9 November 2026

NZGA cross submission on Draft Determination

Introduction

1. NZGA thanks the Commerce Commission (**Commission**, **you**) for this chance to cross submit on submissions on the Draft Determination (**DD**).[1] We have 3 high-level points:

   (1) **Our application was to engage** with Southern Cross Health Insurance (**SCHI**), so that SCHI could make informed decisions when *imposing (in concert with hospitals)*[2] a new and unclear model across all of gynaecology, *reversing* traditional contracting (customer-supplier).[3]

   (2) **There can only be real impacts if**, after any *consultation or engagement*, **SCHI decides** to vary its *proposed* model, ie if it makes a better-informed decision that (still) suits it. Better-informed decision-making must be welfare-enhancing.

   (3) **SCHI knows this but repeats the errors in its earlier submissions** (as does the DD) to wrongly claim adverse impacts based on incorrect assumptions and untested (and unknown) data. SCHI adds no new evidence and continues to deliberately mischaracterise the application.

2. **Authorisation simply provides a forum for engagement** where the broad per se prohibitions (which have no competition test) may create risk (including as incorrectly claimed by SCHI). That is why the process exists, and it would be wrong (possibly improper) to suggest otherwise. At most it enables something *closer to bilateral negotiations* where there is a clear imbalance in bargaining power. This is entirely consistent with your past authorisations.

3. We wonder: *How would you react if your pay was unilaterally cut by up to 50%, terms changed but not disclosed, with no clarity of future cuts, you had new costs and risks imposed, you had no real options (in NZ), and your employer refused engagement?* It is wrong to just claim gynaecologists are highly paid. The public would say that of you and SCHI executives. It is equally wrong – and defies common sense (and economics) – to assume no adverse effects.

4. We reiterate the need for SCHI's *assertions* and impact of its *conduct* (which authorisation could mitigate) still to be **critically reviewed.** *Context* is essential to your assessment – *SCHI's conduct is the context and sole reason for the application*. We urge critical analysis; it is **insufficient and wrong** to *assume* SCHI's Not-for-Profit (**NFP**) insurer status immunises it from scrutiny: that ignores market power, its constitution,[4] incentives, lack of corporate oversight (numerous members who neither have control nor can exercise oversight). **We submit:**

   (1) **SCHI's position has no credibility: you must now critically scrutinise** its statements, assertions & actions.

   (2) **SCHI mischaracterises the nature and scope – and effects – of authorisation.** Its status does not address its own agency issues or lack of competition.

   (3) **SCHI as a member-owned entity is neither subject to the usual shareholder scrutiny nor competitive discipline.**

   (4) **SCHI adds no (new) evidence & its original "evidence" still needs your critical scrutiny.** SCHI/NERA still rely on a single assertion to manufacture more "evidence"**.**

   (5) **There are numerous other / residual errors & inconsistencies in SCHI's submission.**

   (6) **You must squarely address outstanding questions.**

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[1] References to the following use the shorthand in bold: the Commission's Draft Determination (23 September 2026) (**DD**); SCHI's submission on the Draft Determination (7 October 2026) (**SCHI DD Submission**); NZGA's submission on the Draft Determination (20 October 2026) (**NZGA DD Submission**); and Link Economics, "Assessment of economic issues in the draft determination on the NZGA Authorisation" (20 October 2026) (**Link Report**).

[2] Which raise competition issues which the Commission must not ignore.

[3] The DD acknowledges this position at [154] but goes no further. See for example, NZGA Addendum in response to Commission's 9 June email (26 June 2026) (**NZGA Addendum**) at [1]–[2] and [6]; NZGA's cross submission on the Statement of Preliminary Issues (**SOPI**) (4 August 2026) at [7]–[8].

[4] The Rules of the Southern Cross Medical Care Society (**SCMCS Rules**) (16 January 2023).

Executive Summary

5. The real question is not whether SCHI can reduce the fees it pays, but whether imposing those changes without meaningful engagement or adequate recognition of clinical complexity will undermine the sustainability of the specialist workforce and disadvantage women requiring gynaecological surgery. The Commission cannot assess this solely on maximising short-term reductions in insurer costs. It must also consider the consequences for specialist capacity, clinical outcomes, patient access and the wider health system, which will emerge immediately or shortly after SCHI imposes its proposal (ie in the counterfactual).

(1) SCHI's position has no credibility: you must now critically scrutinise its statements, assertions & actions

6. Context matters. SCHI asserts it engaged in a "robust consultation process" which is false.[5] It was a one-sided all-or-nothing process. SCHI cannot now attempt to rewrite history.

7. SCHI created uncertainty and shifted *risk* and *uncertainty* onto gynaecologists by offering ~50% fee reductions and asking them to put in their best price (without seeing full / any contracts) or 'miss out' on SCHI-funded patients.

8. Authorisation was therefore a way for gynaecologists to be informed and seek proper engagement with SCHI. SCHI claimed it would not engage with our board due to Commerce Act (**CA**) concerns despite a CA compliant structure. It *now* says it will not engage at all even with clear immunity. That approach is *inconsistent with good faith* but *consistent with monopsony conduct*. How long will it get a 'free pass' to behave this way?

9. SCHI deliberately (or arrogantly) ignores adverse impacts of its own proposal. This is not the 'decades old' prior approval scheme, and SCHI proposes to restructure the entirety of how private gynaecology is funded and contracted (in concert with hospitals that stand to benefit).

10. As the competition regulator, the Commission should be concerned about the unilateral conduct of a (near) monopsonist, with *market share 150% of the duopolists in regulated grocery markets.* It is your job to scrutinise such conduct (and not assume no adverse effects). Yet the DD ignores whether SCHI's conduct is in fact lawful, anticompetitive and/or a misuse of market power. SCHI's conduct is the reason for this application and forms the counterfactual against which authorisation must be assessed under the CA. **The Commission cannot be blind to SCHI's conduct and must examine whether it is lawful, or at least consider potential detrimental effects (including in hospital markets) either as part of this authorisation or separately (especially if authorisation is not granted).** The counterfactual must not be treated as unequivocally benign.

11. We formally request that you begin to scrutinise SCHI's conduct – you seem to have no problem scrutinising others (yet not SCHI). Failing to do so would be another inconsistency.

(2) SCHI mischaracterises the nature and scope – and effects – of authorisation

12. **SCHI is not obliged to engage or agree terms and said it will not.** SCHI unquestionably has substantial buyer (and seller) power, covering 60% of insured New Zealanders by number and 67% by value and faces little competitive discipline.[6] SCHI knows that even if authorisation is granted, there will be no outcome unless it agrees to those outcomes, ie it can "walk away" (per Commission's precedent[7]). [8] If SCHI refuses good faith discussions, it / hospitals still dictate terms, and there is minimal difference to its asserted counterfactual. But its stance goes to the core issue, confirming SCHI's monopsony power, consistent with a corporate culture of

[5] SCHI DD submission at [10.3(a)].
[6] See Southern Cross Medical Care Society Group (**SCMCS**) 2026 Annual Report – Summary, p 4.
[7] See New Zealand Banking Association Authorisation Final Determination [2026] NZCC 14 at [202].
[8] If as the DD preliminarily finds (which we reject), SCHI cannot "walk away" (because of its contract with its members), it follows that SCHI will raise its fees in the counterfactual until it gets sufficient coverage, likely making any gap between the factual and that counterfactual minimal.

arrogance and attitude of infallibility. We reiterate this must concern the Commission – SCHI's NFP friendly society status does not neutralise market power and conduct concerns (which the DD assumes it does). It is competition, not good intentions that drives efficiency and SCHI clearly faces little.

13. **SCHI would only agree terms (on a basis) that suited it.** A more informed determination by SCHI with proper regard to the impacts of its proposal, which avoids unintended consequences, is welfare-enhancing. Authorisation is the lawful means for that engagement. **So there can be no real detriment and only real benefits.**

14. **A delay (briefly preserving the status quo) is not a collective boycott and authorisation may only result in high-level discussion** (eg on coding, glide-paths / guidance on future reductions).

(3) SCHI as a member-owned entity is neither subject to the usual shareholder scrutiny nor competitive discipline

15. **Unlike other commercial organisations which typically have cornerstone shareholders exercising oversight, members cannot and do not hold SCHI accountable. Even if members could, that is not a substitute for the discipline of workably effective competition.**

    (a) **Members are effectively customers not owners.** SCHI's ownership is spread across hundreds of thousands of policyholders. Each has one vote and none has a material stake or the information to hold management or the Board to account. A member is even less well placed to judge whether SCHI's decisions serve members than to judge their own treatment and its price.[9]

    (b) **In practice, the Board is self-selecting.** The Board may appoint directors between AGMs and can put them to members for approval, often uncontested.

    (c) **Its objects are purely financial.** SCHI's purposes are confined to reimbursing healthcare and related costs. They say nothing about access to appropriately qualified specialists, timely treatment, quality and continuity of care, a sustainable specialist workforce or long-term affordability of premiums.[10]

    (d) **Management incentives favour short-term KPIs to cut costs**. Management faces pressure to deliver cost savings quickly and price is easier to set than monitor quality. As Link Economics, explains SCHI's managers, and even its current members, not being fully informed, may prefer economically lower premiums over economically efficient premiums (to the medium- to long-term detriments of future members).

    The Commission must scrutinise SCHI's claims and incentives, and cannot assume they perfectly align with members' needs. If, as we submit is the case, there are detriments to quality and output then SCHI's (short-term focused) decisions could adversely impact its current / future members.

(4) SCHI adds no new evidence & its original "evidence" still needs your critical scrutiny

16. **SCHI still relies on a single assertion to manufacture more "evidence".** Almost every figure SCHI relies on (surgeon costs, premiums, co-payments, allocative losses and delay costs) is derived from one unsupported assumption (originally Figure 1[11]): that NZGA would secure fees *above* what gynaecologists charge under *current* Fee-for-Service (**FFS**) levels (ie a status quo counterfactual), which is wrong and contradicts NZGA's stated position, its member survey and the fee cap NZGA has offered (<u>any fee agreed would be what SCHI accepts</u>).

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[9] If members cannot discipline costs at the point of treatment (as SCHI alleges) it follows that they are even less able to discipline SCHI. DD at fn 7 states "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[y]." citing SCHI submission on SOPI at [4.3].

[10] See rule 3 of SCMCS Rules.

[11] See Figure 1 of SCHI's cross submission on the Statement of Preliminary Issues (**SOPI**) (3 August 2026) at [2.8]; see also the same graph at Figure 2 at [193] of the DD.

17. Indeed, SCHI's own expert, NERA, does not support (or test) SCHI's factual price forecast. Link finds such an increase to be utterly implausible and has been unable to properly test the underlying data which underpins such an increase, given limited access to SCHI's confidential information.[12] We remain concerned about the inconsistent and uneven approach to confidentiality (between the parties) and would urge the Commission to disclose information so that it may be properly tested. (This approach favours parties with market power and deep pockets, the antithesis of what the Commission's concerns should be.)

18. Removing that incorrect assumption (and in the absence of new evidence), SCHI has no basis to claim that the DD understates the detriments. This is a cynical view by SCHI who should see engagement as an opportunity to make better informed decisions. So the Commission should place no weight on SCHI's baseless assertions regarding outcomes in the factual, unless it can independently and rigorously test the underlying data (with financial and medical experts). We understand this has not happened.

(5) There are numerous other / residual errors & inconsistencies in in SCHI's submission

19. Where SCHI relies on aspects of the DD that are untested (ie not tested independently), incomplete or inconsistent, NZGA asks the Commission to carefully test it (ideally with experts) rather than accept SCHI's suggestions (as it has often done so far in this process).

20. Equally, SCHI cannot argue contagion / spillover in one direction only. If that argument were to be accepted (which NZGA rejects), it would make the counterfactual's adverse effects far greater than SCHI (and the DD) suggest as others would follow SCHI.

(6) You must squarely address outstanding questions in the Final Determination

21. We submit that the early inquiries and DD did not sufficiently engage with us or the issues. We submit that SCHI's 'doubling down' requires that you must, consistent with your role as an investigative and quasi-judicial body, answer the following (among other) questions:

    (a) Has the Commission independently tested SCHI's data? (see paragraph 34)

    (b) On what basis does the Commission depart from conventional economics in assuming a ~50% cut will not reduce supply and quality? (see paragraph 39(b))

    (c) Has the Commission weighed the value of uncertainty for small practices and the specialist pipeline? (see paragraph 45)

    (d) How confident can the Commission be that it has not misquoted or misunderstood NZGA members? (see paragraph 46(b))

    (e) If SCHI's members cannot hold it to account, so who does? (see paragraph 58)

    (f) Has the Commission assessed SCHI's conduct under the CA (and other provisions) and if not, why not? (see paragraph 75)

22. **The Commission must not defer or sidestep these issues by assuming SCHI's conduct is benign or leave them for another day.** This application squarely puts SCHI's conduct and its detrimental impacts before you now**.** A Final Determination that rests on untested assertions and unexamined conduct will be open to challenge and would put the Commission's credibility and reputation at real risk. *If a market study in five to ten years' time reveals the harm we are describing now, you will have to answer why you did not act when the issues were squarely put before you?* **Once the Commission has resolved the errors and inconsistencies and answered these questions, we submit that it must find authorisation should be granted.**

[12] Link Report at [38].

23. We expand on these points in the body of this submission. While we focus this cross submission on SCHI, we note our agreement with the other submitters that serious clinical outcomes are at stake and must be properly assessed.[13]

[13] See Endo Warriors Aotearoa, Women's Health Action and the anonymous gynaecologist submissions. There are serious clinical outcomes at stake here, particularly for patients with complex conditions such as endometriosis. These patients (and a growing number of women) rely on access to experienced specialists through the private healthcare system which supplements a stretched public system. We reiterate that the Commission must assess those impacts carefully.

A. SCHI deliberately mischaracterises the nature, scope and effects of what is being authorised

24. **SCHI (continues to) misleadingly characterise what the application seeks and what impact authorisation has:** SCHI describes the application as ~130 surgeons agreeing "what they will charge" and refusing jointly to contract.[14] That is not what NZGA applied for and/or has since clarified: **(a)** members retain individual autonomy;[15] **(b)** participation is voluntary with an opt-out;[16] **(c)** services continue under FFS during the standstill;[17] and **(d)** NZGA does not seek an increase on FFS.[18] Ultimately, SCHI remains free to reject any proposal it considers uneconomic.[19] **In substance, the authorisation is collective engagement with an unavoidable trading partner that still retains the final decision.** We reiterate that SCHI would only agree terms that suit it. Any change from engagement can only reflect a better-informed decision by SCHI, which is welfare-enhancing.

25. **SCHI conflates the jurisdictional thresholds with the substantive assessment:** SCHI says the authorised conduct would "ordinarily be prohibited as cartel conduct (a criminal offence)", and misleadingly frames collective engagement by NZGA as inherently unlawful or harmful.[20] That is false and not what the DD says.[21]

    (a) **NZGA applied for authorisation because SCHI declined to engage, citing CA concerns**. NZGA could have engaged with SCHI outside the authorisation framework.

    (b) NZGA's position, as set out in the application, is that the Proposed Arrangements would not substantially lessen competition. NZGA remains of this view.

    (c) The Commission finding jurisdiction to consider NZGA's application is not a finding that collective engagement is unlawful, nor a measure of any lessening of competition (as jurisdictional thresholds are deliberately low).[22] SCHI cannot rely on the assessment of jurisdiction to create issues that do not exist. The benefits must be balanced against the extent of any lessening of competition. The DD does not return to assess any lessening of competition. Given individual contracting, the standstill limits and SCHI's control over the outcome, any lessening is minimal.

26. **The cartel framing adds nothing:** Unlike the old law, there is no deemed lessening of competition. Nor must the Commission determine whether a cartel provision in fact exists. SCHI has no basis for equating jurisdiction with unlawfulness.[23]

    (a) **There are a range of (low cost) factuals that do not raise competition law concerns:** We reiterate that engagement can be very simple, including limited information exchange and feedback to SCHI from members, with a clear transparent process for implementation <u>if SCHI agrees</u>. SCHI's proposal could give greater certainty by providing clear bands, glide-paths or some other transparent methodology.

    (b) **Equating cartel statistics to NZGA is disingenuous:** SCHI cites a number of the Commission's 'hardcore' cartel figures, not relevant to this application.[24] They must be disregarded.

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[14] SCHI DD Submission at [2.2] and [14.2].
[15] NZGA authorisation application (19 May 2026) (Application) at [2.4] and [6.2]; Link Report at [115]; DD at [93.4] and [300].
[16] Application at [6.3(b)]; DD at [169].
[17] Application at [11.27]; DD at [169].
[18] Addendum at [7]; NZGA cross-submission on SOPI at [2]; DD at [191].
[19] NZGA cross-submission on SOPI at [7]–[8]; DD at [154].
[20] SCHI DD Submission at [2.2] and fn 37; DD at [123]–[124].
[21] NZGA applied under two limbs: sections 58(1) and (2), where section 27 *might* apply, and sections 58(6B) and (6D), where a provision *might* be a cartel provision.
[22] Under sections 58(1) and (2) of the Commerce Act 1986 there need only be a lessening of competition, which need not be substantial, and a "real chance" of that lessening is enough. See also ss 61(6) and (6A) and the DD at [100] and fn 138.
[23] Under sections 58(6B) and (6D), there need only be reasonable grounds to believe that a provision might be a cartel provision. Commerce Act 1986, s 61(9); DD at [101].
[24] SCHI DD Submission at [4.4(c)] and fns 18 and 37.

27. **A standstill, not a boycott:** SCHI disingenuously continues to portray NZGA's standstill as a boycott, which it is not.[25] A boycott withdraws supply while NZGA's standstill preserves the status quo – members continue treating SCHI members on existing FFS terms.[26] NZGA relied on *Catholic Health Australia* (**CHA**) for the benefits the ACCC recognised in a limited standstill: it can make collective bargaining effective where bargaining alone is insufficient, by encouraging a stronger counterparty to the table.[27] Those passages in CHA about the benefits of collective bargaining and boycotts (which the standstill is not) are not confined to suppliers. Whether the benefits outweighed detriments in CHA turned on bargaining power and safeguards, not on who the counterparty was. [28] Bargaining power is clearly disproportionately in SCHI's favour,[29] and NZGA's standstill is time-limited and conditioned.[30] NZGA therefore aligns closely with the supplier standstill the ACCC authorised (not the one declined).

28. **Authorisation addresses any spurious risks raised by SCHI:** We were happy to engage in high-level discussions with SCHI to get a better understanding of what is being proposed and gain confidence in its proposal. SCHI declined citing CA risk, and the Commission confirms authorisation would safely allow those discussions to occur.[31] Authorisation removes that alleged risk and allows safe engagement (which SCHI says it will refuse). The Commission assesses arrangements of this kind under a settled framework,[32] no valid reason has been provided to depart from that approach.

29. **Even government agencies are subject to independent scrutiny, and must engage meaningfully:** SCHI essentially asks the Commission to "trust us" but that is not even a standard applied to government agencies. Even government agencies have obligations to engage meaningfully and must follow procurement rules. Proper engagement is why NZGA sought authorisation. SCHI has instead gone through the motions, adding just 2 additional codes and stating things are now "largely settled". Its claim that it could not engage with NZGA on competition grounds is now clearly an excuse and inconsistent with what it now argues (that it will refuse to engage with NZGA directly).

30. **NZGA's acceptance of reductions was not coordination (and was inaccurately ignored by the DD in its finding of price increases in the factual):** SCHI should be pleased that NZGA is understanding of its need to manage costs rather than complaining about reductions. Instead, it chooses to make spurious claims. A response to the Commission's questions regarding NZGA's intentions *if* authorised cannot be (illegal) coordination.[33]

B. SCHI's assertions all rest on one untested assumption ("evidence")

31. **Misleading "evidence" which says the factual will lead to costs above FFS:** Unsurprisingly, SCHI's counterfactual sits below FFS but somehow its factual does not. SCHI asserts collective bargaining costs of ~$113m in FY2027 and ~$159m in FY2031, against FFS of ~$66m and ~$105m and its Affiliated Provider Scheme (**APS**) counterfactual of ~$48m and ~$69m.[34] SCHI now extends that forecast to $243m by FY2036, against $105m under its APS.[35] On SCHI's "evidence", NZGA would somehow secure fees well above what members charge acting alone today on the basis that the lower paid gynaecologists would be lifted to a higher percentile. That

[25] SCHI DD Submission at [2.2] and fn 35.
[26] Application at [11.27]; DD at [169].
[27] ACCC *Catholic Health Australia* Final Determination (27 February 2025) at [4.19], [4.56], [4.58] and [4.74].
[28] *Catholic Health Australia* at [4.87], [4.48], [4.51]–[4.55], [4.62] and [4.88]–[4.89]. SCHI misleadingly keeps pointing out the ACCC's decline of the health insurer standstill). The ACCC declined that standstill because it found no disparity in bargaining power, given the hospitals' substantial and sometimes "must-have" bed shares, and because there was no external mediation and it could be triggered merely by an insurer declining to negotiate. Even then, the ACCC found only that higher premiums "may" result: at [4.90] and [4.130].
[29] DD at [59] and [177]; Link Report at [2] and [15].
[30] NZGA DD Submission at [82]–[84].
[31] DD at [269] and [273.3].
[32] New Zealand Tegel Growers Association Incorporated [2022] NZCC 30 at [177]; DD at [264] and fn 333.
[33] The statement responded to the Commission's email of 9 June 2026 in Addendum at [7]. SCHI DD Submission at [5.2(b)].
[34] DD at Figure 2 (reproducing SCHI cross-submission on SOPI (3 August 2026) at Figure 1); Link Report at fns 2 and 17.
[35] SCHI DD Submission at [2.3(a)], [4.3(a)] and fn 11 (extending SCHI's FY2031 forecasts in its SOPI cross-submission at [2.8]).

is irreconcilable with NZGA's consistent position accepting a decrease from FFS levels.[36] Indeed, the NZGA's anonymous workforce survey shows more than [ ]% of respondents would likely accept a reduction.[37] NZGA has also offered a fee cap to FFS levels to address such assertions from SCHI. The Commission rightly finds SCHI's percentile assumption unsupported.[38] SCHI now asks the Commission to treat the assumption of an increase as "reasonable and conservative" offering nothing new to justify this.[39]

32. **SCHI's percentile assumption is neither reasonable nor conservative:** In any event, SCHI's assumption that fees would move to a percentile of current billed-per-minute (**BPM**) rates is flawed:[40]

    (a) SCHI's own analysis is incomplete. It concedes it can only analyse cases where theatre time is supplied, and some facilities and gynaecologists do not routinely supply that data.[41] The assumption is built on a partial dataset with gaps SCHI does not quantify.

    (b) BPM is a misleading measure of price as it punishes the most experienced surgeons who are more efficient but charge the same as their peers. Regardless, theatre time captures only part of the clinical time involved in a procedure.[42] Total fee per procedure can also be misleading, as the most experienced surgeons may conversely undertake the longest and most complex cases (including being more careful to prioritise patient outcomes). This is why clinical engagement is necessary to understand whether comparisons are accurate.

    (c) SCHI's "price floor" fear is without basis. Access to reference prices will only make individual gynaecologists mildly better informed and economic literature suggests price transparency weakens rather than strengthens a gynaecologist's bargaining position.[43] Any residual concern is answered by a cap at each member's current FFS level.

33. **The premium and co-payment figures are not new evidence:** SCHI presents several examples: 12.4% higher premiums (more than $535 a year) for a 30-year-old on Wellbeing 2; 12.4% (more than $310 a year) for the same member on RegularCare; and co-payments 133% higher for a RegularCare member needing surgery.[44] These examples are simply restatements of the same assumption (Figure 1) applied to SCHI's plans and add nothing new. The 133% co-payment figure is arithmetically the assumed ~130–135% fee uplift restated because a 20% co-payment moves one-for-one with the fee (ie not new evidence).[45]

34. **SCHI's quantification is assertion, not tested evidence:** SCHI says the Commission should acknowledge its "significant volumes" of quantitative material.[46]

    (a) Self-selected evidence and volume created using the same underlying data is not reliability. NERA was instructed to adopt fundamental assumptions that SCHI has not supported with independent evidence.[47]

    (b) SCHI relies on data drawn from SCHI's billing records which lacks the qualitative data surrounding the complexity of the procedure (ie the *same* procedure is not the *same* across patients). Nor does SCHI seem to account for the skill or experience of the surgeon.

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[36] Addendum at [7]; NZGA DD Submission at [72(a)] and [83(a)].
[37] Link Report at [39].
[38] DD at [194].
[39] SCHI DD Submission at [5.2].
[40] SCHI DD Submission at [5.2].
[41] SCHI DD Submission at fn 28, where SCHI admits: "In providing this response in relation to percentiles, **SCHI notes that it is only able to review data where theatre times are supplied and some facilities/gynaecologists do not routinely supply this data.**" [emphasis added].
[42] Link Report at [82]–[83] and [90].
[43] Link Report at [35]–[36].
[44] SCHI DD Submission at [4.3(b)]–(c) and fn 12.
[45] Link Report at [37] and fn 17.
[46] SCHI DD Submission at [13.1]–[13.2].
[47] Link Report at [77].

(c) SCHI's comparisons with CPI and Australia do not control for medical cost inflation, procedure mix or the difference of funding models.[48]

Critically, neither NZGA nor Link Economics has been permitted to properly see the underlying data. The Commission must not rely on assertions that no one has tested (any proper testing of that data would likely need to involve a medical specialist, which SCHI is not). The Commission's own Authorisation Guidelines commit to testing information received and giving less weight where a submission cannot be supported by "corroborating evidence".[49] To rely on SCHI's untested figures in the Final Determination would be a material error. **We ask the Commission, has it independently tested SCHI's underlying data and, if not, on what basis can it rely on it?**

C. SCHI misrepresents what fees and wealth transfers are in this case

35. **Specialist remuneration is not a "wealth transfer" to be minimised and fee variation is also a reflection of qualification and expertise:** SCHI now asks the Commission to treat payments to surgeons as a detriment rather than a neutral transfer and treats gynaecologists billing above its chosen percentile as outliers who "would still need to accept a reduction".[50] There is no factual and evidential basis for that. Further, that framing inherently casts specialist remuneration as something to be driven down and fee variation as a defect. It is neither.

(a) Private gynaecologists are senior medical practitioners who have typically spent decades in continuous study and supervised practice before working independently (see **Table 2** below as an example). This pathway involves years of night, weekend and on-call duty and often an overseas fellowship, and it is largely self-funded. Many graduates carry student debt of well over $100,000. Current RANZCOG fees alone total approximately AU$48,000 (about NZ$54,000). Ongoing professional costs run to an estimated $26,000 or more every year.[51] Full specialist earnings typically begin only in the mid-30s or later.

(b) Expertise does not stop at qualification either: skill, judgement and subspecialty capability continue to build over a career. Variation in fees across gynaecologists reflects that spectrum (experience, case complexity, subspecialty and outcomes), as it does in law, accounting or any other profession. Compressing everyone into SCHI's bands does not remove "excess"; it removes all price signals on the market for expertise and replaces it with what SCHI deems is 'right' (which it has not provided any transparency over). SCHI should not solely criticise and then determine gynaecologists' remuneration on the basis of its own untested assumptions and preferred methodology. *SCHI would not accept a third party setting its chief executive and senior management's remuneration without a proper understanding of the roles and a sound or transparent basis for calculation (likewise, nor would you and your staff). So why should we?* **A surgical fee is not just payment for an hour in theatre but a reflection of decades of training, sacrifice and ongoing clinical responsibility.** Fee variation may reflect skill, experience, complexity and subspecialty (SCHI provides no evidence to suggest these aspects have been sufficiently accounted for in its analysis).[52]

36. **Fees are gross revenue, not net profit:** The Commission must not forget that a gynaecologist's surgical fee is effectively a practice's gross revenue. The operating costs of running a private practice are steep (and rising each year) – it is common for a private practice's costs to exceed several hundred thousand dollars. These are largely fixed costs which would remain constant (or do not fall proportionally) despite any reduction in fees by SCHI. We provide an example breakdown below:

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[48] Link Report at [79]–[99].
[49] Commerce Commission, *Authorisation Guidelines* (June 2023) at [199] and [241].
[50] See SCHI DD Submission at Section 4 and [5.2(c)].
[51] College subscription, Medical Council practising certificate, medical indemnity, society memberships and continuing education conferences cost an estimated NZ$26,000 or more every year.
[52] Link Report at [90]–[92].

TABLE 1: EXAMPLE BREAKDOWN OF PRIVATE PRACTICE'S ($) OPERATING COSTS

Costs	Average cost ($) across [ ]
Staff wages, expenses & locum costs	[ ]
Premises (eg rent, electricity, cleaning, etc)	[ ]
General business, administration & IT	[ ]
Medical equipment & supplies	[ ]
Professional fees, compliance & insurance	[ ]
Patient engagement & donations	[ ]
Total expenses	**$[ ]**

Note – this table provides costs for [ ] *as an example. The $ figure above is typical for a gynaecologist in private practice* [ ]. *NZGA is happy to provide a further survey on costs should the Commission find this useful.*

37. **The modified total welfare standard would not change the outcome:** The Commission has already found that applying a modified total welfare standard would be unlikely to change its preliminary view.[53] SCHI's request adds nothing substantive to the balance.

38. **SCHI asserts monopoly rents without basis:** SCHI relies on *AMPS-A* but that would require SCHI to demonstrate that 100% of the reduction in fees is "functionless monopoly rents".[54] SCHI provides nothing to support such a fallacious claim. That false characterisation is SCHI's assumption which it instructs NERA to follow. SCHI contradicts its own proposal in this regard – "structured pricing" compresses fees into narrow bands (which SCHI determines) removing any price signals that would reveal what efficient, competitive pricing is.

D. The allocative detriments from the counterfactual must not be ignored

39. **SCHI assumes away the harm in the counterfactual:** The baseless (and absurd) assumption that fees are simply economic rents is used by SCHI to (wrongly) assert a ~50% fee cut has no effect on quality and supply. That defies common sense and economics and as discussed, only applies if the reductions are pure "functionless monopoly rents" (which they are not). SCHI has produced no evidence for that assertion and instructs NERA to adopt that assertion too. The DD then (wrongly) accepts it untested.

    (a) **When the price paid for a service falls, the quantity and quality supplied also fall with it – that is basic conventional economic theory:** This is even more so for complex, skilled surgical work, where quality is harder to measure than price. NZGA's anonymous workforce survey confirms the obvious – with members likely to reduce workloads, stop complex work, retire early or leave overseas.[55] The factual maintains supply and the counterfactual does not. Further, a lower surgeon fee cannot be assumed to be a lower healthcare cost. If fee cuts reduce specialist availability, delays treatment or shifts complex cases to the public system, total costs may rise. The Commission should assess total healthcare costs and patient outcomes, not just SCHI's costs as a direct proxy for an allocative detriment.

    (b) **We ask, what basis does the Commission have for departing from conventional economic theory and accepting SCHI's assertion that a ~50% fee cut will not materially reduce output, quality and supply?** If there is none, then that would be equivalent to assuming with no evidence or relying wholly on SCHI's word, for which there is no evidence either. That cannot stand and the Final Determination must find a clear, significant harm in the counterfactual.

40. **The cut falls hardest on experienced specialists, which in turn impacts the pipeline of new specialists:** The effect on supply is disproportionate as [ ]% of private gynaecologists are aged [ ] or over and these senior practitioners carry most complex and subspecialty work.[56] Retirement or reduced work is a real and immediate option for them. Authorisation is an opportunity to establish clarity for the entire specialty, which faces ~50% cuts moving forward.

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[53] DD at [222] and [420].
[54] SCHI DD Submission at [4.4(b)(ii)] and fn 17. In any event, *AMPS-A* concerned rents to overseas shareholders, not fees paid to New Zealand clinicians for gynaecological services to New Zealand women.
[55] Link Report at [57] and [59]–[60].
[56] NZGA DD Submission at [44]–[45].

(a) **In subspecialties with only a handful of practitioners, a single exit removes a significant share of national capacity and regional areas are worse off.**[57] New Zealand has only around 10 gynaeoncologists (against an estimated need of 18), three urogynaecologists and 20 advanced laparoscopic gynaecologists. The Commission cannot ignore the significant risk of reducing already small numbers. The impact will also not be uniform across New Zealand as in smaller regions, losing even one experienced gynaecologist may leave no practical alternative provider. Neither SCHI nor the DD has assessed these subspecialty and regional effects.

(b) **Those senior specialists also train and mentor the next generation, so their loss compounds:** Fewer trainees will likely choose gynaecology (or even students choose the medical profession), as a result of SCHI's proposal in the counterfactual.[58] Link estimates capacity for ~8,200 procedures a year would be lost, ~6,600 of them private.[59] The uncertainty will shape decisions in the immediate future. Junior doctors will hear from senior colleagues about dealing with SCHI – negative experiences will shape whether the next generation pursue gynaecology and which subspecialty to train in. Some may decide against a career in medicine in New Zealand altogether. Once made, those decisions are not easily reversed and will play out immediately in the short term but have lasting impacts in the medium to long term. SCHI and (the DD) have no regard to how its conduct affects the next generation of medical specialists.

(c) **Lost specialists cannot be quickly replaced:** Becoming a laparoscopic gynaecological surgeon in New Zealand typically takes 16–19 years from the first year of university (see **Table 2**). Most reach independent practice in their mid-30s to around 40, and many do so later because of career interruptions in a predominantly female workforce. Advanced laparoscopic and subspecialty skills often require fellowships overseas, and New Zealand already struggles to bring those trainees home. SCHI's proposal makes returning even less attractive: a gynaecologist weighing an established career abroad against a ~50% fee cut, unclear terms and uncertainty back at home is unlikely to return. Each lost specialist, whether through exit or non-return, removes capacity that takes well over a decade to rebuild (and on publicly funded training), a cost neither SCHI nor the DD has considered.

TABLE 2: TRAINING PATHWAY TO BECOMING A LAPAROSCOPIC GYNAECOLOGICAL SURGEON IN NEW ZEALAND

Stage	Years	Notes
First year Health Sciences / Biomedicine	1	Highly competitive selection into medicine
Medical school (Auckland or Otago)	5	Completes the six-year medical degree
House officer (PGY1–2)	2	Required before specialist training can begin
Pre-training registrar years	1–2	Common, to become competitive for selection
FRANZCOG specialist training	6	276 weeks: 4 years Basic + 2 years Advanced Training
Advanced laparoscopic fellowship	1–3	AGES 2-year program, subspecialty training (3 years) or overseas fellowship
Total after first year university	**16–19**	Most reach independent practice in their mid-30s to around 40, potentially later due to career interruptions associated with childbirth and family responsibilities, particularly given the predominantly female workforce

41. **The detrimental effects on the public system are in the counterfactual not the factual:** SCHI asserts that in the factual, higher fees would raise premiums, causing some members to drop cover and push more patients into the public system.[60] That rests on a shaky causal chain of assumptions – fees passing through to premiums, gynaecology having a material impact on premiums and members dropping cover as a result. Even if correct (which it is not), that is an indirect (or "second-order") effect.[61] By contrast, the harm in the counterfactual is direct – loss of capacity in both private and public sectors from gynaecologists reducing work, retiring or going overseas. The public system cannot absorb that loss the short term and would likely need

[57] NZGA DD Submission at [48(b)].
[58] NZGA DD Submission at [45(b)]; Link Report at [58] and [64]–[65]; DD at [280] and [288].
[59] Link Report at [60].
[60] SCHI DD Submission at [6.1(c)].
[61] Link Report at [63].

to re-outsource at a greater cost.[62] Further, complex procedure capacity (which will be reduced in the counterfactual) cannot be substituted with more volume of simpler cases,[63] and gynaecology already has some of the longest waits in the health system.[64] SCHI makes no attempt to assess its own proposal's detriment on the public system. The Commission should assess the full cost (and disproportionate time taken) of replacing that capacity – longer public waiting times, Health NZ outsourcing costs, public theatre constraints, the cost of training and retaining specialists, and lost training opportunities when cases are outsourced from public to private. Uncritically, SCHI and the DD have not properly considered any of these.

42. **If contagion applies (which NZGA rejects), the counterfactual is worse:** The Commission has previously – and consistently – found that there are different markets with different monopsonists (ACC and Health NZ, formerly the DHBs). That has not changed. But if SCHI's contagion argument were accepted it would work both ways, and the DD's (wrong) likely counterfactual would likely have much greater adverse effects, which the Commission must consider.

    (a) **SCHI is the price leader:** Other insurers, and public funders to the limited extent they purchase private gynaecology, would follow SCHI's reference prices, equally pushing fees down towards ~50% below current FFS levels. In other words, if contagion applies then SCHI reducing the compensation of the most experienced specialists by ~50% is effectively an overall reduction to their incomes by up to ~50%. **Put quite simply, we urge the Commission to seriously consider how anyone would respond if faced with a halving of total revenue** and no other realistic options except moving abroad or retiring. The answer is obvious – with clear impacts on output, quality and supply.

    (b) **Alternatively, a waterbed effect follows:** SCHI asks the Commission to count greater allocative detriments in the factual, but makes no effort to apply the same detriment in the counterfactual. A ~50% cut imposed on the whole specialty at once cannot simply be absorbed and practices must either recover it from other funders and self-pay patients (ie the waterbed effect), or reduce capacity and exit. The Commission cannot reject both the waterbed and the supply effects unless it proves (which it cannot) SCHI's fallacious claim that reductions are 100% rents.

    Either way, the counterfactual carries a detriment the DD has not counted. The Commission should re-examine the contagion risks running against the counterfactual.

43. **Adverse selection is unsupported:** SCHI adds literature but no gynaecology-specific evidence. The Commission found the effect "unclear",[65] and SCHI's case for it depends entirely on the inflated premium figures above.[66]

E. Transaction costs can be relatively low under the factual and significantly higher in the counterfactual due to the uncertainty

44. **No delta is measured:** SCHI attributes the highest cost to the factual, including several negotiation rounds, and compares it with a (false) counterfactual with nothing. It does not account for likely outcomes in the counterfactual, including staggered uptake, individual refusals (or reduction/exit), regional practice structures and continuing disputes, all of which carry costs for all parties involved (including SCHI and hospitals).[67] How simple the process and costs are depends largely on SCHI's willingness to engage (and could be very high-level as SCHI chooses). Any approach by SCHI (and likewise the Commission for its analysis of the counterfactual) must be consistent.

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[62] Link Report at [62] and [67]; NZGA DD Submission at [49]. See also Health NZ's recognition of the benefits: DD at [9].
[63] DD at [414]–[415.2]. Simple procedures are not a substitute for complex procedures, which will be required to be done elsewhere (ie the public sector, where re-outsourcing means the wider public pays shoulders the cost instead).
[64] NZGA DD Submission at [12(a)].
[65] DD at [341].
[66] SCHI DD Submission at [6.1(b)].
[67] SCHI DD Submission at [7.1]–[7.2]; cf NZGA DD Submission at [26]–[33].

45. **SCHI (and the DD) ignores the cost of uncertainty itself:** Private gynaecology practices are largely solo, clinician-led businesses with their own administrative and clinical staff, premises, equipment and lease commitments. SCHI proposes to restructure fundamentally how those businesses are paid, without transparency. A small business cannot plan staffing, investment or capacity when its main revenue source may fall by ~50% on terms it has not seen. Authorisation gives certainty and that is a benefit itself – even if fees are reduced, gynaecologists could negotiate a clear glide-path and known terms. Certainty allows practices to adjust and manage their business moving forward and avoid decisions to reduce capacity or exit. **Has the Commission weighed the value of certainty to small practices facing a ~50% revenue cut on unseen terms?**

46. **SCHI 'doubles down' on inconsistent finding of heterogeneity:** SCHI agrees with the Commission's (wrong) finding of heterogeneity between gynaecologists. Heterogeneity is used to suggest that gynaecologists will incur significant transaction costs in the factual (due to needing to reach an internal consensus on a number of differences).[68] Yet, inconsistently, the heterogeneity vanishes in the counterfactual, with the DD finding that gynaecologists will all uniformly accept SCHI's proposal 'as is'. Both cannot be true as we have already noted in the NZGA DD submission.[69]

    (a) The finding of heterogeneity ignores the formation of NZGA, where members came together to form the association on the common ground that the industry does not wish to accept SCHI's proposal 'as is'.[70]

    (b) NZGA welcomes the Commission hearing directly from its members. But differences in familiarity or emphasis are not inconsistencies and should be tested. We have mentioned some of these interview examples with the Commission already. They should not be 'cherry picked' to manufacture heterogeneity that (on the DD's own reasoning) disappears in the counterfactual. **How confident can the Commission be that it has not misquoted or misunderstood NZGA members (especially given that we have canvassed members views, and interviewees have complained to us about your selective quotation of evidence)?**

47. **SCHI's own numbers show the costs are small:** SCHI estimates NZGA-side costs at $2,000–$6,000 per member.[71] That is modest against a ~50% fee cut and is borne voluntarily.[72] SCHI's own additional costs are largely minimal because (it admits) it would use existing staff.[73] Its suggestion that those staff would be redeployed elsewhere is doubtful as they are likely to be occupied with ongoing pushback from NZGA and individuals/groups in the counterfactual.

48. **The multiplier costs are overstated:** SCHI renegotiates APS every two to three years in both the factual and counterfactual so we disagree that such costs should be attributed to the factual alone.[74] If such repetition leaves any remaining concerns, a shorter authorisation term can easily address it.

[68] SCHI DD Submission at [7.1]; see also DD at [26.2] and [311.1].
[69] NZGA DD Submission at [31].
[70] DD at [3] and [52].
[71] SCHI DD Submission at [7.1(b)].
[72] DD at [328]; Link Report at [72].
[73] DD at [323].
[74] DD at [166].

F. SCHI's finances are not gynaecologists' fault and its incentives do not align with its members

49. **SCHI smooths costs, as insurers do:** SCHI says it cannot absorb higher costs.[75] But insurers routinely run 'unders' and 'overs' and manage them through reserves and investment returns. SCHI's own Board describes surpluses and deficits as "recurring features of the sector".[76] SCHI has drawn on reserves to hold down premiums eight times in 25 years, and its FY2025 underwriting loss was largely offset by investment income.[77] Its own submission records the Board deliberately rebuilding reserves over three years, outside its risk appetite, to soften premiums.[78] Clearly, passthrough is neither automatic nor one-for-one.[79]

50. **SCHI is narrowing its offering at both ends – paying specialists less and providing members less cover:** SCHI frames the APS as delivering its core insurance service affordably. But at the same time, it is both eroding members' cover and specialists' fees. Members have no formal mechanism to respond as pre-existing condition exclusions and waiting periods present significant barriers to switching. You make no scrutiny of such conduct by a near-monopsonist health insurer. Yet if one of the duopolists in the grocery markets imposed comparable terms on suppliers (non-negotiable, unilaterally set, with no written terms provided) and reduced quality of goods and services supplied to consumers, you would not stand by.

51. **SCHI must manage its costs, which we acknowledge, but that says little about gynaecology:** SCHI has returned to surplus and now says its capital position shows "the importance that SCHI continue to manage claims cost to support sustainable premiums for its members".[80] NZGA agrees – managing claims costs is an insurer's core function. The Reserve Bank has said premium increases are needed to restore the health insurance sector's profitability.[81] But how an insurer manages the broader health sector pressure says nothing about whether gynaecology-specific fees are above competitive levels.

52. **The whole health sector is under strain, and the drivers are not gynaecologists' fees:** RBNZ's findings show that until 2022, medical cost inflation was within a typical range and premiums rose broadly in line with it.[82] That suggests underlying cost inflation, including specialist fees, is not the structural problem SCHI now says it is.

    (a) What changed after 2022 was a combination of other factors: **(i)** greater use of private care because of capacity pressures in the public system (ie utilisation); compounding by global cost drivers such as **(ii)** adoption of high-cost technologies; **(iii)** supply-chain disruption; and **(iv)** rising labour costs. These are sector-wide pressures (often on a global scale), not gynaecology-specific ones. As Link finds, gynaecologists' fees did not change like cost claim inflation.[83]

    (b) Official price data supports broader (global) pressures. Stats NZ's price index for hospital services rose 11–15% a year through 2024, against general inflation of about 2–4%. It then eased to about 3.5–4.5% from the September 2025 quarter.[84] Those are facility prices (ie hospitals) which also rose significantly following the 2022 period.

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[75] SCHI DD Submission at [11.2(c)].
[76] SCMCS 2026 Annual Report – Summary, p 2.
[77] NZGA DD Submission at [56] and [72(c)] and fn 173.
[78] SCHI DD Submission at [12.3].
[79] DD at [336.2] and [337].
[80] SCHI DD Submission at [11.1]–[11.2(b)].
[81] Reserve Bank of New Zealand (**RBNZ**), *Financial Stability Report* (**FSR**) (November 2025) at p.48. See also RBNZ FSR (May 2026).
[82] RBNZ FSR (November 2025) at p.48.
[83] Link Report at [86].
[84] Figure NZ, Year-on-year price change in price of hospital services in New Zealand, 2015 Q4–2026 Q2, % change from same quarter previous year.

(c) SCHI's own annual report puts its FY2024–FY2025 deficits down to an "exceptionally high volume of claims" (not price).[85]

(d) Like RBNZ, Westpac's economists attribute rising private healthcare costs to higher labour costs and wages, new medicines and treatments, and digital equipment.[86]

53. **Capital pressure is SCHI's to manage, and gynaecology is not the cause:** SCHI says absorbing even about $4.7m a year would have taken its capital ratio below 30%.[87] If an amount that small can move SCHI outside its capital settings, that reflects SCHI's own reserving and pricing decisions across its whole book, not gynaecology fees. Gynaecologists face the same staff, technology and facility inflationary pressures like the rest of the wider health sector.[88] Yet their fees have grown well below peak claims inflation of 12–18% (which SCHI points to, but omits the recent drop to 7.1%).[89] Any difference attributable to this authorisation (ie the delta) is marginal as premiums will move with these sector-wide pressures in both the factual and the counterfactual. Regardless, SCHI's estimate of an increase in the factual rests on the flawed forecast as discussed in **Section B**.

54. **The Commission should test SCHI's premise:** SCHI asks the Commission to assume its wider operations are efficient and then to isolate gynaecology fees as the cause. SCHI holds the data to show how much of its claims growth comes from volume, procedure mix and price (across specialties) or to the extent that it is from other external factors, as discussed. Yet it has not shown this analysis or at least has not been transparent so that it can be sufficiently tested. SCHI does not explain why the burden of a whole-of-book deficit should fall first on a specialty whose patients are women. The Commission should be carefully scrutinising those claims.

55. **Good intentions do not equate to good outcomes:** NZGA accepts SCHI may have good intentions. But NFP status does not neutralise SCHI **(a)** making mistakes, **(b)** middle management prioritising short-term KPI incentives to cut costs and **(c)** acting with monopsony market power, engaging in dealings without the discipline of a competitive market. As a dominant player with no competitive discipline, there is no basis to assume that SCHI is run efficiently or always right. SCHI's refusal to engage with key stakeholders, and its apparent lack of concern about quality over the short, medium and long term, are consistent with those monopsony concerns.

56. **SCHI's actions may not be driven by the members' interest:** The DD accepts at face value SCHI's claims that as an NFP it is only acting in its members' interests. But this is false: as explained by Link, SCHI's managers' interests are not fully aligned with those of SCHI or its members. Management faces strong pressure to cut costs quickly, price is easier to set and monitor than quality, and no incentive structure fully aligns managers with an organisation's objectives (this is a well-known agency issue). Even if managers were aligned, SCHI's members, not being fully informed, may still prefer economically lower premiums to economically efficient premiums. That is particularly problematic on a forward-looking basis where there is no market mechanism by which future SCHI members can signal their desire for high quality gynaecological services, whereas current members may not value the same.[90]

57. **New Zealand's light-handed regulation of health insurance creates barriers to switching:** By contrast, in Australia the Private Health Insurance Act 2007 includes 'portability' rules, so members who switch cover to another insurer do not have to redo waiting periods.

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[85] SCMCS 2025 Annual Report – Summary, at p.2.
[86] Westpac, *Healthcare in New Zealand: The changing role of the private sector* (10 March 2026) at p.20.
[87] SCHI DD Submission at [11.2(b)]–[11.2(c)].
[88] For example, top-step registered nurse pay has risen about 74% since 2011, against about 40% growth in household living costs. See NZNO and Health NZ, Nursing Workforce Factsheet (August 2025). That cost falls disproportionately on gynaecology, because a chaperone nurse must be present for intimate examinations and procedures.
[89] See SCMCS 2026 Annual Report – Summary, p.10 (claims inflation of 7.1% in 2026, 12.2% in 2025 and 13.9% in 2024); see also nib NZ, 1H25 result (24 February 2025): claims inflation of 17.6% and in nib NZ, 1H26 result (23 February 2026): a claims inflation of 9.0%. See also Link Report at [86]
[90] See Link Report at Section 2.3.

58. **Members cannot monitor SCHI (and future members have no voice at all):** Most companies (unlike SCHI) have major shareholders with the incentive and capability to scrutinise performance. SCHI's ownership is spread across hundreds of thousands of individual members. None of them has a material stake, nor the information or the expertise to be able to hold SCHI's management or the Board accountable. Formal member voting rights do not change that. Therefore, SCHI is effectively permitted to self-regulate without any oversight (unlike government entities). Nor do members control who sits on the Board – the Board may appoint directors between AGMs and may appoint uncontested candidates without any member vote.[91] As such, there is no mechanism for members to judge whether SCHI's decisions are actually serving members' interests. Members are reduced to customers who can judge only which medical treatment is right for them, or whether price is fair. As discussed, there are no market mechanism through which *future* members can signal dissatisfaction. Some of the worst effects of the APS on gynaecologist supply, especially of the most highly skilled specialists, will fall on women who are children today. **If SCHI's members cannot hold its management to account, who does, if not the Commission?**

59. **It is competition that drives efficiency, dynamism and discovery:** Efficiency and dynamism come from competition, not from good intentions. Competition is also the process by which markets "discover" what suppliers can sustainably provide and what consumers value.

    (a) It is not clear that SCHI is listening to stakeholders on the supply side (gynaecologists) or even to consumers on the buy side (its own members, whose cover/benefits have been reduced).

    (b) Indeed, Simon Gault recently publicised the fact that SCHI is denying consumers clinically appropriate care having quietly removed that cover years earlier and provides no satisfactory recourse (denying Mr Gault all options to receive cover, including offers to top up any additional fees over the procedure which would be covered). Ultimately Mr Gault was left with no option and had to pay for the procedure fully out of pocket.[92]

    That is what one would expect where competition is weak. The Commission should have proper regard to the lack of competition in health insurance and the effect of SCHI's buyer power on the supply side before SCHI's assertions are accepted without testing.

G. Impacts on clinical outcomes are understated and need to be carefully assessed (with appropriate clinical experts)

60. **The code set is not settled:** SCHI asserts coding is settled as it has adopted RANZCOG and ANZSU feedback (yet admits it decided for itself "its own funding decisions")[93] and that pelvic floor concerns are now resolved.[94] Yet complex endometriosis and pelvic floor gaps remain,[95] and SCHI has refused a separate morcellation code, relying instead on discretionary risk corridors.[96] Adding two codes for a total of 55 codes (despite RANZCOG initially proposing 84 codes) and **pointing to open codes and risk corridors is not robust consultation**. In any event, consultation is not agreement: it does not mean clinical concerns are resolved, changes are binding or complex procedures are adequately funded, **nor does it give surgeons commercial certainty or a transparent means of resolving disagreements**.

61. We refer the Commission to the NZGA DD Submission at paragraphs 65 to 68 which clearly show that the current proposed code set has remaining gaps and workability concerns.

    (a) We ask, *when SCHI's model is based on the premise of improving efficiency and reducing cost why is there such a reluctance to add a third-tier hysterectomy code as is*

[91] SCMCS Rules, rule 7.2 and 7.6(d).
[92] Natasha Gordon (NZ Herald) "Simon Gault pays for skin cancer surgery after Southern Cross declines Mohs cover" (15 October 2026).
[93] SCHI admits in fn 82 that it effectively did what it wanted "RANZCOG and ANZSU have provided SCHI clinical advice; **SCHI made its own funding decisions in accordance with the terms and conditions of its policies.**" [emphasis added].
[94] SCHI DD Submission at [10.1(c)] and fns 83–84.
[95] NZGA DD Submission at [65]–[67]; UGSA submission on SOPI at 3.
[96] SCHI DD Submission at fn 84.

recommended by RANZCOG? We reiterate that the application of risk corridors is time consuming and requires a lot of back and forth often with little to no benefit. That is a huge loss of efficiency and ultimately disadvantages patients by causing delays. SCHI is shifting risk to patient and surgeon by doing so (and it refuses to admit this).

(b) Pelvic floor codes remain unresolved and are a significant area of concern. This is particularly important when performing comprehensive three-compartment pelvic floor surgery in combination with a SUI procedure.

(c) RANZCOG has raised morcellation to SCHI but that is not the same as SCHI actually adopting a clinically appropriate approach (it has not taken RANZCOG's advice). In-bag morcellation cannot simply be bundled into a hysterectomy or myomectomy code, as it can add approximately 1.5 hours to the operating time.

(d) A separate code for in-bag morcellation is essential to appropriately recognise the additional time, complexity and resources involved.

RANZCOG suggested approach

(e) RANZCOG has provided three distinct codes for laparoscopic hysterectomy: (i) Simple laparoscopic hysterectomy; (ii) Complex laparoscopic hysterectomy; and (iii) Laparoscopic/vaginal morcellation of uterus or fibroids over 500 grams. Further, RANZCOG provides a separate code for manual or mechanical morcellation of uterus or fibroids with weight over 500 grams performed with associated laparoscopic hysterectomy, myomectomy, or vaginal procedure.

Current proposed SCHI approach

(f) By comparison, the most recent proposed SCHI coding passed on via hospitals includes only two codes: (i) Laparoscopic hysterectomy simple (AP1204) and (ii) Laparoscopic hysterectomy complex (AP 1208). There is no equivalent code for laparoscopic/vaginal morcellation of uterus or fibroids over 500 grams as provided by RANZCOG.

(g) SCHI defines complex code to apply to any uterus that is:

i. Above 12 weeks size or more than 250 grams +/- up to stage 3 endometriosis +/- adhesiolysis, +/- ureterolysis, and removal of fibroids greater than 4 cm; or

ii. Under 250 grams if stage 2 or 3 endometriosis is also being treated with this.

(h) A risk corridor of 225 minutes has been assigned to this code with a length of stay of 4 nights. But the length of stay is not relevant to surgical practice as most patients, including those undergoing large morcellations are discharged after 2 nights. Length of stay represents a fee to the hospital rather than to surgeons. The hospitals will not share the extra length of stay fee they are receiving with the surgeons, even though the surgeons will remain responsible for the entire length of stay and will be required to do daily ward rounds and answer any nursing inquiries on a regular basis.

(i) The practical application of the 225 minute risk corridor requires discussion. **Experience with bundling morcellation procedures with complex hysterectomy and applying risk corridors has resulted in unsatisfactory negotiations with SCHI to date and has never yielded a positive response.**

(j) There is a need for a separate code for morcellation of uteri or fibroids over 500 grams, regardless of surgical route (laparoscopic or vaginal). These procedures are time-consuming and should not be bundled with stage 3 endometriosis cases.

62. **RANZCOG is not a substitute:** SCHI relies on its consultation with RANZCOG to say that non-price concerns have been resolved without collective bargaining. But RANZCOG does not

engage in the commercial aspects of its members' work.[97] The criteria for open codes, risk corridors and top-ups are commercial terms with clinical consequences, and that is where many of NZGA's concerns lie.[98]

63. **Cover is SCHI's to set, but funding conditions are (inappropriately) shaping clinically appropriate care:** We reiterate that NZGA does not seek to set cover.[99] That said, SCHI's framing of these issues as matters of cover ignores that funding conditions dictate technique – the requirement to undock a robot and complete surgery laparoscopically to maintain funding states the obvious.[100]

64. **You must now seek independent clinical review on these matters.** With respect, the Commission on its own does not have sufficient medical expertise to properly test SCHI's assertions and understand the clinical gaps.

H. Other specialties and conditions

65. **Speculation about extending the APS to other specialties carries no weight:** The Commission rightly declined to speculate about how the APS might be extended to other specialties.[101] The converse is also true; assumptions should not be made about other APS schemes efficacy and applicability to gynaecology. SCHI should not seek to influence this application by reference to its wider plans to extend the APS.[102] Those plans confirm that the gynaecology APS is SCHI's strategy, imposed on the specialty with limited engagement. Pushback from the profession is the expected outcome of such an approach, and the answer is more engagement, not less. If anything, those plans make it more important that the model is clinically informed and workable.[103] We note section 9 of the SCHI DD submission is largely redacted, and the Commission must test the substance of those points if it intends to rely on them.

66. **Other applications are not relevant, and there is no basis to depart from precedent:** SCHI's argument that authorisation would open the gate for other applications is not relevant. Any such applications would stand or fall on their own merits. If SCHI is refusing to engage with other specialties then collective bargaining may be justified. In any event, that signals an issue with SCHI's conduct across specialties (which the Commission should examine) rather than any issue with the collective bargaining framework. It is not appropriate to suggest that the Commission has received "too many" applications for collective bargaining authorisation. The law has a broad per se prohibition on cartel provisions, which has been acknowledged to involve deliberate overreach, hence why the RTP authorisation powers exist. The Commission has a well-established approach to collective bargaining applications (which was faithfully reproduced and followed in NZGA's Application). No basis has been given for the Commission to depart from its own precedent in this case.

67. **Conditions resolve any residual concern:** NZGA reiterates that it would accept conditions if needed including:[104]

    (a) a cap at each member's current FFS level, with reductions from each member's own starting point;

    (b) information protocols keeping member-level and prepared prices at board level;

    (c) non-price terms settled before any fee discussion; and

    (d) a shorter authorisation term with a review point.

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[97] DD at [56].
[98] NZGA DD Submission at [69]–[70].
[99] SCHI DD Submission at [10.3(d)]; NZGA DD Submission at [68(d)].
[100] NZGA DD Submission at [68(d)(ii)].
[101] DD at [197] and [294].
[102] SCHI DD Submission at section 9; DD at [166] and fn 215.
[103] NZGA DD Submission at [25].
[104] NZGA DD Submission at [82]–[84].

68. The costs of these conditions are modest and fall largely on NZGA. They are small in comparison to the counterfactual's own costs, which may include potential appeals (including of the authorisation), practice restructuring, and NZGA continuing to engage with SCHI to the extent members hold out individually. Clearly there are merits to engagement as Southern Cross Hospitals and Professor King have each suggested forms of conditioned authorisation.[105]

I. The counterfactual must account for SCHI's detrimental conduct. The Commission must assess its impacts.

69. **Context matters – SCHI disingenuously seeks to rewrite the history of how it attempted to implement APS in gynaecology**: SCHI continues to misleadingly describe its engagement as a "robust consultation process".[106] That is wrong and the Commission must not allow SCHI to rewrite what happened. As the anonymous gynaecologist rightly identifies, the Commission must properly consider the background context to the authorisation, including gynaecologists having lost trust in SCHI due to its conduct prior to authorisation.[107]

    (a) SCHI sought to impose its APS on a compressed timetable[108], putting real pressure on individual gynaecologists to put their best offers forward or risk losing out, without draft contracts or reasonable time to seek legal / commercial advice. NZGA was formed in response to that pressure and uncertainty – with genuine concern that SCHI intended to roll out its model quickly onto the entire industry without considering the impacts.

    (b) SCHI continues to assert it engaged in nationwide consultation. These 'roadshows' between September and November 2025 were effectively one-sided presentations by SCHI telling gynaecologists what it planned to do (and not proper consultation). Indeed, by this point, SCHI had already given notice in August 2025 to gynaecologists about its implementation timetable and that all gynaecological surgical procedures would fall within APS by 31 March 2026. (Clearly SCHI had been motivated to settle APS implementation by the end of its financial year on 30 June 2026.)

    (c) Concerns raised by gynaecologists were largely ignored (SCHI referring them to its generic "AP Training Guide for Surgeons") and SCHI's engagement with RANZCOG only occurred because NZGA members directly sought RANZCOG's assistance. Even with RANZCOG's involvement SCHI only adopted just two additional codes and now claims coding is largely "settled". SCHI still gives no explanation for the discrepancy between this and the 84 codes which RANZCOG initially proposed. The Commission must not accept SCHI's assertions without properly testing these clinical issues with the very medical specialists that carry out the clinical work.

    This authorisation is therefore simply a means for gynaecologists to be informed about what SCHI is dictating and to seek the proper engagement. SCHI has so far refused this, first on CA grounds and now outright despite the legal settings to do so. The Commission must examine SCHI's conduct carefully and whether it raises competition concerns, which we discuss below. SCHI's conduct is important context that is directly relevant to the counterfactual. The DD has (wrongly) ignored it but the Final Determination cannot. **If the Commission were to decline authorisation it would be tantamount to not punishing the playground bully.**

70. **The Commission cannot assume SCHI's conduct is lawful or has no detriments:** SCHI presents its proposal as the benign counterfactual, where APS is simply being rolled out into gynaecology like other specialties (which is incorrect) against which the application should be judged and the DD accepts this without assessing further. But the APS first began only as a prior approval scheme in 1997. SCHI now proposes to restructure how private gynaecology is funded (including determining the scope of cover). SCHI seeks a head contractor model with hospitals

[105] DD at [428] and [430].
[106] SCHI DD Submission at [10.3(a)].
[107] Anonymous gynaecologist submission on Draft Determination (6 October 2026) at [3(b)].
[108] SCHI first asked gynaecologists to put in fees by 31 March 2026 and then shifted this deadline to 31 May 2026 after pushback and delays. NZGA then sought authorisation which put implementation on hold. SCHI even acknowledges these attempted deadlines in its cross submission on the SOPI (16 June 2026) at [11.1(c)]; see also at [6.1]–[6.2].

that stand to benefit. The DD does not ask whether that conduct substantially lessens competition, involves concerted action with hospitals, or is a misuse of SCHI's market power. Accepting SCHI's assertions assumes none of these concerns apply. That is not an assumption the Commission is entitled to make without actually testing further. The counterfactual is central to the legal test for authorisation under the CA. If SCHI's conduct is anticompetitive or creates detriments, the counterfactual cannot be treated as a neutral baseline (otherwise it benefits from potentially harmful action). **SCHI's conduct is the whole point of this application. The Commission must assess whether SCHI's conduct is lawful or it has no detrimental effects, either within this authorisation or separately.**

71. **The experience in other specialties must be critically assessed:** That is a different point from SCHI's speculation about extending the APS in future. SCHI's case, and the DD, assume that this proposed APS is both equivalent to other head contractor APS models and that it has worked well in other specialties without testing that experience. It is equally wrong not to critically assess it. Rather than simply accepting SCHI's view, the Commission should investigate the actual impacts in other specialties where SCHI has reversed contracting arrangements and undertaken similar activities. That said, we reiterate and caution that the experience in other specialties is not directly transferable to gynaecology. In other specialties, APS covers a handful of predictable procedures while SCHI is purporting to capture all gynaecological surgical procedures under APS. This includes complex, variable surgery (eg advanced endometriosis) whose demands are often only apparent intraoperatively and cannot be captured by theatre time or a standardised code. Even colleagues in other specialties report that APS works well only for simple cases. The issue is clinical appropriateness, not simply fees.

72. **The new APS is an exercise of monopsony power:** It is factually incorrect to suggest that the new APS proposal is anything other than the exercise of monopsony power. SCHI covers around 60% of insured New Zealanders by number and 67% by value, a market share 150% of the duopolists' in the regulated grocery markets, and it faces little competitive discipline.[109] That is vital context, yet the DD does not critically examine the evidence in that light. SCHI cannot argue, absent supporting evidence, that its proposal does not raise the following concerns:

    (a) the exercise of buyer power, with potential adverse impacts that the Commission has not yet critically examined. The Commission should do so – that is its role as the investigatory body (with or without this application); and

    (b) apparent concerted action involving both the dominant insurer and hospitals. Commission staff explicitly asked for the application to address hospitals, yet this was not examined in the DD. Again, SCHI's arguments cannot be uncritically accepted as they were in the DD, and we expect the Commission to revise its views having received submissions.

    Again, it is one-sided (and inconsistent) to examine gynaecologists' conduct, yet not SCHI.

73. **Member ownership does not immunise SCHI's conduct:** SCHI says its incentives are to act in its members' interests. But it is wrong to suggest that an insurer has the same interests as its members, as reductions in benefits to consumers show.

    (a) SCHI's formal objects are narrower and state otherwise – Rule 3.1 limits SCHI's purposes to reimbursing healthcare and related costs, paying money on a member's death, illness or injury, and other purposes permitted by the Act.[110] SCHI's own objects focus entirely on financial costs (this is evident throughout its submissions). They say nothing about access to appropriately qualified specialists, timely treatment, quality and continuity of clinical care, sustainable provider participation in private healthcare, or the long-term affordability of premiums. Members plainly value all of these. SCHI cannot rely on member ownership to show its decisions on these matters serve members' interests when its own rules do not even prioritise let alone mention them.

[109] SCMCS 2026 Annual Report – Summary, p 4.
[110] SCMCS Rules, rule 3.1.

(b) In any event, SCHI's NFP, member-owned status does not immunise anticompetitive conduct or ensure efficiency (as discussed in paragraphs 55–59). A finding along those lines would be inconsistent with the Commission's previous approach.

74. **SCHI's conduct raises a range of concerns the Commission must examine:** In summary, SCHI's conduct:

(a) is consistent with the Commission's well-documented concerns about buyer power in the grocery sector, so the competitive effect of its current actions must be considered, including impacts in hospital markets through reduced competition and concerted action. It would be perverse to ignore those concerns on SCHI's NFP status alone;

(b) raises issues about misleading representations to both consumers and medical practitioners, including potentially unsubstantiated representations under the Fair Trading Act 1986 (**FTA**);

(c) raises issues about potential unfair contract terms under the FTA, including the absence of terms being provided to medical practitioners and the non-negotiable nature of those terms; and

(d) raises concerns about unconscionable conduct under the FTA.

75. **SCHI's conduct must not be treated as immune from scrutiny (which, respectfully, has been the case so far). The impacts of its conduct must be assessed:** SCHI's market power and NFP status do not make its conduct immune from scrutiny. Otherwise the detriments of the counterfactual will be understated, and SCHI would benefit from conduct that has never been examined (and could be unlawful). That would be a perverse premise for the Final Determination to rest on. **We formally request that the Commission begin to scrutinise SCHI's conduct and its effects, either as part of this authorisation or separately. The Final Determination should state clearly the Commission's assessment of SCHI's conduct and its effects, including whether it is lawful under the CA (and FTA).**

Conclusion

76. SCHI's submission asks the Commission to go further than the DD on every category of detriment. It rests on one untested forecast, relies on aspects of the DD that have not been tested, and treats SCHI's own proposal as the efficient benchmark. The Commission should not accept that invitation, and should instead re-examine the gaps in the DD on which SCHI relies. Properly assessed, any lessening of competition is minimal, the detriments are small, and the counterfactual carries real risks to supply and patient outcomes. Nor can the Commission continue to assume that SCHI's conduct is lawful and benign. That conduct is the reason for this application and the basis of the counterfactual. It must be examined before a conclusion can be drawn. NZGA submits that once examined, this will lead the Commission to correctly find that authorisation should be granted.