure volumes among remaining gynaecologists, who retain discretion over their case volumes and procedure mix, and may seek to enhance profitability through greater throughput and improved list efficiency.[382]

290. Finally, we consider again that SCHI is incentivised to ensure fees are at a level to maintain adequate supply of gynaecological services for its members. SCHI is a member focused friendly society. SCHI has a structural incentive to ensure that fees are at levels that maintain an adequate supply of high-quality healthcare services for its members.[383] When other specialities that have transitioned to AP, SCHI has not seen a reduction in volume.

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378 SCHI response to RFI dated 1 July 2026 (3 August 2026) at [1.1].
379 SCHI response to RFI dated 1 July 2026 (3 August 2026) at page 1.
380 Interviews with RANZCOG (30 June 2026), NZGA (13 July 2026).
381 Interviews with nib NZ (7 July 2026), [ ] (14 July 2026).
382 SC Hospitals submission on SOPI (23 June 2026) at [1.7(c-e)], Interview with SC Hospitals (9 July 2026).
383 SCHI cross-submission on SOPI (3 August 2026) at [6.2(a)].

291. Overall, while there may in theory be some benefit accruing from increased supply, we do not have strong evidence in support of this conclusion. As discussed, the evidence that there are higher fees in Australia is unclear. Secondly, there are additional financial and non-financial frictions that may reduce the incentive or motivation of a gynaecologists to leave the market. Finally, we consider that SCHI is incentivised to ensure fees are at a level to maintain adequate supply of gynaecological services for its members. We have overall assessed this benefit as small and theoretical.

Potential detriments

292. There are six main categories of potential detriments from the Proposed Arrangements that we have considered:

292.1 higher transaction costs (a productive efficiency loss);

292.2 higher SCHI premiums and/or reduction in coverage (an allocative efficiency loss);

292.3 higher reference prices (an allocative efficiency loss);

292.4 reduction in the private hospital provision of facilities for gynaecology (an allocative efficiency loss);

292.5 reduction in private hospital funding of gynaecology equipment and innovation (a dynamic efficiency loss); and

292.6 a reduction in anaesthetist provision of services for gynaecology (an allocative efficiency loss).

293. We consider the likelihood and magnitude of these potential detriments in more detail throughout the remainder of this section.

294. We have not considered potential detriments associated with medical professionals in other specialties being authorised to collectively bargain. That falls outside of the scope of the Proposed Arrangements for which the NZGA seeks authorisation, and any consequential benefits or losses of any other arrangements are too far removed from the facts of this authorisation to be likely and causative.

Higher transaction costs

Applicant's view

295. NZGA submitted that the Proposed Arrangements would result in reduced transaction costs.[384] It submitted that collective negotiations were in this case likely to be less complex and the needs homogeneous,[385] and that transaction cost savings

384 Application at [2.28(f)], [4.9]

385 Ibid at footnote 90.

were likely to arise because bilateral negotiations between each Participant and SCHI / hospitals would be avoided.[386]

296. NZGA estimated that in the counterfactual, if each gynaecologist obtained legal advice in negotiating AP agreements, this would cost between [ ] across NZGA's members for straightforward engagement or [ ] for more complex or prolonged negotiation.[387] NZGA acknowledged that not every member would incur identical costs or would negotiate individually. In contrast, NZGA conservatively estimated that collective negotiation would cost approximately [ ].[388]

297. NZGA intends to approach negotiations on fees in a manner that would reflect the experience of the gynaecologist, the complexity of the surgery, and that "everything should be considered".[389] NZGA would also seek to negotiate non-price terms with SCHI.[390]

298. NZGA also provided evidence about what preparation for collective bargaining might look like in practice. NZGA expected, amongst other things, to:[391]

298.1 consult members views on the clinical work involved in each procedure, the practical operation of the AP model and their priorities, using a structure questionnaire settled by counsel;

298.2 gather gynaecology clinical and operational evidence and develop objective costing and benchmark material;

298.3 settle NZGA's opening position, drawing on the priorities developed; and

298.4 implement information safeguards including:[392]

298.4.1 using an independent third party to aggregate any member-level pricing information, which would be used to identify outliers, usual ranges, price inflation, and an acceptable level of reduction. NZGA would seek to have SCHI ground its pricing in the clinical work and resources required rather than any aggregation of members' actual fees; and

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386 Ibid at [11.33].

387 NZGA response to RFI dated 30 July 2026 (18 August 2026) at [25].

388 Ibid at [26]-[28]. This assumes several rounds of negotiation with SCHI, and the time taken to draft and settle reference terms which are then reflected in the head contracts and subcontracts as the starting point for each surgeon. These costs depend on the scope, duration and complexity of the engagement, and may include legal advice, financial or economic analysis, preparation of supporting clinical and operational information, member consultation, negotiation meetings and administration.

389 Interview with NZGA (13 July 2026).

390 Application at [ ].

391 NZGA response to RFI dated 30 July 2026 (18 August 2026) at [9].

392 We have not turned our minds to whether in the absence of authorisation this would obviate concerns under the Commerce Act 1986.

298.4.2 assessing competitive overlap with reference to geography, subspecialty and actual patient or referral patterns, so that if confidential practice-level factual information is received, it is received by a designated officer who did not compete with the supplying member for the relevant services, so that an officer would ordinarily handle information from a region other than their own. Where no officer is sufficiently removed, the information would be aggregated by NZGA's external legal counsel before any officer received it.

299. NZGA would have feedback loops where the negotiating team would report to the board, take further instructions and revert to members where SCHI's position falls outside its mandate.[393]

300. Following development of negotiated reference terms, each surgeon would then decide independently whether to contract on those terms. NZGA stated that in practice, there may be minor individual variation on practice specific matters. NZGA would take no part in any individual negotiation and could not collect or circulate what any member agrees.

SCHI's view

301. SCHI submitted that the Proposed Arrangements would not result in material transaction cost savings or negotiation efficiencies. It submitted:

301.1 "the heterogeneity among gynaecology surgeons (in terms of expertise, experience, and significant variation in prices… means there will likely be significant internal transaction costs and negotiating inefficiencies within any collective bargaining group";[394] and

301.2 SCHI's AP negotiations are not with surgeons, they are with hospitals or facilities.[395]

302. [
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Interested parties' views

303. Hospitals interviewed consistently indicated that they have a small number of FTE dedicated to addressing all AP contracting activities.[397]

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393 NZGA response to RFI dated 30 July 2026 (18 August 2026) at [11].
394 SCHI submission on SOPI (16 June 2026) at [9.6(q)].
395 Interview with SCHI (17 June 2026).
396 SCHI response to RFI dated 1 July 2026 (3 August 2026).
397 Interviews with Mercy Hospital (25 June 2026), Allevia Hospitals (18 June 2026).

304. We have received consistent evidence from various sources suggesting gynaecologists are unlikely to incur any significant transaction costs in the counterfactual. This is because:

304.1 some surgeons are likely to be ambivalent about their contractual relationships, and will be content to sign the contract if colleagues do.[398] This may include not engaging external professional advice; [399] and

304.2 some hospitals do not require a separate formal agreement to be signed with individual surgeons,[400] instead working on the basis that undertaking the procedure constitutes acceptance of the scheduled surgeon fee for that procedure.[401]

305. Other hospitals suggested that individual negotiations are better managed by individual gynaecologists than through NZGA. Such negotiations build off regional and localised relationships where they can understand each individual surgeons' nuances.[402] Hospitals have submitted that facility-led service provision contracts accommodate local and regional dynamics while also enabling local negotiations with specialists to secure whole of service sustainable funding arrangements.[403]

306. NZSA submitted that shared resourcing would free up medical practitioners to undertake more patient care.[404]

Our preliminary view

307. Generally, transaction cost savings are likely to arise from collective bargaining, as collective bargaining permits participants to engage common professionals such as lawyers and accountants and reduce the number of negotiations that would take place. This may result in time and cost savings for both the members of the collective bargaining group and the counterparty to the negotiations. This is more likely to be the case where negotiations are similar in both the factual and counterfactual.

308. These benefits have two caveats:

308.1 First, if the parties in the collective bargaining group are heterogeneous, they may incur costs negotiating amongst themselves (internal transaction costs) due to their diverse needs and interests.

308.2 Second, collective negotiations can be more complex than bilateral negotiations if the parties have diverse interests and the contract must cater to the interests of all of those party to the arrangement (external transaction costs).

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398 Interview with [ ]

399 Interview with [ ] (30 July 2026).

400 [ ] Interview with [ ].

401 Forté Health submission on SOPI (9 June 2026).

402 Interview with Grace Hospital (30 June 2026).

403 Mercy Hospital submission on SOPI (8 June 2026) at page 1.

404 NZSA submission on SOPI (3 July 2026) at [7] and [36-37].

309. Therefore, any benefits of collective bargaining may be offset by internal transaction costs within the collective bargaining group, or external transaction costs arising from more complex negotiations as the collective represents a wide range of interests. In theory, the benefits from collective bargaining are more likely to flow when the group has both limited and homogeneous membership.[405]

310. Our overall preliminary view is that transaction cost savings are unlikely to manifest if the Proposed Arrangements are authorised in this case.

    310.1 In the counterfactual, both hospitals and SCHI will be able to implement the APS within their existing FTE, and for the most part gynaecologists and hospitals will leverage their existing local relationships in negotiations. Evidence from other specialties indicate that these negotiations rarely involve external advisors.

    310.2 In the factual, we expect additional transaction costs to arise. We consider there will likely be materially higher internal and external transaction costs because NZGA is seeking to represents a diverse member base, and the scope and intensity of negotiations proposed by NZGA in the factual appear to be materially greater than what would occur in the counterfactual. The factual is unlikely to remove much of the transaction costs incurred in the counterfactual as there may still be individual negotiations.

<u>Transaction costs for gynaecologists/NZGA</u>

311. Our preliminary view is that gynaecologists/NZGA are likely to incur significantly higher transaction costs in the factual preparing to negotiate and negotiating with SCHI and/or hospitals than individual gynaecologists would incur negotiating with individual hospitals/hospital groups in the counterfactual. This is because:

    311.1 gynaecologists are relatively heterogeneous;

    311.2 NZGA's plans for negotiating appear to be of materially greater scope and intensity than we would expect negotiations between individual gynaecologists and hospitals in the counterfactual to be; and

    311.3 negotiations on price terms are likely to occur with individual hospitals across New Zealand in the factual.

312. Gaining consensus from NZGA members on what their fees should be seems in preparing to bargain and through the negotiating process likely to be a complex and onerous process for NZGA. To prepare for collective bargaining, we understand that NZGA would obtain and analyse its members' fee expectations, costs, and other benchmarking material. We have heard that gynaecologists differ in their

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[405] Stephen King (2013) Collective Bargaining by Business: Economic and Legal Implications. UNSW Law Journal, 36(1), [107]-[138].

experience, subspecialties, input costs, and fee structures.[406] It has been submitted by both gynaecologists and insurers that gynaecologists in the status quo have significantly diverging fee expectations for the same surgeries.[407] Furthermore, we understand that NZGA intends to approach negotiations on fees in a manner that would reflect a multitude of characteristics.[408]

313. This also appears likely to lead to complexities in the negotiating process given the feedback loops NZGA intends to carry out with its members. That SCHI may refuse to negotiate on price directly is not a mitigating factor, as NZGA may instead negotiate with hospitals (which as discussed below is likely to lead to even more transaction costs).

314. Gaining consensus on non-price terms may be more straightforward, as there is likely to be less variation between gynaecologists on the appropriateness of those terms. In our interviews with gynaecologists other than NZGA Board Members, concerns about non-price terms were limited to the clinical appropriateness of coding and they did not raise concerns about other non-price terms such as risk allocation under the APS.[409] This suggests that gynaecologists are unlikely to engage in meaningful discussions on APS contractual terms beyond clinical appropriateness of coding, and that transaction costs associated with negotiating non-price terms is not likely to be significant.

315. As negotiations on price and non-price terms will likely occur at hospital level, we expect that NZGA would also incur significant time and cost in engaging in multiple negotiations with hospitals across the country. Hospitals will have different expectations on what portion of the bundle they are willing to pay to gynaecologists, depending on their costs, relative bargaining power with gynaecologists bargaining as a collective, and the markets in which they compete. Hospitals do not have authorisation to collectively negotiate, and so NZGA cannot negotiate with several hospitals/hospital groups at once. Therefore, our preliminary view is that NZGA would incur transaction costs negotiating not just once with SCHI but with multiple hospitals.

316. Moreover, despite the significant effort NZGA would undertake in negotiating reference terms and prices, individual gynaecologists would remain free to independently decide whether to contract on those terms and may undertake further negotiations.[410]

317. In the counterfactual, we preliminarily consider it unlikely that specialists would incur significant transaction costs in negotiating price and non-price terms with

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406 Interviews with NZGA (13 July 2026), [ ] (26 June 2026), [ ] (29 June 2026), [ ] (28 July 2026), [ ] (29 July 2026), [ ] (30 July 2026) and [ ] (3 August 2026).

407 Interview with [ ] (29 July 2026)], SCHI submission on SOPI (16 June 2026) at [1.3(a)] and [5.2(b)(iii)] and nib NZ response to RFI dated 30 July 2026 (27 August 2026) at pages 6-7.

408 Interview with NZGA (13 July 2026).

409 Interviews with [ ] (29 June 2026), [ ] (28 July 2026) and [ ] (29 July 2026).

410 NZGA response to RFI dated 30 July 2026 (18 August 2026) at [12].

individual hospitals. The contracting behaviour of doctors in other specialties may be indicative of contracting behaviour of gynaecologists. Evidence gathered to date indicates that doctors in other specialties have not tended to engage legal counsel when signing up to AP agreements with hospitals, and while some doctors engaged in price negotiations with hospitals we do not think it likely that these price negotiations exceeded the complexity of the feedback loops envisaged by NZGA. Furthermore, we understand that some doctors in other specialties do not sign the AP agreement but simply implement it on an understanding with the hospital.[411] Although there may be a few gynaecologists who would incur legal and administrative costs trying to negotiate with SCHI and/or hospitals, on price and non-price terms, this is unlikely to be indicative of broader behaviour by specialists who are generally time-poor. The transaction costs incurred by gynaecologists in the counterfactual are therefore likely to be minimal.

318. Therefore, our preliminary view is that gynaecologists are likely to incur significant transaction costs if authorisation is granted, and that these costs would not arise in the counterfactual.

Transaction costs for SCHI

319. Our preliminary view is that SCHI is likely to incur marginally more transaction costs in the factual than the counterfactual. For SCHI, the evidence before us indicates that in the factual:[412]

    319.1 SCHI may incur additional transaction costs in negotiating price terms in the factual vis-à-vis hospitals, who in turn negotiate with NZGA.

    319.2 SCHI would not negotiate price terms directly with NZGA.

    319.3 SCHI, hospitals and NZGA may incur additional transaction costs negotiating non-price terms in AP Agreements.

320. Under the APS, SCHI delegates administration of contracts and negotiation on pricing with medical professionals to hospitals and is not typically involved. While SCHI has been involved in some conversations with gynaecologists concerning the appropriateness of fees under APS to date as part of the process of transitioning gynaecological surgeries to the APS,[413] we understand SCHI's involvement in the most part to be limited to discussions with hospitals. Therefore, to the extent that the Proposed Arrangements increase the level of engagement by SCHI, even if only on non-price contract terms, this will be an increase in transaction costs from SCHI's perspective.

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411 Forté Health submission on SOPI (9 June 2026), Interview with [ ].

412 In both the factual and the counterfactual, we expect that SCHI would incur costs in engaging in discussions regarding coding and clinical matters, whether this is with NZGA and/or RANZCOG. We have therefore disregarded transaction costs associated with negotiating coding and clinical matters (as distinct from other non-price terms).

413 Interviews with Allevia Hospitals (18 June 2026) and [ ] (29 July 2026).

321. On the evidence before us, it seems unlikely that SCHI would incur materially higher transaction costs negotiating price terms with hospitals. SCHI has expressly ruled out negotiating with NZGA directly on price terms,[414] meaning that negotiations would likely occur sequentially between NZGA and hospitals, and hospitals and SCHI. While hospitals may bargain harder to increase the overall size of the bundle to compensate for collectively higher fee expectations by gynaecologists, it is not clear that this would result in significantly higher transaction costs for SCHI given hospitals would also be negotiating on price in the counterfactual.

322. As discussed in the above section ***More efficient contracts***, in the factual, NZGA may seek to negotiate non-price contract terms. We understand that the terms of the AP contracts signed by gynaecologists are determined by each individual hospital, and while SCHI does not prescribe the form those agreements must take, there are some minimum requirements for those subcontractor agreements.
[

].[415] If NZGA wishes to negotiate any of the non-price terms reflecting the minimum requirements required by SCHI, SCHI would likely need to be involved in such discussions and any time spent negotiating would represent a cost to SCHI that it would not otherwise incur.

323. SCHI estimated that it would use its existing FTE to address atypical negotiations but that it would come at an opportunity cost for other initiatives otherwise undertaken, which would be delayed.[416] Overall, SCHI may experience minor additional transaction costs under the Proposed Arrangements.

<u>Transaction costs for hospitals</u>

324. We have considered transaction costs for hospitals resulting from negotiating on price terms and non-price terms in the factual and counterfactual.

325. Our preliminary view in respect of negotiations on price terms for hospitals is that transaction costs are likely to increase in the factual compared to the counterfactual.

    325.1 Hospitals that would engage in collective bargaining with NZGA already engage in AP negotiations with specialists in other fields, and are unlikely to save any costs negotiating with a collective since those transaction costs would continue to be incurred.

    325.2 Hospital resourcing for negotiating AP contracts in the counterfactual is fairly minimal. Hospitals tend to have minimal staff allocated to negotiating AP contracts across all specialties (or these discussions are led by the Chief

414 Interview with SCHI (17 June 2026).
415 SCHI response to RFI dated 1 July 2026 (3 August 2026) at page 30.
416 SCHI response to RFI dated 1 July 2026 (3 August 2026) at page 13.

Executive, with no additional support staff).[417] Based on experience negotiating with union collective bargaining, one hospital suggested that collective bargaining with surgeons would be a "torturous process", as collective bargaining involves much more negotiation of details.[418]

325.3 The approach to fee setting by hospitals also varies, reflecting the competitive context they operate in: one hospital we spoke to negotiates prices with individual specialists, and others indicated they set schedules for all specialists.[419] One hospital submitted that it would not negotiate with NZGA on price at all.[420] Hospitals with fee schedules applying to all gynaecologists would incur relatively small transaction costs in the counterfactual.

325.4 In the factual there may be further resource required to negotiate harder with a collective entity (eg, petitioning SCHI for additional funds) and multiple rounds of negotiations with NZGA, in addition to individual negotiations with surgeons following agreement on reference terms with NZGA.

326. Negotiations on non-price terms are likely to require additional resourcing from hospitals but it is not clear that those costs would be of any material magnitude. As discussed above, we understand that although the contractual terms sit between gynaecologists and hospitals, only certain terms of those contracts are informed by obligations by hospitals under their AP agreements with SCHI. If NZGA wishes to negotiate any of the non-price terms reflecting the minimum requirements required by SCHI, those negotiations are likely to require involvement of hospitals, NZGA and SCHI. This would represent an increase in transaction costs to hospitals who would not otherwise need incur costs to engage in such discussions. However, it seems unlikely on the evidence before us that hospitals would need to hire more staff to engage in them.

327. Our preliminary view is that hospitals are likely to incur some minimal additional transaction costs associated negotiating non-price terms, and are not likely to experience any savings in negotiating with a collective entity on price terms.

Overall

328. Overall, our preliminary view is that it is likely the Proposed Arrangements will lead to significantly higher transaction costs in the factual compared to the counterfactual. We consider this detriment is likely and of a medium size relative to other benefits and detriments. Gynaecologists/NZGA are likely to experience the greatest additional transaction costs from collective negotiations. They may be willing to bear those costs if they do not outweigh the benefits they may receive

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417 Interviews with Mercy Hospital (25 June 2026) and Allevia Hospitals (18 June 2026).

418 Interview with [ ].

419 [ ] negotiates individual prices with individual surgeons. Interview with [ ].

420 Forté Health submission on SOPI (9 June 2026).

through the Proposed Arrangements. There will also likely be increased transaction costs for hospitals and SCHI.

Higher SCHI premiums and/or reduction in coverage

329. Allocative efficiency is lost when inefficient (higher) prices result in consumers switching some of all of their purchases to otherwise inferior, or less satisfactory products and services or reducing the quantity demanded.[421]

330. In this section, we consider whether higher collectively negotiated prices are likely to produce allocative efficiency losses through SCHI customers cancelling or reducing their insurance, or switching to an inferior or less satisfactory product, and/or SCHI reducing the coverage of its insurance policies. It is the resulting loss of allocative efficiency rather than the change in fees itself which is considered as a detriment within our assessment.

Submissions received

331. NZGA did not identify allocative efficiency losses from higher premiums as a potential detriment in its application.

332. SCHI submitted authorisation of the Proposed Arrangements would result in significantly higher annual gynaecology surgeon costs to SCHI, which would necessarily manifest in either higher premiums to SCHI members (affecting affordability and retention) or reductions in policy coverage to maintain sustainability – being outcomes that in turn also place increased pressure on the publicly funded health system. It submitted:

    332.1 higher claim costs flow through to higher premiums charged to SCHI members. Illustrative analysis on [ ] pricing [ ] using a subset of SCHI members, illustrates this relationship;[422]

    332.2 SCHI has no plans to reduce coverage for gynaecological services. SCHI's preference is to manage affordability through efficient purchasing arrangements, product design choices such as excess options, and ongoing review of healthcare funding arrangements, rather than reducing member access to covered services.[423] However, if healthcare costs continued to increase significantly and on an ongoing basis, SCHI submitted it may need to consider a range of measures to maintain the affordability of private health insurance [ ];

421 Authorisation Guidelines at [63].
422 SCHI response to RFI dated 1 July 2026 (3 August 2026).
423 Ibid.

332.3 SCHI's members can choose from different levels of cover and can move within the SCHI product portfolio to balance coverage and affordability.[424] Members can move to a lower level of cover, increase their excess, or remove optional modules to reduce their premium. Where a member increases coverage, additional underwriting, stand-down periods or other eligibility requirements may apply, particularly in relation to pre-existing conditions.

332.4 SCHI's data indicates that members respond to higher premiums in a range of ways, including retaining cover, increasing excesses, changing products, reducing cover, or cancelling insurance altogether.[425] The response depends on the size and nature of the premium increase, however affordability is an important factor in member decision-making. In the past two years, SCHI has implemented premium increases [ ] in response to sustained claims inflation. Analysis on SCHI member retention shows [ ] and that [ ][426]

332.5 In the past two years SCHI has implemented premium increases [ ]. In FY2026, SCHI saw [ ] policy downgrades to a lower tier of coverage (affecting [ ] members), and [ ] policies add or increase their excess (affecting [ ] members). In contrast, [ ] policies were upgraded to a higher tier of coverage (affecting [ ] members) and [ ] policies had their excess reduced or removed (affecting [ ] members). Furthermore, in FY2026 SCHI saw approximately [ ] members cancelling their SCHI insurance. It is unclear how many switched to other insurers or exited private insurance entirely.

332.6 An SCHI survey of data estimates that [ ] of the cancelling members recorded switching to a competitor. However, this result should be considered tentatively as [ ].[427]

333. More generally, customer switching may be easier within an insurance provider, and customers may face some barriers switching to other insurers which limits the viability of customer switching. The practicality and attractiveness of switching insurers will depend on the individual members circumstances. Relevant consideration may include their age, health needs, existing level of cover, treatment

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424 Ibid.

425 Ibid.

426 Ibid. However, SCHI cannot definitively separate the observed impact between cost-based premium increases and age-band related increases, as customer decisions are often made some time after a premium change and may also be influenced by renewal timing, employment changes, or other life events. However, the trend provides quantitative evidence that periods of significant premium increases are associated with [ ]

427 SCHI response to RFI dated 1 July 2026 (3 August 2026) at page 10.

history (pre-existing conditions), premium affordability and the availability of alternative products.[428]

334. NERA, on behalf of SCHI, has submitted that:[429]

334.1 From the literature, insurance premiums reflect expected claims costs. Premiums are primarily determined by expected claims costs across the insured pool. As average claims costs per member increase, premiums must also rise.

334.2 Again, from the literature, higher provider prices ultimately increase insurance costs. Persistent increases in healthcare prices raise insurers' average claims costs, reducing any surplus over claims costs unless offset by higher premiums or lower claims volume. Insurers respond by increasing premiums, removing or reducing benefits, or negotiating lower provider prices.

334.3 While SCHI is a friendly society, in line with its pricing principles, premiums are set to meet expected claims costs, operating expenses and solvency requirements. Thus, while SCHI is not targeting profits for shareholders in its pricing, the relationship between expected claims costs and premiums still holds. As a result, provider costs ultimately place upward pressure on premiums, policy coverage and terms, or SCHI's financial position, rather than generating shareholder returns.[430]

335. NZGA in its cross-submission stated that although SCHI is a not-for-profit society so has no ability or incentive to depress gynaecology surgery prices below sustainable levels,[431] funding decisions made by management can diverge from SCHI members' long to long-term interests where they try to limit costs, and that SCHI is unable to identify what a "sustainable" fee is without workforce engagement.

Our preliminary view

336. The evidence before us suggests that:

336.1 as set out above, we expect bargaining power in the factual will lead to higher surgical fees paid by SCHI;

336.2 SCHI's insurance premiums are related to its costs, as premiums are determined with reference to expected claims costs, operating expenses, and solvency requirements. As a friendly society, SCHI does not seek to generate returns for external shareholders. Although the relationship between gynaecology costs and premiums is unlikely to be one-for-one, because

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428 SCHI response to RFI dated 1 July 2026 at (3 August 2026).

429 NERA "Assessment of claims benefits of collective bargaining by gynaecologists: Report for Southern Cross Medical Care Society" (3 August 2026) at 9B-C.

430 NERA "Assessment of claims benefits of collective bargaining by gynaecologists: Report for Southern Cross Medical Care Society" (3 August 2026) at [32].

431 NZGA cross-submission on SOPI (4 August 2026) at page 7.

premiums are set having regard to SCHI's broader portfolio of costs and risks, increases in gynaecology costs would nevertheless be expected to place upward pressure on premiums charged to SCHI members;

336.3 in response to higher health insurance premiums, some SCHI members may choose to forfeit their private health insurance, increase their excesses, or downgrade to a less preferred private health insurance plan (ie, it results in allocative efficiency losses).
[
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336.4 where consumers have forfeited private health insurance, they would likely rely on the public health system going forward as there are barriers to regaining private health insurance.

337. Therefore, we expect that the higher gynaecology fees that SCHI is likely to pay in the factual compared to the counterfactual will place upwards pressure on the premiums that SCHI charges. It is unclear precisely how large of an effect these higher fees would have on insurance premiums.

338. In response to premium increases, SCHI members may switch to a lower tier plan, increase their excess, remove optional modules, switch to another insurer (noting the barriers discussed above), or leave the private insurance market all together.[432] This is how customers have responded in the past to premium increases. Within our framework this would be a loss of allocative efficiency.

339. In the factual, SCHI may seek to reduce the scope of cover for gynaecology services (or other areas that it covers) to maintain affordability.[433, 434] For members requiring those surgeries that are not covered, or only partially covered (eg, if SCHI introduced caps or co-payments), reduced coverage may cause some members to forgo or delay surgery in a private hospital, or rely on the public health system if they are unable to pay for the work required.

340. In response to higher costs, SCHI
[
]435 As higher gynaecology costs would be shared amongst
[ ] allocative efficiency losses may be higher as premium increases would be [ ].

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432 We reach no view on whether switching to an inferior policy, increasing excesses, removing optional modules or switching to another insurer would lead to greater allocative efficiency losses.

433 SCHI submission on SOPI (16 June 2026) at [5.3(b)].

434 Interview with SCHI (18 June 2026).

435 SCHI response to RFI dated 1 July 2026 (3 August 2026) at page 4; SCHI response to RFI dated 6 August 2026 (27 August 2026) at pages 3-4.

341. Finally, we note that at least in theory, higher premiums (linked to higher gynaecology costs in the factual) may exacerbate concerns regarding adverse selection. That is, higher premiums or reduced benefits make private health insurance less attractive, particularly for lower risk individuals (individuals who claim less) who may in response forfeit their policy. This leaves a member pool containing a disproportionate share of high-risk individuals which would lead to higher premiums as the remaining members claim more. This in turn, can lead to a reinforcing cycle of less insurance coverage and higher insurance premiums.[436] However, it is unclear if in practice collective bargaining by NZGA would significantly contribute to adverse selection risk for SCHI.

342. Cumulatively, as SCHI's customers respond to higher premiums by switching to lower-tier plans, increasing their excess, removing optional modules, switching to another insurer (noting the barriers discussed above), or leaving the private health insurance market altogether, and as SCHI may respond by reducing coverage, health outcomes for affected individuals may worsen. Individuals may forgo treatment altogether or delay treatment while they self-fund or seek care through the public health system. This may, in turn, place additional pressure on the public healthcare system. Moreover, these effects on both health outcomes and the public healthcare system may extend beyond gynaecological services to all procedures for which customers were previously insured.

343. The magnitude of allocative efficiency losses to consumers caused by higher premiums will depend on:

    343.1 the fees negotiated between SCHI and NZGA (via hospitals), which cannot be determined prior to those negotiations occurring (although our preliminary view, as discussed above, is that fees will be higher than in the counterfactual);

    343.2 the effect this has on premiums and/or coverage; and

    343.3 ultimately, how many customers cancel or reduce their health insurance cover.

344. Given it is not clear how large the difference in premium would be in the factual, we have conservatively taken the view that the magnitude associated with this detriment is small. We nevertheless do consider this is a likely outcome from the Proposed Arrangement. Higher reference prices

345. We have considered in this section whether allocative efficiency losses might arise from the Proposed Arrangements establishing points of reference that may place upwards pressure on the fees that gynaecologists charge to other sources of funding

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[436] NERA "Assessment of claims benefits of collective bargaining by gynaecologists: Report for Southern Cross Medical Care Society" (3 August 2026) at [2.3.3].

(including self-funded patients and Health NZ). The points of reference could arise from either or both NZGA and its members preparing to collectively bargain and from any fee schedule(s) agreed by SCHI and/or hospitals. This may result in subsequent premium increases and/or reductions in coverage by other insurers, which ultimately could result in their customers switching to otherwise inferior or less satisfactory products. It may also result in self-funded patients deferring or avoiding treatment, and public funders procuring fewer services. The size of this potential allocative efficiency loss likely depends on how much higher the reference point is compared to the counterfactual, and the certainty that members have over this reference point. It is the resulting loss of allocative efficiency rather than the changes in fees itself which is considered as a detriment within our assessment.

Submissions received

346. SCHI submitted that, if authorised, the Proposed Arrangements would involve the exchange of competitively sensitive information - including information about NZGA members' current pricing, cost structures, and approaches to contracting. Once members had established a collectively negotiated reference price, that would become a price floor below which no surgeon would charge, with a particularly strong inflationary effect on prices given the wide variation in surgeon pricing.[437]

347. ACC and nib NZ raised concerns and Health NZ noted that the Proposed Arrangements would lead to a point of reference for gynaecology surgery fees that would overall lead to higher gynaecology costs paid by them respectively.[438]

348. nib NZ raised concerns that the Proposed Arrangements would result in higher healthcare costs.[439] In nib NZ's experience,
[ ].[440]
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349. UniMed also raised concerns that it may incur higher prices if authorisation was granted as the prices agreed between NZGA/gynaecologists and SCHI may set a new price floor and lift other existing providers currently pricing lower to the new prices.[442] Conversely, UniMed also raised the possibility of a waterbed effect occurring in the counterfactual, where the gynaecologists may seek to recover perceived losses by increasing prices to other insurers.

350. Health NZ submitted that any upward or standardising effect on specialist remuneration will influence pricing negotiations with Health NZ, and to the extent that collective bargaining increases costs or reduces flexibility in how hospitals

437 SCHI submission on SOPI (16 June 2026) at [9.6(c)].
438 Health NZ submission on SOPI (10 June 2026) at page 2; ACC submission on SOPI (2 July 2026) at pages 2 - 3; nib NZ submission on SOPI (19 June 2026) at page 20.
439 nib NZ submission on SOPI (19 June 2026) from [12 to 15].
440 Interview with nib NZ (7 July 2026).
441 Interview with nib NZ (7 July 2026).
442 Interview with UniMed (28 July 2026).

engage specialists, there may be implications for Health NZ's ability to use the private sector to manage demand and impact access to health care.[443]

351. ACC's submission was focused on the detriments associated with structured pricing in general and how they could constrain ACC's ability to negotiate differentiated terms or respond to variation in provider performance and clinical practice.[444, 445]

352. NZGA submitted that it would only seek a small reduction from current FFS levels and that it neither seeks nor could achieve higher prices charged to other funders.[446] NZGA also submitted that any reference price or anchoring effect arises not just from collective bargaining but "*equally from SCHI's own proposal for uniform pricing*."

353. NZGA also submitted that a SCHI-based reference price would not apply to ACC or Health NZ because ACC has its own statutory bargaining framework and Health NZ purchases services under its own contractual arrangements and budgetary frameworks.[447] NZGA also noted that ACC and Health NZ make up a small share (less than 5%) of a typical private gynaecologist's cases and so any passthrough impacts would be unlikely or minimal.[448]

354. NZGA further submitted that price reductions in one part of a gynaecologist's activities (eg, through lower fees through APS) may conversely cause gynaecologists to seek to recover lost revenue from Health NZ and ACC.[449] NZGA did not provide any evidence that gynaecologists would price in this manner except to note that gynaecologists generally charge 10% lower for ACC/Health NZ work under the status quo.[450]

355. NZGA clarified that in preparing to bargain with SCHI and/or hospitals, member-level information would not be disclosed to competing members.[451] The wider membership would receive only aggregated conclusions, general clinical and operational findings, and the proposed collective position. NZGA did not rule out that NZGA's opening position would be agreed or viewed by its members.

Our preliminary view

356. Allocative efficiency losses may arise where the reference prices developed in the factual (by NZGA in preparing to collectively bargain and/or by NZGA and SCHI as a result of the Proposed Arrangements) inform what gynaecologists charge to other funders or place upwards pressure on those prices, this may lead to a degree of allocative efficiency loss associated with forfeiture of private health insurance or

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443 Health NZ submission on SOPI (9 June 2026) at pages 1 and 2.
444 ACC submission on SOPI (1 July 2026).
445 We note that we expect some form of structuring around prices to occur within the context of the APS in both the factual and the counterfactual. The primary difference would lie in the level of those fees.
446 NZGA cross-submission on SOPI (4 August 2026) at [19-21].
447 NZGA cross-submission on SOPI (4 August 2026) at page 8.
448 NZGA cross-submission on SOPI (4 August 2026) at page 5.
449 "Waterbed effects" are discussed in the Application at [11.5(f)].
450 Interview with NZGA (13 July 2026).
451 NZGA response to RFI dated 30 July 2026 (18 August 2026) at [49].

downgrading of health insurance plans, reduced ability by self-funded patients to afford private healthcare, and fewer outsourced public procedures. As noted in the discussion of the preceding detriment – **higher SCHI premiums and/or reduction in coverage** - customer response to higher premiums may result in worse health outcomes, and increase the strain on the public health care system. This is in addition to the increased strain imposed by the potentially higher costs that Health NZ may face when outsourcing gynaecology procedures.

357. We have considered two points of reference that may be used. The first is the prices developed by NZGA for the purposes of its negotiations with SCHI (even if these are not the prices eventually agreed) (**prepared prices**). To prepare for negotiations with SCHI, NZGA would develop a set of prices to put to SCHI.[452] NZGA may consult members on those prices to ensure the opening position is acceptable.[453]

358. The second set of reference prices we have considered is the prices resulting from negotiations between NZGA, SCHI and/or hospitals (**agreed prices**). These prepared and agreed prices may differ by region, hospital, or other factors. As noted in the section ***The situation with the Proposed Arrangements (factual)***, we expect the agreed fees to be higher than fees in the counterfactual, and note that there is a mismatch between SCHI's desire for structured pricing under its APS and the varied fees charged by gynaecologists under FFS.

359. We consider that authorisation would reduce the asymmetry that gynaecologists have around how much each other charges, or is willing to accept, on a FFS basis.[454] In this context:

    359.1 gynaecologists who under FFS charge lower than both the prepared and agreed prices may decide to charge more to non-SCHI funders with reference to either the prepared prices or the agreed prices;

    359.2 gynaecologists who under FFS charge above the prepared prices may continue to charge non-SCHI funders at higher rates;

    359.3 gynaecologists who under FFS charge between the prepared prices and the agreed prices might be tempted to charge at (or closer to) the prepared prices to non-SCHI funders.

360. The presence of a most favoured nation clause would place a significantly higher likelihood on gynaecologists increasing the fees that they charge to other funders, as

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452 Interview with NZGA (13 July 2026).

453 We note it is possible some gynaecologists may already understand to some extent what other surgeons charge, but this is unlikely to be comprehensive or systematic and therefore not reliable as a point of reference in the same way the prepared prices would be. For example, [ ] was aware of another gynaecologist who charged twice as much for a particular procedure. Interview with [ ] (29 July 2026)].

454 We note gynaecologists would continue to compete on reputation and win work through GP referrals as they do under FFS as described in the section ***Patient pathway***. This means gynaecologists would not win additional work by offering lower prices to non-SCHI funders. Patients funded via Health NZ and ACC are allocated according to the relationships between the hospitals and those entities.

fees would have to be at least as high as the collective bargained prices they have extracted from SCHI. While [ ],[455] [ ] [456] It is not clear to us whether future AP contracts signed in the implementation of the APS to gynaecology would include a most favoured nation clause.

361. We nonetheless preliminarily consider that gynaecologists who would otherwise charge lower than the prepared or agreed prices to non-SCHI funders in the counterfactual may increase their fees to match the prepared fees or agreed fees, resulting in higher claims costs for private insurers and resulting allocative efficiency losses.

362. The variation in fees charged by gynaecologists under FFS means that there may be a material number of gynaecologists who charge higher rates to other funders in the factual. SCHI provided evidence of significant variation in the fees charged by gynaecologists under FFS, with gynaecology surgeon fees ranging from approximately [ ].[457] These significant variations exist within specific geographic regions. Figure 4 below, which uses hysterectomy surgical pricing, demonstrates this. There is therefore scope for lower charging surgeons to increase their FFS prices if the prepared and agreed prices are higher than their status quo FFS prices. While this figure shows SCHI's experience with variable FFS fees, this is consistent with evidence from other funders.[458]

Figure 4: [[459]

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363. nib NZ stated that while surgical complexity is a relevant consideration when assessing surgeon fee variation, it is not consistent with information it holds. As surgeons predominantly receive patients through established referral pathways they would generally expect the distribution of case complexity to be relatively consistent across the provider pool. However, [

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455 SCHI response to RFI dated 1 July 2026 (3 August 2026) "SCHI Template AP Agreement".

456 [ ].

457 SCHI submission on SOPI (16 June 2026) at [5.2 (b)(iii)], Figure 9.

458 Interviews with UniMed (28 July 2026), nib NZ (7 July 2026).

459 [ ]

460 nib NZ response to RFI dated 30 July 2026 (27 August 2026) at pages 6-7.

Impact on other insurers

364. We first consider potential allocative efficiency losses associated with higher gynaecology cost claims paid by other private insurers, by considering the effect of higher gynaecology costs on their premiums and customer responses to higher premiums.

365. For other insurers, like SCHI, increases in gynaecology claims costs are not directly linked with increased premiums on a one-to-one basis but rather, premiums are calculated with reference to a host of factors including expected claims costs and measures available to reduce claims, operational costs, and profit expectations.

366. UniMed and nib NZ provided evidence about their approaches to mitigating claims costs.

366.1 nib NZ pays specialists on a FFS basis and optimises its network by listing all the providers for a particular specialty on its website as part of its First Choice Network (FCN) and include policy terms requiring reasonable charges.[461] Any providers charging over what nib NZ considers to be an efficient price can be excluded from the FCN, meaning members are not guaranteed to be fully reimbursed should they choose that provider. However, nib NZ does not have the same scale as SCHI nor the market share or volume to negotiate in the way SCHI does. It is more effective for nib NZ to have the FCN and monitor fee outliers. In response to recent claims inflation, nib NZ redesigned some of its products by adding a co-payment.

366.2 UniMed's premiums reflect [ ].[462] It is also a not-for-profit entity, so makes a small profit margin of approximately [ ].[463] As UniMed compensates on a FFS basis, they have [ ] tools available to control rising costs and also more limited scale to pool rising gynaecology costs against. They may require charges to be reasonable but aim to cover [ ] of the range of costs they see. [ ][464]

367. UniMed and nib NZ also provided evidence on the ability of customers to switch and their sensitivity to price increases.[465]

368. Like SCHI members, UniMed's members may generally be able to reduce their premiums by moving to a plan with reduced cover, removing optional benefits or modules, increasing a voluntary excess or removing dependents.[466] Although their

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461 Interview with nib NZ (7 July 2026), nib NZ "Health Insurance Claim | How To Claim" (30 May 2019) https://www.nib.co.nz/free-resources/article/how-to-claim.

462 UniMed response to RFI (13 August 2026).

463 Interview with UniMed (28 July 2026).

464 Interview with UniMed (28 July 2026).

465 UniMed response to RFI dated 30 July 2026 (13 August 2026), nib NZ response to RFI dated 30 July 2026 (27 August 2026).

466 UniMed response to RFI dated 30 July 2026 (13 August 2026).

data does not definitively indicate customer elasticity, UniMed observed that following a 2025 premium increase:[467]

368.1 [ ] policies added or increased excesses between August to December 2025 compared with [ ] adding or increasing excesses between August to December 2024;

368.2 [ ] policies reduced cover between August to December 2025 compared to [ ] policies reducing cover between March to July 2025;

368.3 [ ] policies removed an optional module between August to December 2025 compared to [ ] policies reducing cover between March to July 2025;

368.4 [ ] policies removed one or more insured lives between August to December 2025 compared to [ ] policies reducing cover between March to July 2025; and

368.5 [ ] policies were cancelled for any reason compared to [ ] policies reducing cover between March to July 2025. Of these policies, [ ] cancellations were recorded as being for affordability reasons, and most were [ ].

369. For customers switching to UniMed, there is [ ] underwriting for entry to cover for employer-sponsored group members and [ ] underwriting applied for retail members
[ ].[468] While UniMed holds imperfect data on customers switching to other insurers, it estimates that between [ ] to [ ] of cancellations were to other insurers between 2019 to 2025.[469]

370. This indicates that UniMed's customers are more likely to [ ] or [ ] before they forfeit private healthcare altogether.

371. nib NZ's customers may similarly downgrade or change cover to reduce premiums. However,
[ ][470]
[ ][471]

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467 UniMed cannot determine from the aggregate data whether these changes were caused by the premium increase. UniMed response to RFI dated 30 July 2026 (13 August 2026).

468 UniMed response to RFI dated 30 July 2026 (13 August 2026).

469 Ibid.

470 nib NZ response to RFI dated 30 July 2026 (27 August 2026) at pages 2-3.

471 nib NZ response to RFI dated 30 July 2026 (27 August 2026) at page 3.

372. nib NZ's experience is that its members are [ ] to premium increases. Healthcare cost inflation and rising utilisation have generally outpaced wage and salary growth, and this has been compounded by wider cost of living pressures experienced by its members.[472] nib NZ has seen that when its members are faced with premium increases, members seek to reduce the cost of their cover through measures including removal optional benefits, increasing excess levels, moving to a lower tier of cover, seeking premium holiday arrangements, and in some cases cancel their cover altogether.[473] Following a [ ] average premium increase in the last 12 months, nib NZ's membership
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[474]

373. The evidence indicates that higher gynaecology claim costs may be absorbed across insurance companies' wider books, that it is not clear that adverse selection risk would occur to the same extent across all insurance companies
[
], and that they may have some limited tools to address higher costs. Because of this we consider that there is likely to be a small detriment associated with allocative efficiency losses from higher reference prices as they impact other insurers' customers. We note that the higher the reference prices are compared to counterfactual prices, the larger the detriment may be.

<u>Impact on Health NZ, ACC and self-funded patients</u>

374. The link between higher agreed and/or prepared prices and the associated allocative efficiency losses for consumers that self-fund or are funded through ACC or Health NZ is more direct.

375. Even if the references prices themselves are not precisely what is charged to the funder (for instance, we understand that self-funded patients are typically offered discounts, and ACC's and Health NZ's prices are generally lower than what is charged to insurers and calculated differently), these prices may still act as an anchoring point to the overall direction of pricing.

376. The prices paid by ACC and Health NZ may be pushed higher in order to ensure a sufficient number of gynaecologists are willing to perform the work outsourced to the private system. We have been told that gynaecologists have waiting lists and that there is a shortage of surgeons to perform the work.[475] This may lead to allocative efficiency losses associated with fewer outsourced surgeries performed within a fixed organisational budget, or reallocation of public funding that could have been spent on additional healthcare elsewhere within the public system. This is particularly the case for Health NZ, as we have received evidence that in some

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472 Ibid.
473 Ibid.
474 Ibid.
475 Interview with NZGA (13 July 2026).

contexts Health NZ funds anywhere between 5%[476] to [ ] of gynaecology surgeries.[477]

377. Similarly, self-funded patients may be charged higher rates than in the counterfactual (even if those fees are lower than those paid by SCHI). This may cause those patients to forfeit or delay surgery.

378. Finally, it is unclear if waterbed effects would occur in the counterfactual arising from gynaecologists seeking to recover lost revenue.[478] Firstly, the ability of gynaecologists to raise prices to other funders appears to be unchanged between the FFS and APS, secondly the likely squeeze on profit does not seem likely to be sufficient, and lastly the market does not appear to have the features that commonly facilitate waterbed effects.[479] In contrast, we consider that the Proposed Arrangements will establish reference points that increase the likelihood gynaecologists charge higher fees to other funders.

Overall view

379. Overall, we consider that the allocative efficiency losses associated with higher gynaecological surgery fees charged to insurers, Health NZ and self-funded patients (and to a lesser extent ACC) in the factual to be small and likely.

Reduction in the private hospital provision of facilities for gynaecology

380. As part of our assessment, we have considered the potential for an allocative efficiency loss from a reduction in the private hospital provision of facilities for gynaecology. We assessed whether this loss of allocative efficiency would arise from the Proposed Arrangements supressing the facility fees that hospitals receive in relation to gynaecology to a level that would result in hospitals reducing their supply of facilities to gynaecologists.

Submissions received

381. We understand that within an APS framework SCHI would agree a bundled procedure price that it pays to the hospital, which would then contract with the surgeon and anaesthetists and reach an agreement on how the bundled fee is allocated between the hospital, surgeon and anaesthetist.[480] We have heard from hospitals that absent the Proposed Arrangements it is unclear that there is a bargaining imbalance between individual gynaecologists and hospitals, and if the

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476 NZGA cross-submission on SOPI (4 August 2026) at page 5.

477 Approximately [ ] of gynaecology surgeries are funded by Health NZ or ACC at Southern Cross branded hospitals. Interview with SC Hospitals (9 July 2026). At Braemar Hospital, approximately [ ] of gynaecology work is attributable to private funders and the remaining is split between ACC and Health NZ. However, [ ] Interview with Braemar Hospital (1 July 2026). At St George's Hospital, approximately [ ] of its overall work is funded by Health NZ. Interview with St George's Hospital (6 July 2026).

478 Application at [11.5(f)].

479 Aaron Schiff The "Waterbed" Effect and Price Regulation Review of Network Economics – Vol 7, Issue 3 – September 2008.

480 *Connor Healthcare Limited and Acurity Health Group Limited* [2014] NZCC 39 at [70] and [71].

Proposed Arrangements were authorised there are concerns this would have a material impact on hospital margins and their ability to provide facilities for gynaecological procedures.

382. Absent the Proposed Arrangements, it is unclear that there is a bargaining imbalance between individual gynaecologists and hospitals.

382.1 Surgeons can move frictionlessly between hospitals. Surgeons are often (at least in major centres) credentialled at, and actively work across, multiple hospitals.[481] As a result, and regardless of the funding model, hospitals compete vigorously to attract surgeons to their facilities,[482] as surgeons ultimately decide which patients to treat at which hospital.[483]

382.2 Hospitals may be limited in their ability to credibly threaten not to deal with gynaecologists. Across NZPSHA members, gynaecology represents approximately 6-7% per year of their total number of discharges over the last five years.[484] Some more specialised hospitals have a stronger focus on providing facilities for women's health, and at these facilities the volume of gynaecology surgeries and contribution to total revenue can be much higher.[485] Furthermore, across hospitals that provide gynaecology services there has likely been some investment into gynaecology equipment and training which cannot be transferred to other specialities.[486]

382.3 In some regions hospitals may benefit from being the only private hospital in the region.[487] However we have heard that in these regions hospitals may still have to compete for surgeons with hospitals from outside the region.[488]

383. In circumstances where hospitals are required to negotiate with a collective NZGA, hospitals have submitted that the price hospitals pay would likely rise (relative to the counterfactual where there is no collective bargaining and instead bilateral negotiations).[489] And those prices would rise even if the bundle the hospital received from SCHI does not rise.[490] This would put pressure on hospitals margins and could ultimately result in a reduction in the investment and provision of gynaecology services.[491]

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481 Allevia Hospitals submission on SOPI (17 June 2026) at [8.2], Interviews with [ ] (29 July 2026), [ ] (29 June 2026).

482 Allevia Hospitals submission on SOPI (17 June 2026) at [8].

483 Allevia Hospitals submission on SOPI (17 June 2026) at [8.3(c)], Interview with SC Hospitals (9 July 2026). There may be some limited input by patients in deciding which hospital to have the procedure at. Interviews with [ ] (29 July 2026), [ ] (29 June 2026).

484 Calculated from NZPSHA response to RFI dated 22 July 2026 (24 July 2026) "2025 Statistics".

485 Interview with [ ], Allevia Hospitals submission on SOPI (17 June 2026) at [8.3(a)].

486 Allevia Hospitals submission on SOPI (17 June 2026) at [8.3(a)].

487 Interview with [ ].

488 Interviews with Mercy Hospital (25 June 2025) and [ ] (26 June 2026).

489 [ ] at [14].

490 Interview with Braemar Hospital (1 July 2026).

491 [ ] at [14], [ ].

384. NZGA has submitted that the extent of any hospital level engagement will be solely because of, and will depend on, the model SCHI ultimately chooses and how hospitals implement it.[492] NZGA submitted that SCHI and hospitals are acting in concert under a combined contractual initiative and that many of the hospitals have passed down fees (whether passively or in agreement with SCHI). NZGA found that pricing lists from different hospitals were near-identical for each procedure, [493] and submitted that hospitals benefit from aligning with SCHI's proposal to bundle fees stating that it would allow hospitals to determine the allocation of bundled fees and to take margin from gynaecologists and anaesthetists (risking double marginalisation).[494] However, NZGA has also recognised that if collectively negotiated fees for gynaecology increased while bundled fee remained unchanged, this could compress margins for hospitals (and anaesthetists).[495]

Our preliminary view

385. Our provisional view is that there does not appear to be an imbalance of bargaining power between individual gynaecologists and hospitals in the counterfactual. We have considered the bargaining dynamics affecting hospitals under the Proposed Arrangements against this baseline.

386. Within a fixed funding envelope, we consider the interdependency of hospitals and surgeons limits the likelihood of allocative efficiency losses that could arise from hospitals reducing the provision of facilities for gynaecology surgeries in response to reduced margins. In both the factual and counterfactual, a hospital cannot earn the relevant bundled payment or utilise its theatre capacity without attracting suitably qualified surgeons to perform surgeries.[496] At the same time a gynaecologist requires access to the facilities at hospitals to be able to complete their surgeries. This dynamic holds regardless of the funding model and results in hospitals competing for surgeons.[497]

387. When competing for surgeons, hospitals develop the composition of their surgical 'lists' to maximise the utilisation of facilities, in addition to broader objectives such as providing a full suite of surgical services to their region.[498] When developing its surgical lists SC Hospitals submitted that its main aim is to get the volume mix right. Compared to price, volume is more important in determining the financial position of a hospital.[499] They consider that this is also true for gynaecologists, as it is likely more financially rewarding for surgeons to complete an additional surgery in a list than it is to increase their fees across surgeries.[500] However, within the fixed funding envelope it is possible that NZGA may be able to extract a higher proportion of the bundled fee

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492 NZGA supplemental submission (26 June 2026) at [1-2].
493 NZGA cross-submission on SOPI (4 August 2026) at page 7.
494 NZGA supplemental submission (26 June 2026).
495 Application at [5.49].
496 NERA "Assessment of claims benefits of collective bargaining by gynaecologists: Report for Southern Cross Medical Care Society" (3 August 2026) at [118].
497 Interview with SC Hospitals (9 July 2026).
498 Ibid.
499 Ibid.
500 Ibid.

before hospitals reduce the provision of facilities for gynaecological care. For example:

387.1 a hospital that is underutilised and has capacity to accommodate further supply of gynaecology may already be trying to attract gynaecologists to increase its utilisation.[501] These hospitals may be willing to accept an increase in gynaecologist fees to attract volume to their facility. The limit of the increase in fees depends on the costs of providing the facilities for surgery, as a hospital would likely be unwilling to provide facilities at a loss; and

387.2 a hospital that faces excess demand may only be willing to accept an increase in gynaecologist fees without reducing volume, up to the point that it becomes more profitable to provide their facilities to other specialities. At this point the hospital may adjust the composition of its surgical lists, reducing the spaces provided to gynaecology. The effect this has on gynaecologists would extend beyond their SCHI patients as their lists include patients of all funding backgrounds.[502] The point at which hospitals may reduce the provision of facilities to gynaecologists may be delayed by their wider objectives such a providing a full suite of surgical facilities to their region.

388. However, we consider NZGA and hospitals are unlikely to reach an agreement within their current funding envelope as NZGA looks to achieve prices significantly different from those estimated in the counterfactual.
[

].[503] As discussed in the previous sections, SCHI requires a sufficient mass of surgeons at a hospital to agree to the APS before SCHI can implement it. Additionally, SCHI is contractually bound to its members to fund eligible gynaecology surgical treatment, meaning it may not have the option of simply "walking away" if it considers surgeons prices to be too high and is also obliged to achieve adequate provider coverage for its members.[504] Therefore, to the extent that NZGA and hospitals are not able to reach an agreement within the current funding envelope, SCHI may have to reconsider the bundle it provides in order to maintain the provision of gynaecology services at hospitals. The link between SCHI having higher costs and allocative efficiency losses has been discussed above in the section ***Higher SCHI premiums and/or reduction in coverage***.

389. Finally, in the unlikely scenario where NZGA's Proposed Arrangements achieve gynaecologist fees that causes hospitals to reduce their supply of facilities for gynaecology, there may be an (partial) offsetting of allocative efficiencies losses as

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501 [ ] at [8.4].
502 [ ].
503 SCHI cross-submission on SOPI (3 August 2026) at [6.2(b)].
504 Ibid at [3.20(c)].

more facilities are provided to other specialities as hospitals rebalance the composition of their surgical lists.

Reduction in innovation

390. As part of our assessment, we have considered the potential for a dynamic efficiency loss from a reduction in innovation. We assessed whether this loss of dynamic efficiency would arise from either hospitals or gynaecologists reducing their investment in innovation, along with the concerns that gynaecologists may compete less on innovation.

Submissions received

391. Hospitals have submitted that the relationship between the extent of innovation and gynaecologist fees is unclear. They submit that the bulk of innovation in gynaecology arises from adopting new technologies and instruments. Hospitals invest in these features rather than gynaecologists, along with the attached operating costs.[505]

392. A hospital's decision to purchase new technologies and instruments is driven by a number of factors.

392.1 Firstly, hospitals will invest in new technologies and instruments to attract surgeons to their facilities and make use of their operating theatres.[506] As explained above hospitals look to make efficient use of their facilities by having full lists which they achieve by competing for surgeons.

392.2 Secondly, a hospital's decision to invest in new technologies and instruments is a multi-factorial business decision.[507] Hospitals will look for new technology that is commercially viable, and can improve patient outcomes.[508] However, it is possible that hospitals may fund some innovation that is not well reimbursed if surgeons want to use it.[509, 510] Additionally, where a new procedure or technology is introduced, hospitals, credentialling bodies and professional colleges require assessment of the evidence, practitioner competence, facility capability, patient safety considerations and ongoing outcome monitoring before it becomes part of routine practice.[511] SCHI has submitted that where new procedures, technologies or techniques demonstrate benefits for members SCHI's existing governance processes

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505 Allevia Hospitals submission on SOPI (17 June 2026) at [21], Interviews with St George Hospital (6 July 2026), SC Hospitals (9 July 2026).

506 Interviews with St George's Hospital (6 July 2026), Allevia Hospitals (18 June 2026).

507 Interview with Boulcott Hospital (23 June 2026).

508 Interviews with Boulcott Hospital (23 June 2026), Grace Hospital (30 June 2026).

509 [ ].

510 It appears that the investment requirements within the public sector may be more strict, as it will only take on a technology if it gives them a return on investment. Interview with Grace Hospital (30 June 2026).

511 SCHI cross-submission on SOPI (3 August 2026) at [10.5].

allow for consideration of policy coverage and the development of appropriate funding mechanisms.[512]

392.3 For example, hospitals decide whether to invest in facilities to enable robotic surgery based on several factors, of which SCHI funding availability is one.[513] Robotic surgery is already included under SCHI's APS, including for gynaecology surgery. We understand the application of the APS to robotics was driven by several factors, including that robotic surgery can add significant cost, SCHI did not consider it provided value for money in all contexts, and it could be excluded because SCHI had visibility of robotic specific consumables that needed to be used. SCHI will continue to undertake its own cost-benefit analysis informing eligibility criteria for surgeries, taking into account both patient outcomes and likely claims costs arising without those criteria.[514]

393. NZGA has submitted that clinical innovation depends equally on surgeons to gain expertise.[515] While hospitals purchase the equipment used by specialists the new technology has no value unless surgeons invest time and money into training to learn new techniques and technologies.[516] Therefore, individual gynaecologist contributions to innovation are the result of adopting improvements and innovations. We have heard that much of the innovation learning takes place in public hospitals because of the variety of procedures, and availability of research grants and opportunities for clinical trials.[517] Surgeons at private hospitals may have to self-fund trainings. For example, NZGA has indicated that one of the costs for operating a gynaecology practice is Mandatory Continuing Professional Development (CPD) requirements for gynaecologists and their staff, and RANZCOG educational requirements.[518] However, surgeons still do not typically bear the cost of investment in physical innovations.[519]

394. NZGA has also submitted that gynaecologists may be less inclined to compete on innovation if compensation is materially reduced and / or below workably competitive pricing.[520] However these concerns are primarily concerned with the approach to APS coding which is discussed above at ***Health benefits***. In contrast, SCHI has submitted that if gynaecologists are permitted to coordinate, the incentive to innovate to achieve costs savings and offer better services will reduce.[521]

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512 SCHI cross-submission on SOPI (3 August 2026) at [3.8].

513 Interview with St George's Hospital (6 July 2026).

514 We consider it unlikely that even if authorised to collectively negotiate that SCHI would cede power over the extent of its policy coverage to a professional group, as that professional group does not have information on claims costs.

515 NZGA cross-submission on SOPI (4 August 2026) at page 8.

516 Ibid.

517 Interview with Boulcott Hospital (23 June 2026) and NZGA "NZGA Q&A" (14 July 2026) at [36] and [39].

518 NZGA "NZGA Q&A" (14 July 2026) at [11(j)- 11(k)], pages 2-3.

519 Allevia Hospitals submission on SOPI (19 June 2026) at [21].

520 Application at [2.19(d(i))].

521 SCHI submission on SOPI (16 June 2026) at [9.6(o)], SCHI cross-submission on SOPI (3 August 2026) at [6.2(o)].

Our preliminary view

395. The evidence indicates that gynaecologists and hospitals have a joint role in driving innovation. Hospitals bear the financial burden of investment in new technologies and equipment while gynaecologists require the skills and know-how to engage with the new technology. While some of this training may be self-funded, for those that work within public hospitals it will likely be publicly funded.[522] We understand that this would be the case for many of NZGA members as there is a shared workforce between public and private hospitals.[523] Additionally, we understand that under APS, investment in innovation is one of the ways in which hospitals compete for surgeons and how surgeons may compete for either patients or hospital space.[524] It is not clear that the Proposed Arrangements will change this.

396. We do not consider it likely that if faced with the Proposed Arrangements SCHI would cede power over the extent of its policy coverage to a professional group, to decide which innovation should be funded, as that professional group does not have information on claims costs.

397. Therefore, a change in the fees that gynaecologists receive for treating SCHI patients may have limited impacts on their willingness to adopt new technologies. However, for hospitals, a reduction in margins may have an impact on their ability to invest in new technology. Although as discussed above, it is not clear that hospitals margins will be affected by the Proposed Arrangements, and we note that hospitals may still invest in innovation to attract gynaecologists.

Reduction in anaesthetist provision of services for gynaecology

398. As part of our assessment, we have considered the potential for an allocative efficiency loss from a reduction in anaesthetist provision of services for gynaecology. We assessed whether this loss of allocative efficiency would arise from the Proposed Arrangements supressing the fees that anaesthetists receive in relation to gynaecology to a level that would result in hospitals reducing their provision of services to gynaecologists.

Submissions received

399. NZSA member feedback for some time has indicated the AP model is no longer fit for purpose.[525] NZSA has submitted that it does not oppose the NZGA application for authorisation to bargain collectively with SCHI.[526] However, NZSA also submitted that authorisation may negatively impact the anaesthesia market and compress anaesthetists' shares of the bundle, while noting that it may encourage quality negotiation and integration of clinical expertise which could mitigate the

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522 NZGA "NZGA Q&A" (14 July 2026) at [36] and [39], page 15.
523 Application at [5.6].
524 Interview with SC Hospitals (9 July 2026).
525 NZSA submission on SOPI (3 July 2026) at [27].
526 Ibid at [3].

compression of fees. We have also heard that in response, anaesthetists may well seek to collective bargain with SCHI.[527]

400. NZGA has submitted that it cannot comment on proposed arrangements between SCHI / hospitals relating to anaesthetists.[528] To the extent that SCHI's proposal affects anaesthetists indirectly (via bundled payments) that is a feature of SCHI's proposal and a decision made solely by SCHI alone.[529] However, the Applicant acknowledges that if collectively negotiated fees for gynaecology were to increase while the bundled fees remained unchanged this could compress margin for hospitals and anaesthetists.[530] Others have also raised that the Proposed Arrangements are likely to increase the size of the overall bundle or reduce the payments to other providers involved in services with NZGA members.[531]

Our preliminary view

401. Anaesthetists are essential at every stage, before, during and after surgery.[532] A gynaecologist cannot complete surgery without an anaesthetist.

402. While anaesthetists are an essential input of surgical gynaecological the evidence does not indicate that anaesthetists are captive to gynaecology.

402.1 Anaesthetists can work across all surgical specialties. Although there are some subspecialties for which they can undertake additional training and increase their involvement in such as paediatrics and cardiology, gynaecology is not one of these subspecialties.[533] The choice of an anaesthetist to provide their services for gynaecology is primarily based on personal preferences and relationships with gynaecologists.[534]

402.2 It is common for anaesthetists in New Zealand to work a hybrid between public and private hospitals. Previous surveys of NZSA members indicate that at least 75% of NZSA members work some time in private practice and of those, their time working in private practice is a minority of their public/private mix.[535]

403. Because anaesthetists appear to be mobile across different specialities as well as between public and private hospitals it is not clear that NZGA could, or would have an incentive to, to negotiate fees in a way that reduced those received by anaesthetists. If anaesthetist fees are set too low, they could viably look to increase the services they provide to other specialties or increase the work they do within public hospitals. This would reduce the volume of surgeries that gynaecologists

527 Ibid at [31].
528 NZGA supplemental submission on SOPI (26 June 2026) at page 2.
529 Ibid at page 8.
530 Application at [11.29].
531 Professor Jaime King submission (on behalf of NZPSHA) (11 August 2026) page 5.
532 NZSA submission on SOPI (3 July 2026) at [12].
533 Ibid at [14].
534 Interview with [ ] (22 June 2026).
535 NZSA submission on SOPI (3 July 2026) at [15].

would be able to complete. Additionally, we note again that SCHI has submitted that as a members-focused friendly society, SCHI has a structural incentive to ensure that fees, including anaesthetists fees, are at levels that maintain an adequate supply of high-quality healthcare services for its members.[536]
[
].[537]

404. As a result, we consider it is unlikely that the Proposed Arrangements would lead to allocative efficiency losses from anaesthetists reducing the provision of services for gynaecology at the risk of gynaecologists no longer being able to complete surgeries, and any impact on the cost of SCHI has been discussed above under the section ***Higher SCHI premiums and/or reduction in coverage***.

Other benefits and detriments raised

405. In this section we address other benefits and detriments raised by interested parties.

Gender equity concerns

406. NZGA and the Australasian Gynaecological Endoscopy & Surgery Society (**AGES**) submitted that the Proposed Arrangements would mitigate gender imbalance in remuneration received by male and female gynaecologists by reducing reliance upon individual negotiation and increasing visibility of remuneration frameworks.[538] One gynaecologist also raised concerns that similar procedures undertaken specifically for men or women (ie, for women and men), would be compensated to a lower degree for gynaecologists.[539]

407. AGES provided evidence in support of the claim that there is a significant gender pay gap among medical specialists, referencing:

    407.1 a study linking Census and Inland Revenue data for the New Zealand public specialist workforce where it found that female medical specialists earned an average of 12.5% less per hour than male specialists in the same specialty;[540] and

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536 SCHI cross-submission on SOPI (3 August 2026) at [6.2(a)].

537 Ibid at [6.2(c)].

538 AGES submission on SOPI (19 June 2026); NZGA supplemental submission (26 June 2026), AGES response to RFI dated 25 June 2026 (3 July 2026).

539 Specifically that most prostatectomies (surgery to remove the prostate, posited as comparable to hysterectomies) are billed between [ ] Interview with [ ] (28 July 2026).

540 AGES response to RFI dated 25 June 2026 (3 July 2026), citing Sin I, Bruce-Band B, Chambers CNL. "The Gender Wage Gap Among Medical Specialists: A Quantitative Analysis of the Hourly Pay of Publicly Employed Senior Doctors in New Zealand. BMJ Open. 2021;11e045213. DOI: 10.1136. https://bmjopen.bmj.com/content/11/4/e045214.

407.2 a report from RANZCOG identifying that 61% of practising obstetricians and gynaecologists are female, 84% of specialists under 40 years are female, and 86% of trainees are female.[541]

408. On this point SCHI submitted that existing FFS pricing is decided by surgeons without influence by SCHI and that the majority of specialist gynaecologists in New Zealand are female and gynaecologists on average charge materially more than specialists in [ ].[542]

409. We have not received evidence that hospitals differentiate their AP fee schedules by gender or factors that would influence gender inequity.

410. Our provisional view is there is insufficient evidence of a gender pay imbalance in the remuneration of gynaecologists in New Zealand that may be ameliorated or mitigated through the Proposed Arrangements. While the reports from AGES are indicative of gender pay imbalances existing within the medical workforce generally, it is not clear that the same is true for gynaecology, and the reports primarily relate to employed specialists. We have therefore discarded this as a potential benefit arising from the Proposed Arrangements.

Impact on public health system

411. NZGA submitted that gynaecologists would be disincentivised to perform more complex procedures in private hospitals in the counterfactual, and that these procedures would be pushed to the public healthcare system, which is already pressured.[543]

412. One gynaecologist stated patients have increasingly relied on the private health sector because access to the public system has declined over time, particularly following the COVID-19 pandemic. As a consequence of this increased demand, and improvements to private health sector infrastructure, procedures performed in private facilities have become increasingly complex and resource intensive.[544]

413. Three gynaecologists gave evidence that in the counterfactual, there may be incentive for gynaecologists to reduce the work they do in the private sector in favour of more work in the public sector given the reduced discrepancy between income streams.[545] Another gynaecologist stated that the concern arises for very complex procedures where an approach that is not time-based may not lead to appropriate recompense for the complexity and work required. However, [ ] was not

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541 Sin I, Bruce-Band B. "Is the Pay of Medical Specialists in New Zealand Gender Biased?" Motu Working Paper 19-21. Motu Economic and Public Policy Research; 2019. DOI:10.29310/WP.2019.21. https://www.motu.nz/our-research/population-andlabour/ individual-and-group-outcomes/is-the-pay-of-medical-specialists-in-new-zealandgender-biased

542 SCHI cross-submission on SOPI (3 August 2026) at [5.2(e)].

543 Application at [2.19(c),(f)], and [5.33(b)(iv)].

544 Interview with NZGA (13 July 2026).

545 Interviews with [ ] (29 June 2026), [ ] (3 August 2026), [ ] (29 July 2026)].

certain whether this would lead to an increase in patients being referred to the public system.[546]

414. One gynaecologist stated in interview that in cases where there are few specialists in New Zealand capable of performing complex procedures (eg, advanced laparoscopic procedures for stage 4 endometriosis), patients with serious but benign (ie, non-cancerous) pathologies will not necessarily be able to access medical care in the public system in certain regions because other patients with cancer or high cancer risk will be prioritised.[547] [ ] also stated that the necessary care may be available in other regions like Auckland albeit subject to long waiting lists.

415. It is not clear on the evidence before us that this claimed benefit, derived from avoiding gynaecologists being disincentivised to perform more complex procedures in private hospitals is likely for the reasons that follow.

    415.1 The theoretical disincentive to perform complex procedures in private hospitals would arise due to perceptions that the remuneration did not reflect the work, cost and risk of such a procedure. However, SCHI has funding flexibility mechanisms including risk corridors, add-ons and top-ups to accommodate clinical complexity, intraoperative findings and circumstances where multiple procedures are appropriately undertaken at the same time.[548] Some gynaecologists may have some hesitancy in relying on these to the extent that they are not clearly contractually guaranteed or are uncertain. In such a case, it is in SCHI's interest to expediently and reliably demonstrate a track record of using these mechanisms so it can satisfy its members' policies.[549] As discussed at paragraph 290, SCHI is incentivised to offer fees that ensure its members receive the services they are entitled to.

    415.2 We understand that private gynaecologists have waiting lists. These can encapsulate a variety of complex and simple work. To the extent that one longer or more complex procedure is no longer within the private system, this may allow a greater number of simpler and shorter procedures to be performed. We have not taken a view on whether one type of procedure should be prioritised over another.

416. We consider detriments relating to the public health system arising from the Proposed Arrangements at paragraph 342.

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546 Interview with [ ] (14 July 2026).

547 Interview with [ ] (28 July 2026).

548 SCHI supplemental submission (11 August 2026).

549 SCHI submitted that these flexibility mechanisms are used successfully and reliably for other specialties. SCHI submission on SOPI (16 June 2026) at [6.9(e)(iii)].

Reduced competition for surgeons

417. NZGA submitted that under the APS, there would be reduced competition for surgeons by hospitals, as hospitals would become the provider of hospital services to surgeons.[550]

418. Evidence received to date from hospitals and SCHI indicates that under APS in the counterfactual, hospitals will continue to compete to offer facilities to surgeons in accordance with the competitive dynamics of the market that the hospitals operate within.[551] This may mean that in particular regions where competition between hospitals is stronger, hospitals may also compete on price to offer facilities to surgeons.[552] Accordingly, our preliminary view is that the claim that the Proposed Arrangements would mitigate or address reduced competition for surgeons is not made out.

Balancing benefits and detriments

419. The benefits and detriments we have identified are not possible to reliably quantify on the evidence available, and no party (including NZGA and SCHI) has sought to quantify them. We have therefore undertaken a qualitative weighting of the relevant benefits and detriments. Our preliminary view of the evidence before us is that the magnitude of the detriments is likely to outweigh the benefits in aggregate.

420. This view has been reached by applying the total welfare standard. However, we consider that adopting a modified total welfare approach would be unlikely to change our preliminary view to decline authorisation.

421. The evidence before us indicates that the Proposed Arrangements are likely to give rise to several detriments:

    421.1 Increased transaction costs (productive inefficiencies), which we assess as likely and of medium magnitude

    421.2 Higher SCHI premiums and/or reduction in coverage (allocative inefficiencies), which we assess as likely and of small magnitude

    421.3 Higher reference prices (allocative inefficiencies), which we assess as likely and of small magnitude.

422. We consider that jointly, the allocative efficiency losses above are of a medium size relative to the other benefits and detriments. Furthermore, we consider that the more successful NZGA is at collectively bargaining higher fees, the greater these allocative efficiencies losses will likely be.

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550 Application at [1.2] and [1.7].

551 SCHI submission on SOPI (16 June 2026) at footnote 35.

552 [ ].

423. The evidence before us indicates that there are likely to be two benefits associated with the Proposed Arrangements:

423.1 Greater supply of gynaecologists, which we assess as likely and of small magnitude; and

423.2 More efficient contracts, which we assess as likely and of very small magnitude.

424. We provisionally consider the following potential benefits and detriments are unlikely to arise as a result of the Proposed Arrangements:

424.1 greater health benefits;

424.2 reduced private hospital provision of facilities for gynaecology surgeries;

424.3 reduced innovation; and

424.4 reduced anaesthetist provision of services for gynaecological surgeries.

425. Our preliminary view on the evidence before us is that the detriments of granting the authorisation would significantly outweigh the benefits of doing so. We also consider that the evidence in support of the detriments is strong and more comprehensive, and we place greater weight on them accordingly. Consequently, our draft decision is to decline the authorisation.

426. The NZGA, as an applicant for authorisation, bears the practical burden of persuading the Commission that the benefits of authorisation would outweigh the detriments.[553] We are not currently persuaded that they do, based on the evidence that the Applicant has provided and the investigation that the Commission has undertaken. While it is true that collective bargaining often generally leads to certain public benefits, there must be sufficient evidence to demonstrate that this is likely in any particular case. To date, we have not seen sufficient evidence that the claimed benefits are likely to eventuate, nor that they would outweigh the likely detriments. We welcome further evidence from the NZGA or any other interested party may wish to provide to assist us in our assessment of the likely benefits and detriments of the Proposed Arrangements.

Proposed conditions

Submissions received

427. In the Application, NZGA indicated it would be open to implementing the following conditions as part of any authorisation:[554]

427.1 Reporting obligations involving regular quarterly reports to the Commission setting out material activities taken under the authorisation.

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553 *NZME Ltd v Commerce Commission* [2018] 3 NZLR 715 (CA) at [86(b)]; Authorisation Guidelines at [25].

554 Application at 6.15.

427.2 5 working day pre-implementation notification to the Commission prior to any proposed collective agreement(s) and/or common contractual framework collectively negotiated is agreed.

427.3 Oversight of all meetings and discussions in relation to the Proposed Arrangements by an external legal adviser with expertise in competition law.

427.4 All authorised conduct occurring within designated forums between NZGA, SCHI and/or hospitals to ensure structured oversight and compliance with the scope of the authorisation.

428. SC Hospitals submitted that interim authorisation should be granted subject to conditions that would limit the Proposed Arrangements to collective negotiations on coding, to support a contracting framework funded by SCHI, and any standstill arrangements necessary to give effect to that process.[555]

429. An anaesthetist submitted that conditions should be imposed that would protect the interests of independent anaesthetists and the public, specifically:[556]

429.1 mandatory inclusion of anaesthetist representation eg, NZSA or an equivalent body;

429.2 a requirement that any collectively negotiated contractual framework include a separately negotiated and transparent anaesthetic fee schedule which is not left to hospital discretion;

429.3 transparency and reporting conditions expressly including anaesthetic fee allocation data; and

429.4 shorter intervals for review of any authorisation with specific reference to outcomes for anaesthetic remuneration.

430. Professor Jaime King suggested that authorisation could be granted subject to conditions that would limit discussions between NZGA and SCHI to what services should be covered and the nature of the coding for billing, but then allow insurers or private hospitals to negotiate separately with physicians or physician practice groups over the prices paid and volume of services.[557] Professor King also suggested that the Commission could agree to review prices paid to healthcare providers in New Zealand on a regular basis (every 3 years) by health insurers.

Our assessment of conditions

431. Where we are not satisfied that the public benefit test would be met, we can nevertheless grant authorisation subject to conditions. We will do this where we consider the conditions will enable the conduct to pass the public benefit test.

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555 SC Hospitals submission on SOPI (23 June 2026) at [1.4], [1.5], [1.6] and [1.13].

556 Dr David Pirotta submission on SOPI (4 June 2026)] at [17].

557 Professor Jaime King (on behalf of NZPSHA) Expert Report (11 August 2026) at pages 6-7.

432. We do not consider that the conditions proposed by the applicant would materially reduce the detriments we have identified such that the Proposed Arrangements would pass public benefit test. The allocative efficiency detriments that we consider are likely to arise are inherent to the main aims of the Proposed Arrangements (being higher fees for gynaecology surgery). These would not be obviated by reporting obligations, oversight by a competition lawyer or designated forum protocols.

433. We have also considered a condition limiting collective bargaining to non-price terms. However, it is not clear that this would lead to an overall net public benefit. If we did impose such a condition, the Proposed Arrangements would likely result in greater transaction costs (although to a lesser extent than without the condition) and a benefit would also likely arise from more efficient contracts, both of which we provisionally consider to be of small magnitude. It is not clear on the evidence before us that the benefit from efficient contracts would outweigh the transaction costs incurred to achieve them. In any event, it is not clear whether this would be an acceptable condition for the Applicant.

434. Finally, the evidence before us does not indicate that anaesthetists are likely to be adversely affected by the Proposed Arrangements.

435. We therefore do not consider that the imposition of any proposed conditions would enable the conduct to pass the public benefit test.

Draft Determination

436. The Commission's preliminary view is that it is not satisfied that the expected public benefits from the Proposed Arrangements would outweigh detriments. Accordingly, we would decline authorisation.

437. For completeness, we note that the Applicant also applied for interim authorisation. The Commission's consideration of the application for interim authorisation was considered simultaneously to this draft determination and for the reasons set out in this draft determination and in the interim determination, the Commission has declined to grant interim authorisation for the Proposed Arrangements.

Next steps in investigation

438. The statutory deadline for the Commission to make a decision on whether or not to grant authorisation to the Proposed Arrangements is 12 November 2026.

Making a submission

439. If you wish to make a submission on the Draft Determination, please send it to us at registrar@comcom.govt.nz with the reference 'NZGA Authorisation' in the subject line of your email, or by mail to The Registrar, PO Box 2351, Wellington 6140.

440. Submissions are due by close of business on 7 October 2026.

441. If you would like to make a submission but face difficulties in doing so within this timeframe, please ensure that you register your interest with us at registrar@comcom.govt.nz so that we can work with you to accommodate your needs where possible.

442. Please clearly identify any confidential information contained in your submission and provide both a confidential and public version. We will be publishing the public versions of all submissions on the Commission's website. If you make a submission and we do not acknowledge receipt of that submission within two working days, you should resubmit your submission.

443. All parties will have the opportunity to cross-submit on the public versions of submissions received from other parties by close of business on 21 October 2026.

444. All information we receive is subject to the Official Information Act 1982 (**OIA**), under which there is a principle of availability. We recognise, however, that there may be good reason to withhold certain information contained in a submission under the OIA, for example in circumstances where disclosure would be likely to unreasonably prejudice the commercial position of the supplier or subject of the information. If your submission contains information which you consider there is good reason to withhold under the OIA, please identify specifically the information which you consider should be withheld and explain the reasons for that position (preferably with reference to the criteria for withholding information under the OIA).

Dated this 23rd day of September 2026.

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Dr John Small

Chair