4 August 2026

NZGA cross submission on Statement of Preliminary Issues

Introduction – Patient outcomes are at the centre of this application

1. The New Zealand Gynaecology Association's (**NZGA**) authorisation application is, at its heart, about women's health and the care women receive. NZGA's members are the gynaecologists who care for New Zealand women and they are concerned that a fundamental change to how women's surgery is funded is being designed without the proper clinical input needed to protect patient outcomes.

2. We reiterate that NZGA does not oppose Southern Cross Health Insurance (**SCHI**) managing its costs. NZGA accepts that cost pressures across the health system is real (which equally applies to gynaecologists running their own practice) and are willing to negotiate a reduction of fees. The design of a funding model determines clinical behaviour and a model built without clinical input risks poorer outcomes for the patients who most need care. NZGA's concern remains that changes proposed by SCHI are being made without proper clinical input needed to get the changes 'right' and there are real risks to patient outcomes from implementation as proposed.

3. The practical effect of getting it 'wrong' (as is the case for gynaecological surgeries already under AP and as shown in the pilot study) is that surgeons are placed in a position no clinician should face. Where additional necessary treatment is identified mid-procedure but may not funded, the surgeon must choose between performing that treatment without reimbursement or stopping and returning the patient for a second operation. Neither outcome serves the patient. One asks the surgeon (alongside all other medical staff) to absorb the cost of doing the right thing and the other subjects a woman to a second anaesthetic, a second recovery and a second period of risk for a single clinical problem.

4. Viewed properly, this application is a request for collective advocacy (despite being framed as 'collective bargaining'). It seeks a lawful mechanism for gynaecologists to engage with SCHI as a body, so that the model SCHI ultimately chooses is clinically informed. It is a response to SCHI's refusal to engage with NZGA and not an attempt to displace competition. Accordingly, the Commerce Commission (**Commission**) should approach the application through that lens (disregarding the misunderstandings or assertions raised in some submissions).

5. We set out our response to key assumptions / assertions raised in submissions in **Appendix 1**. NZGA's responses to specific clinical assertions by SCHI are provided in a separate accompanying document.

Authorisation in this case should be a simple assessment

6. A lot can be said about the potential benefits and detriments in the abstract (as does many submissions without clear analysis or evidence). The correct framework (which the Commission has applied in its past authorisations) is that collective bargaining can help address bargaining imbalances particularly with unavoidable trading partners (like SCHI, who is a cherished NZ entity with market dominance, but it is not omnipotent) and information asymmetries, leading to more efficient outcomes.[1]

7. The Commission emphasises that collective bargaining does not compel agreement. This remains true for NZGA's application and engagement by SCHI remains voluntary following authorisation. SCHI could reject what it considers are uneconomic proposals and ultimately walk

[1] In NZBA authorisation final determination [2026] NZCC 14, the Commission states at [338]: "***Outcomes from bargaining, bilateral or collective, can be efficient/more efficient (beneficial to the public)*** *or inefficient/less efficient (detrimental to the public). Inefficient/less efficient outcomes can arise if bargaining terms tend strongly towards the position of the party with greater bargaining strength while* ***more efficient outcomes tend to arise if the parties move towards maximising their joint surplus****.[478] In the authorisation context, a collective bargaining arrangement produces a public benefit (or detriment) if the outcome is more (or less) efficient than the situation without the arrangement.*" See also [179]: "*Successful collective bargaining can improve allocative efficiency through lower, more competitive prices that increase service volumes, service levels or access to cash compared to that provided under bilaterally negotiated contracts. This could reduce or eliminate inefficiencies that arise from bilaterally negotiated contracts.*"

away (at the end of the standstill).[2] SCHI continues to enjoy the discretion to do as it chooses and authorisation would not compel any outcome.

8. The practical reality of this application makes the assessment simple – it turns on SCHI's conduct. Therefore, there are only two possible outcomes if authorisation is granted. In the worst case, SCHI declines to engage meaningfully and a result nothing changes and SCHI implements its changes as it wishes. No detriment arises as a result of the authorisation in that case. In the best case, SCHI engages, becomes clinically informed and makes better decisions, in which case the benefit is real and accrues directly to patients and the sustainability of gynaecology as a medical profession.

9. This obvious asymmetry answers many of the concerns raised by interested parties in relation to the application. Authorisation cannot force prices up, cannot bind SCHI and cannot compel any agreement. It can only enable engagement that should have happened already. The downside is neutral and the upside is better outcomes for women. In those circumstances, the case for authorisation is straightforward.

SCHI is not omnipotent and good intentions are not a substitute for engagement

10. We should be careful to assume that SCHI will get this right on its own and that its Not-for-Profit status means its management interests (eg short term KPIs such as cost reductions) are aligned with medium- to long term patients' outcomes. With respect, NZGA cautions against that assumption. This is a clear agency issue. No single organisation, however well-intentioned, has perfect information on or approach to the clinical realities of gynaecological surgery. The absence of any medical commentary about impacts on women's health is telling.

11. Institutional objectives do not directly translate into frontline decisions. The economic literature recognises that large organisations (like SCHI) act through management and management can drift from long term goals due to being guided by short-term operational and cost targets.[3] SCHI may say its proposal is directed at affordability and member value, but the design choices appear to be driven by cost containment KPIs and administrative standardisation without sufficient clinical input into the patient and sector consequences. That is why external clinical engagement matters and is sought by NZGA – clinical views should inform (and guide) management views on what is workable (not the other way round).

12. Fundamentally, SCHI proposes to design and apply a single pricing structure across an entire specialty and NZGA understands that hospitals proposed to adopt those prices in near-identical terms. That reflects the degree of market power SCHI holds. Unlike ACC and Health NZ, which purchase under statutory and contractual frameworks, SCHI sets that structure with no external check and without input from those who deliver the care.[4] Clinical engagement is the practical check which should be utilised (that is what NZGA seeks and offers).

13. If SCHI is trusted to make the right decisions, it should do so from a place of transparency (including as to its figures and data) and engagement with those who hold the clinical qualitative information. This is precisely why authorisation should be granted – engagement with clinicians should lead to benefits for SCHI and its members through greater buy in and SCHI may develop new ideas on how it implements changes which benefit patients and creates efficiencies/cost savings for the parties.

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[2] This is in line with the Commission's conclusions in the NZBA final determination that Armourguard is not obliged to accept unsustainable prices and could 'walk away'. See [202]: "*Further, there is no legal or regulatory obligation for Armourguard to accept unsustainable prices, and in fact it submitted elsewhere that collective negotiations "would be privately run, and all parties could "walk away". Armourguard also submitted that it was not obliged to accept demands it considered uneconomic or commercially unsustainable."*

[3] This is a well-recognised problem/distortion identified in economic literature. See for example: Kevin Laverty, *Economic "Short-Termism": The Debate, the Unresolved Issues, and the Implications for Management Practice and Research* (July 1996) The Academy of Management Review Vol 21, No 3 pp.825-860; Jeremy Stein *Efficient Capital Markets, Inefficient Firms: A Model of Myopic Corporate Behavior* (November 1989) The Quarterly Journal of Economics Vol 104, No 4 pp.655-669; see also breakthrough article Robert Kalplan and David Norton *The Balanced Scorecard — Measures that Drive Performance* (January – February 1992) Harvard Business Review Vol 70, No 1 pp.71-79 which sets out how organisations can improve traditional financial performance measures to include broader long term objectives including continuous improvement and innovation.

[4] Such a position sits uncomfortably with the fundamental belief in functioning markets.

Getting it wrong has clinical consequences and SCHI is shifting risk and creating perverse deterrents/incentives

14. SCHI proposes to structure surgical funding in a way that shapes clinical behaviour. Uninformed AP coding shifts risk onto individual surgeons.

15. Gynaecological surgery is characterised by unexpected intraoperative findings. Unexpected pathology is common and complexity often only reveals itself once surgery is underway. An AP coding model that does not properly account for this passes the risk of that complexity onto the individual surgeon.[5] The outcome is that SCHI may inadvertently create perverse deterrents/incentives. Surgeons are deterred from taking on the complex cases where problems are most likely to arise and are encouraged towards simpler more predictable cases that are better remunerated relative to effort and risk. This is not an active decision being made by gynaecologists but rather a systemic deterrent/incentive created from the proposed AP coding. In a specialty already facing acute workforce shortages, the patients most affected are those with the greatest clinical need.

16. Indeed, for gynaecological procedures already under AP coding, surgeons are forced to spend time chasing SCHI to exercise its discretion to apply risk corridors and top-ups in order to secure cover for their patients. That administrative burden is placed directly on the surgeon as they must provide direct clinical input into any application to SCHI as they must explain why the surgical procedure has changed or request for SCHI to apply a risk corridor. This is precious time that a surgeon could be spent consulting or operating on patients. NZGA members have found surgeons under existing AP schemes in gynaecology often have to 'fight' to get patients covered or often 'pay out of pocket'[6] for the unexpected changes themselves. Therefore, there is little confidence that this already burdensome process could work reliably if extended across the full breadth of gynaecological surgery. Engagement must happen to iron out all of these issues.

17. The same problem appears in how fees are analysed. An approach that rewards shorter operating times risks penalising the most skilled specialists, who complete difficult procedures efficiently, while rewarding slower work.

18. A funding model should not, even inadvertently, incentivise surgeons to be slower or to avoid difficulty. These are fundamental design flaws that clinical engagement would assist SCHI in addressing before implementation.

The concern around contagion is backwards

19. NZGA does not seek a fee increase and accepts a reduction from current levels (seeking alignment with what would reasonably expected in workably competitive markets). The concerns raised in submissions that authorisation would allow NZGA to set higher prices which would flow through to other funders (ie 'contagion') does not reflect what NZGA seeks or what collective engagement can achieve.

20. SCHI remains the dominant funder and retains the ability to decide whether to engage, what to accept and what model to adopt. Engagement cannot compel SCHI to pay more than it is willing to pay (indeed, any outcome is SCHI's own commercial judgement). As recognised by the Commission in past authorisations, a powerful counterparty, like SCHI, retains the ability to decline any proposal it regards as uneconomic. So any concern that a collective voice would drive prices upward assumes an outcome SCHI itself controls and could simply refuse. The purpose of engagement is not to raise prices but to ensure that whatever level SCHI sets is clinically informed and sustainable for the workforce on which every funder relies. Any suggestion of prices "rising" also mistakes the direction of the arrangement: SCHI is proposing a substantial reduction, and NZGA seeks only to inform the degree of that reduction, not to reverse it. The contagion concern therefore does not point against authorisation.

[5] SCHI proposes to capture all gynaecological surgical procedures in under 100 codes (a broader estimate based on current work with RANZCOG to expand the number of codes), by comparison Australia has more than 600 codes for gynaecology.
[6] For example, paying second surgeons who were brought in following unexpected pathology. Other times, procedures are carried out and all parties are left out of pocket in order to prioritise the patient.

21. Any risk of a rigid reference price arises from SCHI's proposal for uniform pricing (which lacks clinical input) rather than NZGA's request to inform it. NZGA reiterates that its preference is to preserve market signals but understands SCHI's need to manage its costs and seeks only to engage on the degree of the proposed reductions and the design of the model, which would protect patients and the sustainability of the gynaecology specialist workforce on which every funder, including ACC and Health NZ, ultimately relies.

The risk to the workforce is real and should not be underestimated

22. The most serious risk which NZGA urges the Commission to weigh most heavily, alongside patient outcomes, is the risk to the gynaecology workforce. The private sector effectively subsidises the public system, with many private specialists working across both sectors, treating public work as giving back and easing the strain on an already stretched public system. That balance depends on private practice remaining viable.

23. SCHI-funded work represents approximately 50 to 60% of a typical private gynaecology practice. A reduction of the fees (by ~50%) as proposed by SCHI would equate to an overall ~25–30% decrease in total revenue. Such a change does not require complex modelling to assess its likely effect – specialists would likely consider exit or relocating to jurisdictions that remunerate significantly more highly. Likewise, junior doctors may not consider entering the specialty altogether.

24. It is no answer to say that some attrition of the workforce occurs regardless, so the marginal effect of authorisation is small. Against existing shortages, any incremental increase in exit risk is serious, particularly at subspecialty level, where the numbers are very small (for example, there are only approximately 3 urogynaecologists, 10 gynae-oncologists and 20 laparoscopic gynaecologists practising in New Zealand). Each specialist represents a material proportion of the country's gynaecology workforce. The loss of even a handful would materially reduce women's access to care and would be slow and costly to reverse, given the years required to train a replacement and the reality that those who leave rarely return.

25. Where a dominant funder sets fees below sustainable levels, the detriment is not confined to price; it is a reduction in the quantity and quality of services supplied. Workforce exit is that reduction in practice and reflect a clear example of the competitive harms that may likely arise from SCHI's proposal. It is precisely because this risk is difficult to reverse that NZGA urges engagement before the model is imposed, so that SCHI's approach is clinically informed and does not inadvertently trigger an outcome no party intends.

Context matters – the pressure was real

26. It is important to recognise that this application did not arise in a vacuum. Context matters and the threat of foreclosure by SCHI was real and imminent. SCHI applied genuine pressure on individual gynaecologists to submit their best prices by 31 March, and then by 31 May, or risk being excluded from funding. That is part of the context in which NZGA's members concluded that individual engagement was not working and that a collective, lawful avenue for proper engagement was necessary. SCHI cannot now point to its deferral after the application was made as a sign that it had never pressured gynaecologists.

Conclusion

27. This authorisation is about a women's health issue and turns on a simple and uncontroversial view – that decisions of this significance should be clinically informed. NZGA's members are willing to engage. Authorisation asks only that they be permitted to do so collectively so that SCHI's model, whatever form it takes, is built on clinical inputs rather than solely on macro-level data focused on cost containment. Accordingly, the authorisation assessment for the Commission becomes simple: If SCHI does not engage, there is no difference;[7] if it does, women's healthcare is better for it. That decision remains with SCHI and authorisation should be granted to ensure the better outcome for women in New Zealand is possible.

[7] Specifically, the Δ between the factual and counterfactual(s). Any detriments from SCHI's proposal would still remain.

APPENDIX 1: TABLE OF NZGA RESPONSES TO KEY ASSUMPTIONS / ASSERTIONS

1. Most of the submissions appear to misunderstand the nature of what's proposed and the effect of authorization – but this may have been clarified following our supplemental submission on 26 June 2026.

2. The following table addresses specific concerns raised, each of which resolves back to the same point – engagement improves patient and clinical outcomes and cannot compel anything from SCHI.

ASSUMPTION / ASSERTION	NZGA'S RESPONSE
Collective bargaining by NZGA will increase prices.	• This is incorrect. NZGA does not seek to increase fees and accepts a level of reduction. SCHI retains the ability to dictate prices irrespective of any authorisation.
Gynaecologists' fees are too high.	• This assertion ignores context. Gynaecological surgery is highly specialised, complex and intraoperatively variable; headline fee comparisons strip that away. Fee per hour/minute measures ignore pre/post-operative and after-hours care, complexity, training, indemnity, staffing, accreditation, equipment and overheads, and inappropriately penalises skilled surgeons who operate efficiently. • Private fees underwrite the public system as most specialists also do public work as goodwill; private remuneration sustains that capacity and the minimum ~14-years required for training cannot be quickly replaced. • Variations in fees are not an absence of competitive discipline and is common across medical specialties internationally. Fees differ according to: surgeon experience; case complexity; patient factors; intraoperative reality; operating time; hospital used; geographic location; overhead costs; subspecialty expertise. A headline or per-minute comparison strips those clinical qualitative differences away.
NZ fees are higher than overseas jurisdictions.	• Comparisons to other jurisdictions (Australia, US, UK etc) are inaccurate as funding systems differ. • For example, Australia blends Medicare, private insurance and co-payments; NZ depends predominantly on insurers (public funding and self-funding each under 5% of volume and fees). • Comparisons with ACC schedules are also inappropriate because ACC operates under a completely different statutory purchasing model and regardless are typically only 1% or less of a gynaecologist's cases. • NZ's small scale also precludes the case volumes that would typically lower unit costs elsewhere. • The workforce evidence points the other way. Current fees are already not high enough to stem attrition; NZ faces unprecedented shortages and loss of specialists overseas, so further compression would accelerate exit, not correct an excess.
SCHI is not a monopsonist and there is no bargaining imbalance	• Clearly SCHI does have substantial market power. We refer to the authorisation application at paragraph 5.20 onwards. It could not implement such a proposal without substantial market power. • The relevant market is privately-insured gynaecology, where SCHI funds around 60% of lives and patients cannot switch insurers because pre-existing conditions are not covered on transfer. Blending public and ACC funded volumes to present SCHI as a "minority funder" is misleading. • Outside options are not substitutes – Health NZ/ACC together make up less than 5% of cases. No other insurer replaces the ~50% of cases that SCHI represents. • Clearly SCHI is the unavoidable trading partner for private practice.
NZGA has not quantified the public benefits / provided economic evidence.	• If SCHI does not engage in the collective bargaining process, there is no detriment as result of the authorisation, if it does, then any benefits go directly to patient and clinical outcomes. • The benefits stated at paragraph 11.11 of the application are largely qualitative and structural as SCHI would have a clinically informed funding model that avoids inadvertent harms to patients and the workforce. The Commission has previously accepted qualitative benefits in collective bargaining authorisations. • Nevertheless, both legal and administrative costs of individual bilateral negotiated agreements and subsequent negotiations to get it 'right' are clearly

	quantifiable and would be significant. Collective negotiation would directly cut across this and get better buy in.
The standstill agreement is an inherently harmful collective boycott.	• We disagree. • NZGA is not seeking to withhold any services. The standstill provides limited time to maintain the status quo and puts a limited pressure for a 6 month period where members do not enter/negotiate any new terms while collective negotiations take place. • Similarly, the ACCC in *Catholic Health Australia* did in fact permit a limited collective boycott for members to not individually negotiate while collective negotiations are occurring. (SCHI's submission on *Catholic Health Australia* is inaccurate as the ACCC in *Catholic Health Australia* acknowledged the benefits of a collective boycott (see [4.56]–[4.61]) and in its decision authorised a limited collective boycott (see[5.7.1.c.]).)
Fees have increased faster than inflation.	• We disagree. • SCHI's own FY25 annual report shows total claims rose ~16% while the total cost of claims rose ~14% (a lower percentage than the increase in claim numbers). That indicates the cost of individual claims is not materially rising and therefore, the driver is volume and demand, not gynaecologist fees. • NZGA however acknowledges that medical inflation is real and is a challenge equally faced by individual gynaecologists running their own practice. • Specialists have experienced significant increases in: nursing salaries; administrative staff costs; practice rents; indemnity insurance; medical consumables; accreditation costs; technology; compliance requirements; hospital charges. Those increases have been absorbed and not passed on.
There is no change in patient outcomes compared to the increase in fees. Specialties under AP score better on surveys.	• It is impossible to comment on any confidential survey evidence without testing the data. The Commission should therefore place limited weight on the assertion unless the underlying survey evidence is disclosed and can be tested. Survey evidence can be useful, but only where its methodology, sample, questions and conclusions are transparent and reliable; otherwise it risks overstating what the data actually shows. • High satisfaction scores risk a false positive: they likely reflect the administrative convenience of not managing claims (which NZGA supports, and which any funding model can deliver), not the clinical merits of AP. (This is equivalent to a credence claim which cannot/has not been tested.) • The survey may also have significant blind spots, missing clinical outcomes, complication rates, and cases that would have been staged or deferred under SCHI's processes. Surgeons proceed as clinically appropriate regardless of cover and absorb the shortfall, so the patient experience looks seamless while the systemic impact stays invisible. • The cross-specialty comparison is also not like-for-like.
The proposed model removes cost and administrative burden from patients (no need to collect invoices and seek reimbursement).	• NZGA agrees these are genuine benefits for patients and does not oppose them. Third-party billing and electronic claiming are a welcome improvement on patients collecting invoices and seeking reimbursement themselves. • But those changes can be delivered irrespective of the pricing and coding changes SCHI proposes. The point does not assist SCHI's case. Simplified claiming is an administrative arrangement between the hospital, the provider and the insurer. • Those benefits are not a reason to implement the model as proposed without clinical input. Engagement would preserve those administrative gains while addressing the coding and complexity issues NZGA has raised.
Changes to coding will resolve the issues raised by NZGA (pricing should not be considered).	• Coding and prices are interdependent. How a procedure is coded determines what work is captured. It is important to get this right given unexpected pathology in gynaecology. • Clinical engagement is necessary to assist in how codes are designed and how they are funded. • Coding structures and reimbursement influence the ability to adopt innovations, perform complex surgery and take on higher-risk cases without fear of taking on risk personally.
Clinical consultation does not require authorisation. SCHI has already consulted extensively.	• NZGA seeks proper engagement. • SCHI claims engagement with gynaecologists since August 2025 but NZGA, both collectively and through individual members, has made repeated attempts to engage constructively. Those attempts have not resulted in meaningful engagement or resolution. • NZGA also sought to assist SCHI by facilitating clinical input from RANZCOG for clinically appropriate AP coding. While SCHI made some

	positive steps towards amending codes, it has resisted fully considering the clinical advice received around issues/gaps in the proposed AP coding. • NZGA now seeks a lawful way to engage with SCHI because SCHI declined to engage citing competition law concerns. • Informal advocacy has been tried and did not work. The application is a direct result of that.
Variation in fees would remain as hospitals would negotiate bilaterally with individual gynaecologists.	• We disagree. • NZGA understands that many of the hospitals have passed down fees (whether passively or in agreement with SCHI) as agreed with SCHI. Proposed pricing lists from different hospitals were found to have near-identical pricing for each procedure.[8]
Risk corridors are already in place and used.	• For the few gynaecology procedures already under AP, surgeons must spend scarce clinical time applying to SCHI to exercise its discretion on risk corridors and top-ups to secure cover for their patients. • That discretion is exercised by SCHI, not the surgeon, and members' experience is that they frequently have to fight for cover or absorb the cost themselves. There is little confidence this already burdensome process would scale across the full breadth of gynaecological surgery. • SCHI's own usage figures support NZGA's point – the frequency with which surgeons must apply for top-ups and risk corridors suggests base codes fail to fit clinical reality, not that the mechanisms work well. Each application being made is scarce clinical time being spent seeking cover that the coding should have captured.
Applying the modified total welfare standard, a narrow group of ~130 surgeons benefit over ~940,000 SCHI members.	• The public benefits of the proposed arrangements are set out in section 11 of the application and are not repeated here. In short, they accrue to patients and the wider health system, not to a small group of specialists. • There cannot be a price transfer when no fee increase is sought.
Dynamic efficiency / innovation in gynaecology will be lost	• Clinical innovation in gynaecology is surgeon-led (technique, staging, intra-operative judgement), and engagement would support innovation not reduce it. • The greater risk to innovation is a uniform, cost-driven code set imposed without clinical input, which is precisely what engagement would help avoid.
Authorising gynaecology as a speciality to collectively bargain will set a precedent for other specialties.	• This concerns is misconceived. • Authorisation turns on a merits-based balancing of the benefits and detriments of the particular arrangement before the Commission. • Each application is decided on its own facts. Authorising the NZGA arrangement determines nothing about any future applicant, which would present its own benefits, detriments and balance. • The prospect of future applications is not a detriment of the present arrangement and should carry no weight in the analysis.
Granting authorisation will allow members to irreversibly share competitively sensitive information and engage in coordinated pricing discussions.	• This concern is overstated. • The application does not authorise members to exchange pricing or negotiating information. As set out in the application, NZGA would use binding competition guardrails and legal oversight to prevent any discussion, alignment or signalling on fees, volumes, capacity or allocation. • Engagement would be channelled through the NZGA board and directed at clinical and process matters, not individual commercial terms.
Collective bargaining is typically reserved only for genuinely vulnerable producers.	• Vulnerability is not the statutory test. • Authorisation turns on whether the benefits outweigh the detriments, not on whether the applicant resembles a particular past applicant. • By that logic, the relevant vulnerability here is the patients' and the workforce's, not the surgeons' incomes. The application is directed at protecting women's access to care and a sustainable specialist workforce.
SCHI is a friendly Not-for-Profit society so has no ability or incentive to depress prices below sustainable levels.	• While this may be the case at the institutional level, funding decisions are made by management guided by short-term cost-containment targets, which can diverge from SCHI members' medium- to long-term interests. • SCHI assumes it can identify what a "sustainable" fee is. That is precisely the clinical and workforce judgement SCHI is not positioned to make on its own and is why engagement is needed.

[8] A comparison of proposed procedure pricing schedules circulated by multiple hospitals saw near-identical pricing across the procedure set which suggests hospitals are largely passing through SCHI pricing rather than looking to independently negotiate surgeon fees.

	• NZGA does not question SCHI's good intentions, but they (alongside its NFP status) are not substitutes for the clinical input necessary to avoid inadvertently setting fees below sustainable levels.
A collectively negotiated reference price becomes a floor set at the highest prices dragging up all lower-priced surgeons which risks contagion of raising prices for ACC / Health NZ.	• Any reference-price or anchoring effect arises equally from SCHI's own proposal for uniform pricing. SCHI cannot characterise NZGA seeking to negotiate the level of fee reductions when it is the one setting up uniform pricing.[9] • ACC has its own statutory bargaining framework and Health NZ purchases services under its own contractual arrangements and budgetary frameworks. Therefore, a SCHI-based reference price would not transfer/apply. Regardless ACC and Health NZ make up a de minimis share (<5%) of a typical private gynaecologist's cases so any passthrough impacts would be unlikely or minimal.
Innovation is funded by hospitals.	• Hospitals purchase the equipment used by specialists. However, new technology has no value unless surgeons invest time and money into training to learn new techniques and technologies. • Surgeons often: o undertake overseas fellowships o purchase instruments o develop new operative techniques o train junior colleagues o participate in research • Innovation therefore depends equally on surgeons to gain expertise.
~15% of procedures undertaken in private hospitals are publicly funded and further ~25% are funded by ACC.	• While these figures may reflect the private hospital sector as a whole, they are not representative of gynaecology. • Based on data provided by NZGA members, fewer than 5% of private gynaecological procedures are funded by Health New Zealand, and fewer than 1% are funded by ACC. The overwhelming majority of private gynaecological services are funded either by private health insurers or by self-paying patients.
Interim authorisation should be declined as there are no emergency and deadlines are deferred; not the status quo.	• The relevant status quo is the active, imminent pressure placed prior to the application filing. SCHI set successive deadlines (31 March, then 31 May) for individual surgeons to submit best prices or face exclusion; the application is a direct response to that. SCHI's deferral of those deadlines after the application was filed does not remove the threat and should not be rewarded as a reason to deny interim relief. • Absent interim relief, terms may be locked in on a surgeon-by-surgeon basis before the Commission rules, foreclosing the NZGA from seeking successful collective engagement. Indeed, we understand SCHI continues to engage with key gynaecologists in an attempt to weaken the potential collective engagement before the Commission makes its decision.
The proposed conditions (reporting, disclosure, legal oversight, designated forums) do not cure the competitive harm as they are retrospective.	• The conditions are not intended to 'cure' harm – they are safeguards that confine engagement to its stated purpose. They operate alongside the fact that SCHI retains full discretion so no outcome can be imposed. • The guardrails directly address the information-exchange concerns raised. • Pre-implementation disclosure and reporting give the Commission live visibility and the ability to intervene. • NZGA remains open to further or tighter conditions the Commission considers appropriate.
NZGA cannot seek authorisation for two distinct arrangements (collective bargaining and a collective boycott) under a single s 58 application.	• This is a technical objection without substance. The standstill and the collective negotiation are limbs of a single, integrated arrangement (a time-limited standstill to enable the very engagement for which authorisation is sought). • Further, the application already offered that the standstill may be treated separately and made subject to its own conditions if the Commission prefers.
Participation is not genuinely voluntary because the proposed Standstill Deed removes any member who declines to participate,	• Removal is not coercion – it defines who the collective is negotiating for. A member who prefers to negotiate individually remains free to do so which is the opposite of coercion.

[9] While SCHI disputes that it is creating any uniform pricing as hospitals retain the ability to negotiate prices with individual gynaecologists, this does not reflect reality where hospitals are simply passing down prices as suggested by SCHI.

making it a coercive collective boycott.	
The 10 year authorisation would entrench collusion for a decade (and lacks clarity as it could permit repeated 6 month standstills).	• The 10 year term is consistent with Commission practice. The Commission has recognised that authorisations for a period of approximately 10 years are not unusual and the application relies on that in seeking the term. • The authorisation is a permission to engage collectively, not a fixed price lock-in, so it does not entrench any pricing outcome. We reiterate that SCHI retains full discretion throughout to accept, reject or walk away. • For completeness we note there is no lack of clarity. The application contemplates a single standstill of up to 6 months to enable the collective engagement, not a series of rolling standstills across the decade.