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Determination

New Zealand Gynaecology Association – Interim Authorisation [2026] NZCC 39

The Commission:	Dr John Small Anne Callinan Tristan Gilbertson
Summary of application:	The New Zealand Gynaecology Association has applied for interim authorisation for itself and its members to undertake certain activities relating to collective bargaining with Southern Cross Health Insurance and/or hospitals, until the Commission declines or grants its application for authorisation.
Determination:	The Commerce Commission has declined to grant interim authorisation as it is not satisfied that it is appropriate to do so.
Date of determination:	23 September 2026

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

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Determination

1. The Commerce Commission (the **Commission**) declines to grant interim authorisation in respect of the application for interim authorisation lodged by the New Zealand Gynaecology Association Inc (**NZGA**) on 19 May 2026.

2. The Commission is not satisfied that it is appropriate to grant the interim authorisation requested because the evidence before the Commission does not suggest that the potential benefits would outweigh the potential detriments of granting interim authorisation and there are no other compelling reasons in the public interest to grant interim authorisation.

3. The Commission's decision to decline interim authorisation is based on our assessment of the evidence available at this time. In coming to this decision, the Commission has taken into account the factors set out in the Commission's *Authorisation Guidelines*.[1] The Commission's decision to decline to grant interim authorisation at this time is not determinative of what the Commission might ultimately decide in respect of NZGA's authorisation application.

Proposed Arrangements for which Interim Authorisation is sought

4. On 19 May 2026, the Commission received an application from NZGA seeking authorisation and interim authorisation, on behalf of itself and its current and future members (the **Participants**) to:

    4.1 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[2] to SCHI-insured patients (including to periodically negotiate any further changes as needed during this period); and

    4.2 enter into a limited Standstill Agreement between the Participants to defer any contracting with SCHI for a period of 6 months.[3]

    (together, the **Proposed Arrangements**).

5. NZGA's application provided that this would include interim authorisation to: [4]

    5.1 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);

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1 Commerce Commission, *Authorisation Guidelines* (June 2023) (**Authorisation Guidelines**) at [168-197].

2 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.

3 NZGA members would continue to provide services to SCHI-insured members during this period under existing arrangements.

4 Application at [6.2].

5.2 enter into a limited Standstill Agreement between the Participants;

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

5.4 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

5.5 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).

6. This determination only concerns that proposed interim authorisation.

Background

7. We refer to the Commission's Draft Determination issued in respect of this matter, which comprehensively sets out the background facts on which the Commission's determination on interim authorisation has been made.

How we assess applications for interim authorisation

8. The Commission may grant interim authorisation if it considers it appropriate to do so.[5]

9. To grant interim authorisation, the Commission does not need to be satisfied that the proposed arrangements meet the "public benefit test" that applies when determining whether to grant final authorisation.[6] As set out in our *Authorisation Guidelines*, the Commission has a broad discretion as to what it can consider when deciding whether it is "appropriate" to grant interim authorisation.[7]

10. The overall assessment for interim authorisation still involves balancing the potential benefits against the potential detriments, taking into account all relevant factors (including those listed in the *Authorisation Guidelines*). This ensures broad consistency in approach with the established public benefit test framework and balancing exercise applied when ultimately assessing the final authorisation, while also accommodating interim authorisation specific factors.

11. Consistent with the *Authorisation Guidelines*, we broadly apply the below framework when considering whether it is "appropriate" to grant interim authorisation:

11.1 **Step 1: Consider all potential benefits and detriments that are likely and agreement specific.** Taking into account the interim authorisation specific factors ("other factors") set out in the *Authorisation Guidelines*, which includes factors outside the standard public benefit test (such as urgency and

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5 Commerce Act 1986 (the Act), s 65AAA.

6 Section 65AAA(2).

7 Authorisation Guidelines at [177-178].

any risk the conduct could significantly alter the competitive dynamics of the market); and

11.2 **Step 2: Balance the likely potential benefits, detriments and interim authorisation specific factors to determine whether it is "appropriate".**[8] In doing so, we assign the discretionary interim authorisation specific factors' weight in the same way as benefits and detriments under the full public benefit test.

12. The Commission will grant interim authorisation only if satisfied it is appropriate to do so. If it is not satisfied, or remains in doubt, we will not grant interim authorisation.[9]

13. We consider the above approach balances: (i) the need for predictable and consistent outcomes: and (ii) the flexibility and discretion needed to address the wide variety of scenarios the Commission may be called upon to consider for interim authorisation.

14. As stated in our *Authorisation Guidelines*,[10] the Commission is most likely to grant interim authorisation at or near the beginning of the authorisation process, or at the same time as making a draft determination on the application for which authorisation is sought.[11] The timing of when interim authorisation is determined will depend on the facts of the case. In this case, the complexity of the subject matter and early evidence indicating that urgency was not likely to be present suggested it would be appropriate for the Commission to issue the interim determination at the same time as the draft determination.

Assessment procedure

15. In preparing this interim determination the Commission reviewed submissions, correspondence, and other information, including:

15.1 the Application;

15.2 submissions and cross-submissions, including those responding to our Statement of Preliminary Issues (**SOPI**);

15.3 interviews with interested parties; and

15.4 responses to our voluntary requests for information.

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8 Following the broader test for authorisation set out in *Woolworths Ltd v Commerce Commission (No 2)* [2008] NZCCLR 10 (HC).

9 *NZME Ltd v Commerce Commission* [2018] 3 NZLR 715 (CA) at [86(b)] where the Court referred to the applicant bearing a "practical burden of persuasion".

10 Authorisation Guidelines at [173].

11 Where an emergency situation exists, the Commission will aim to make a decision on an interim authorisation application within 20 working days from the date the application is received. See Authorisation Guidelines at footnote 105.

Our assessment of the application for interim authorisation

16. The Commission has made this interim determination following the framework above. This included, but was not limited to, a consideration of the potential benefits and detriments of granting interim authorisation. Based on the information available at the time of this decision, the Commission does not consider it appropriate to grant interim authorisation. We set out our reasoning below.

With and without interim authorisation

17. In reaching our view, we have considered submissions and evidence received on the likely situation/s that would arise with and without interim authorisation being granted. We do this to identify the benefits and detriments resulting from interim authorisation.

18. Our view on what is likely to occur with and without interim authorisation is materially the same as what is likely to occur with and without authorisation as set out in the Draft Determination under the section ***With and without the Proposed Arrangements***. We consider there is only one likely factual and one likely counterfactual. The following table summarises our preliminary view on the key features of each:

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
Timing of APS expansion	Likely to be delayed by at least the 6-month term of the Standstill Agreement	Work towards APS expansion to continue
Level of fees	Materially higher costs for bundled gynaecology surgery (including surgeons' and other fees)	Lower costs for bundled gynaecology surgery relative to the factual
Non-price terms	Slightly more efficient terms, with more marginal issues agreed between the parties	Marginal issues remain unresolved between the parties

Transactions costs	Significantly 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

19. We refer to the Commission's Draft Determination for further detail on our views.

Market definition

20. We refer to the Commission's Draft Determination for detail on our views regarding market definition.[12]

21. In summary, we have not undertaken a detailed market definition assessment because we ultimately do not consider that the exact boundaries of the relevant market(s) would change our assessment of whether the benefits of the Proposed Arrangements are likely to outweigh the detriments.

Potential benefits and detriments of interim authorisation

22. Our Draft Determination, which we published on the same day as this Interim Determination, is to not authorise the Proposed Arrangements for the reasons set out in the Draft Determination and summarised in the attached Draft Determination executive summary (Appendix A).

23. Broadly, 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. Our findings in the Draft Determination weigh against granting interim authorisation.

24. We have used the potential benefits and detriments of authorisation as the starting point to determine the benefits and detriments of granting interim authorisation. We consider that, in the interim period, NZGA would seek to commence collective bargaining and the Standstill Agreement. However, for example, without the benefit of a final authorisation determination we do not think any party would execute any negotiated contracts during the interim period. Due to this, we do not consider that all of the benefits and detriments identified as likely in our Draft Determination would be as likely to eventuate in the interim period as they would be in the authorisation period (if authorisation was granted).

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12 *New Zealand Gynaecology Association Inc – Draft Determination* [2026] (**Draft Determination**).

25. The benefits and detriments we consider are most relevant to interim authorisation are:

    25.1 a medium sized detriment arising from increased transaction costs; and

    25.2 a very small benefit arising from parties negotiating marginal non-price terms that would not have otherwise been agreed.

26. In our overall weighting of these interim specific benefits and detriments, we do not consider the benefits will be larger than the detriments.

Consideration of other factors for interim authorisation

27. In addition to the potential benefits and detriments set out above, we have considered several interim specific factors as part of our overall determination.

Urgency

28. In relation to urgency, the Commission's view is that there must be some minimum reason to grant interim authorisation now, rather than waiting for final authorisation.[13]

29. As a general rule, we consider urgency in the context of interim authorisations is likely to arise where there is a need to avoid an imminent and substantial detriment, or where there are material benefits that could be gained by bringing forward the conduct for which authorisation is requested.

30. NZGA submitted that there was genuine urgency at the time the application was made.[14] It considered that SCHI's proposed APS expansion is a fundamental change and that SCHI was signalling tight timeframes, which may lead to the new structure being "locked in", leading to potentially irreversible harm to the public.[15]

31. SCHI submitted that there is no urgency.[16] SCHI submitted that the proposed AP transition has followed extensive consultation over many months, no mandatory implementation date is in place, and gynaecology surgeons remain free to decide whether to negotiate individually with relevant hospitals/facilities.[17]

32. The Commission considers urgency is not present. We consider that SCHI is unlikely to be able to materially conclude or introduce its APS to gynaecology surgery whilst the authorisation application is being considered, nor would hospitals likely be able to agree contracts with gynaecologists during this period.

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13 *New Zealand Tegel Growers Association Incorporated* [2021] NZCC 26 at [67.2].
14 Application at [12.2], NZGA cross-submission on SOPI (4 August 2026) at [26].
15 Application at [12.2-12.6].
16 SCHI submission on SOPI (16 June 2026) at [1.3(k)].
17 Ibid.

Granting or declining interim authorisation may cause irrevocable harm

33. SCHI and some other submitters have raised concerns that granting interim authorisation could cause irrevocable harm to the competitive process and higher costs to health insurers, their customers, and other purchasers/funders of gynaecology surgery services through the exchange of competitively sensitive information.[18]

34. In the context of this interim authorisation decision, we have taken into account that the nature of this harm has the potential to be irrevocable. That is, the potential harm from sharing information in preparation for collective bargaining has potential to endure, regardless of whether our final determination is to grant or decline authorisation. Accordingly, we have placed some weight on this detriment as an interim factor.

Extent to which markets may change if interim authorisation is granted or not granted

35. We considered the impact of an interim determination on existing relevant markets. We are more likely to grant interim relief when it will "maintain the market status quo."[19]

36. If interim authorisation is not granted we do not expect that there will be significant changes to the status quo, given the lack of any negotiations concluding to date whilst the Commerce Commission has been considering this authorisation.[20]

Overall balancing test

37. Overall, the Commission does not consider that it is appropriate to authorise the Proposed Arrangements in the interim period, as we are not satisfied that the benefits outweigh the potential detriments or that any of the interim-specific requirements would be met. As a consequence, we have determined that it is not appropriate to grant interim authorisation.

Dated this 23rd day of September 2026

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Dr John Small

Chair

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

19 Authorisation Guidelines at [178.4.1].

20 Interview with SCHI (18 June 2026); SCHI submission on SOPI at [6.7].

Appendix A – Draft Determination 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.[21] 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.[22] The APS has existed for several decades and is the primary means by which SCHI funds healthcare for its members.[23] Under the APS, SCHI and healthcare facilities (typically hospitals) negotiate contracts under which set prices are agreed for certain procedures provided to SCHI members.[24] 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.[25]

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.[26] 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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21 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].

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

23 Interview with SCHI (17 June 2026).

24 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))].

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

26 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.[27] 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.[28] 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.[29] 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.[30]

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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27 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)*

28 Application at [1.3].

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

30 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.[31]

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.[32] 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.[33] 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.[34] 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

[31] Health NZ submission on SOPI (10 June 2026) at page 2.
[32] ACC submission on SOPI (2 July 2026) at pages 2-3
[33] Health NZ submission on SOPI (10 June 2026) at page 3
[34] 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.[35] 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.[36] 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.[37] 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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35 Addendum to NZGA's supplemental submission (9 June 2026) at [3].

36 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'.

37 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,[38] although we can give weight to qualitative factors where appropriate.[39] 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.[40] 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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38 *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].

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

40 *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[41]. 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

[41] 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.[42] 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.[43]

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.[44]

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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42 Authorisation Guidelines at [63].

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

44 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.