

NZGA submission on Draft Determination

Executive Summary

Overview

1. The New Zealand Gynaecology Association Inc (NZGA) thanks the Commerce Commission (**Commission**) for the opportunity to comment on its Draft Determination of 23 September 2026 (**Draft Determination**). **NZGA submits that the Commission must revise its preliminary view and grant authorisation.**
2. **The Draft Determination starts from a flawed assumption that SCHI can do no wrong.** It incorrectly assumes that because Southern Cross Health Insurance (SCHI) is a Not-for-Profit friendly society, its interests are the same as those of its members (and blurs that boundary with the wider public). But an insurer's interests cannot be assumed the same as its customers' (even with good intentions), and SCHI is no exception. It has strong short-term (management) incentives to cut costs and resulting in detriments to the medium- to long-term health of patients, the wider health system or the sustainability of the gynaecology workforce in New Zealand.
3. **That assumption leads to a Draft Determination with errors, inconsistencies and omissions.** SCHI's claims (and those with shared interests) are accepted without testing, and contested points are resolved on SCHI's word alone. Conversely, NZGA's evidence is recorded and then either not addressed or set aside for lack of quantification, yet the detriments relied on to decline authorisation are not quantified either. With respect, that approach risks being read as biased.
4. The result is a Draft Determination that contradicts itself and leaves key questions untested:
 - (a) It inconsistently assumes that **SCHI can both dictate terms and cannot "walk away"**;
 - (b) It incorrectly states that **APS has existed for decades, when it was first introduced only as a prior approval mechanism**, markedly different from the current proposal;
 - (c) It wrongly compares the **most expensive factual with a costless (and unrealistic) counterfactual** (without adequately considering other counterfactuals which raise costs);
 - (d) It assumes that **a fee cut of up to ~48% will not change supply**, failing to examine the delta (change) between the factual and counterfactual on marginal gynaecologists, contrary to logic and economics;
 - (e) It incorrectly **assumes reduced costs with efficiencies**, without proper regard to SCHI's monopsonistic market power and management incentives;
 - (f) **No consideration is given to the impact on hospital markets;**
 - (g) It uncritically **adopts arguments that support its preliminary conclusion as evidence** while discounting evidence to the contrary without reasoning;
 - (h) **It relies on SCHI's clinical evidence without independent testing;**
 - (i) It fails adequately to consider qualitative differences between the factual and counterfactual, including health outcomes.
5. **Once these errors are corrected, the balance reverses.** The detriments are small and the benefits are real: with a more sustainable workforce, better-informed contract terms and protection of patient outcomes.
6. **NZGA is not asking the Commission to prefer its evidence, only to test both sides to the same standard.** Done properly, that supports granting authorisation. If any concern remains, targeted conditions can address it.

The errors overstate the detriments and understate the benefits

7. Once the errors, inconsistencies and omissions are corrected, the basis to decline falls away. In particular:
- (a) **SCHI cannot both dictate terms and “walk away”:** It finds SCHI sets the terms,¹ but SCHI cannot walk away because it is contractually bound to provide cover. Both cannot be true. If SCHI controls the outcome, authorisation cannot force uneconomic fees. If it cannot walk away, it would raise fees anyway in the counterfactual. Either way, the fee gap that results in the allocative detriments is small, and has not been measured.
 - (b) **This Affiliated Provider Scheme (APS) is new and untested (not “existed for several decades”) nor is APS working well in other specialties:** It ignores NZGA’s clarification that the APS proposed for gynaecology differs from the historic arrangements other specialties moved onto (‘partial’ forms of APS) and never tests whether SCHI’s current proposed form of APS is in fact efficient or working well for other specialties. In any case, experience in other specialties is no comparator or evidence that APS will be implemented smoothly for gynaecology. They are different and must be distinguished.²
 - (c) **One incorrect (costless) counterfactual is wrongly compared with one (most costly) factual:** The Draft Determination compares individual gynaecologists simply accepting SCHI’s terms (with minimal pushback and cost) against “significantly higher transaction costs”³ from comprehensive negotiations in the factual. That is not a like-for-like comparison.
 - i. NZGA seeks collective advocacy so that SCHI’s decisions are clinically informed. This can be a relatively costless exercise and SCHI remains free to reject uneconomic proposals.⁴
 - ii. Conversely, the Commission assumes gynaecologists will simply accept SCHI’s terms, ignoring likely and costly counterfactuals eg: individual refusals (like the Manawatu ophthalmologists), causing staggered, delayed uptake and wasted time, money and effort for all parties; local or regional practice structures formed to negotiate and counter SCHI’s monopsony power; and NZGA and its members pursuing further regulatory and legal (including appeal) processes. No basis is given for ignoring them, and as above, comparisons with other specialties accepting APS ‘as is’ are flawed. In the factual, engagement works through those concerns.
 - (d) **Contrary to economic theory,⁵ it cannot assume a ~48% fee cut will not materially affect the supply of gynaecologists:⁶** It relies on anecdotes that gynaecologists stay in New Zealand for non-financial reasons but those who would stay regardless (the inframarginal) say nothing about the marginal in the delta: how many would leave, retire or not return because of such a cut. NZGA’s member survey indicates []% of private gynaecologists would change their practice in the counterfactual.

It contemplates SCHI setting a hard transition date, refusing to deal directly with NZGA, not changing the Affiliated Provider Scheme (APS) framework, and refusing to depart from APS “structured pricing”, which fixes fees within narrow bands SCHI determines and hospitals pass down (among other things).

For example, the Commission could reasonably distinguish and assess each of: (a) **APS** (as started in 1997 as a pre-approval process), (b) **APS-BBC** (APS with the back to back head contractor model), (c) **APS-G** (APS as proposed to apply to gynaecology, whereby APS-BBC would apply with all surgical procedures in the specialty captured under AP coding). Regardless, even where APS has been implemented in specialties, the Commission should be aware that a number of different business models emerged from different specialties in an attempt to resist SCHI’s market power.

The Commission measures the transaction cost detriment against the most detailed (and therefore most costly) negotiation process described in NZGA’s RFI response of 18 August 2026, rather than the far simpler process NZGA has consistently envisaged.

NZGA does not seek a fee increase and would accept a reduction from current Fee-for-Service (**FFS**) levels: NZGA cross-submission on SOPI (4 August 2026) at [2] and [7]; Draft Determination at [154] and [191]. Any fee difference from the counterfactual is therefore ultimately SCHI’s decision and is small, as SCHI would in any event raise its offer in the counterfactual until it has sufficient coverage (Draft Determination at [146]–[147] and fn 193). See further **Section C**. Which the Commission itself accepts at [35].

Indeed, the Draft Determination notes the converse effect that higher fees increase supply. At [35], [283].

- (e) **SCHI's proposal should not be assumed an efficient benchmark:** Every allocative detriment assumes that any fee above SCHI's proposal is inefficient. But SCHI has monopsony (like) power as the *unavoidable trading partner* (covers 68% of gross written premiums) and aims only for *sufficient* coverage.⁷
- i. **In healthcare, the lowest fee will rarely be the efficient one: surgical services differ in skill, experience and case complexity,** and must recover fixed costs, so fee differences often reflect real differences in what is supplied.
 - ii. NZGA accepts SCHI may well have good intentions and broader objectives that align in *principle*, but that is not enough. Management incentives mean it favours short term outcomes (cutting costs and reducing premiums for members now) and is inconsistent with broader health outcomes or the long-term sustainability of the workforce, so it risks setting fees inefficiently low.
 - iii. The Commission has previously held serious concerns with SCHI's potential inefficiencies (see *Aetna* merger⁸). Yet it has not tested whether SCHI's fees sit below competitive levels, so as to inefficiently reduce entry into / increase exit from gynaecology (the supply of gynaecologists). If they do, higher fees in the factual are a gain not a detriment.
 - iv. Likewise, no analysis of the impacts by the head contractor model (where hospitals stop competing for surgeons) on hospital markets is made despite evidence of near-identical hospital price lists.
- (f) **It treats the evidence on the record inconsistently:** It adopts claims supporting SCHI without testing, despite those submitters' clear self-interest, while evidence supporting NZGA is recorded and then discounted for lack of quantification (yet neither are the detriments). NZGA and other parties have raised concerns that the Draft Determination appears to be biased, as it inaccurately represents the interviews and evidence provided. With respect, the Commission cannot pick and choose evidence it prefers, it must rigorously test the evidence on each side before forming a conclusion.
- (g) **Key clinical findings rest on untested evidence from SCHI:** The Commission lacks the specialist expertise to test SCHI's clinical evidence. NZGA reiterates that the Commission should seek its own independent clinical advice before reaching any conclusions. By declining access to the public (including NZGA's independent clinical adviser) the Commission has also prevented that evidence from being properly tested, contrary to natural justice.
- (h) **It wrongly treats health outcomes as "unaffected":** It assumes clinical issues will be resolved in the same way with or without authorisation. But in the counterfactual gynaecologists bear the risk of unfunded complexity and are reliant on SCHI's discretion (through open codes, risk corridors and top ups). As a result, many will stop doing complex work, reduce their private work, or stop working altogether, pushing that work onto an already stretched public system. Engagement in the factual directly addresses this.
8. **Properly assessed, the benefits outweigh the detriments:** (a) Transaction costs are small or a net saving; (b) the allocative detriments, which depend on an unmeasured fee increase above an untested benchmark, are minimal; and (c) the supply, health and contract benefits are material.

Draft Determination at [146].

Commerce Commission v Southern Cross Medical Care Society (2001) CA89/01. SCHI's market position is essentially unchanged since that merger, yet the Draft Determination assumes SCHI's proposal is efficient without the same scrutiny the Commission previously held for SCHI's potential inefficiencies when it sought to acquire Aetna Health (NZ) Limited.

Once process concerns, further evidence and targeted conditions are settled, the conclusion is that authorisation should be granted

9. **NZGA also has concerns that these errors appear to stem, at least in part, from (apparent) bias and process issues:** With respect, the Commission appears from the outset to have adopted SCHI's framing and resolved each contested point in SCHI's favour, on SCHI's word alone.⁹ It treats SCHI's Not-for-Profit, friendly society status as a sufficient proxy for efficiency and good incentives,¹⁰ and accepts SCHI's account that gynaecologists' fees are driving SCHI's financial losses (a narrative SCHI's FY2026 surplus no longer can assert).¹¹ This is compounded by process issues including the handling of SCHI's confidential clinical evidence, the timing of the interim decision and an interview record that has not been corrected. We discuss this in more detail at **Section I**. NZGA raises them now so they can be addressed before the Final Determination. In particular, the Commission should independently test the clinical evidence and put any adverse proposition to NZGA before relying on it.
10. **NZGA also provides further evidence which, properly tested, supports authorisation.** In response to the Commission's invitation, NZGA has sought an independent expert report from Link Economics, provided separately to this submission (**Link Report**). That is supported by an anonymous workforce survey of its 129 private gynaecologist members and further evidence on issues with APS.
11. **Notwithstanding the above, if any reservation remains, targeted conditions could address it:** NZGA would be open to conditions such as fee safeguards, information protocols, settling non-price terms before fees, and a shorter authorisation period (see **Section J**).
12. **Ultimately, this is about patients:** NZGA accepts that the Commission must weigh benefits and detriments within its statutory framework. But its focus has been drawn to transaction costs and the fee difference between the factual and counterfactual, which draws the focus away from the effect on health outcomes (which are also swept aside as "unaffected" without careful consideration). That must not happen. Ensuring those outcomes are properly assessed and given appropriate weight is why NZGA seeks engagement. Women's health and wellbeing are at stake.
 - (a) Once the errors above are corrected, it is clear that SCHI's proposal would have significant and lasting effects on patients in the counterfactual. Gynaecology waiting lists are already among the longest in the health system. Many public units no longer accept GP referrals unless cancer is suspected, and women often wait more than 120 days for a first specialist appointment and then again (an additional 120 days, often more) for surgery.¹² Conditions such as endometriosis, prolapse and incontinence are debilitating, affect women's ability to work and care for others and worsen while untreated. Where serious pathology goes undetected, delay can cost lives.
 - (b) Fees matter only to the extent that they must cover the real cost of delivering that care, including the necessary staff (which are sometimes being paid for 'out of pocket' by gynaecologists) and the risks gynaecologists disproportionately bear. Fees must also reflect the quality of care, expertise and responsibility that patients rely on, built over decades of time spent training and developing it. The Draft Determination appears to proceed on an implicit assumption that gynaecologists can absorb a cut of this size and are somewhat homogenous. They cannot, and the incentives are real. NZGA's workforce survey shows that []% of private gynaecologists would change their practice under SCHI's proposal: by stopping complex procedures, reducing their workload, retiring early or moving overseas. That does not account for the pull factors, where fewer specialists may return to, or choose to practise in, New Zealand. The complex work private specialists disproportionately perform would fall to an already strained public system. As an impartial

See for example, Draft Determination at [147], [163]–[166], [278.1], [290].

Draft Determination at [147], [290].

Draft Determination at [60], [200].

[RANZCOG "Raises Alarm Over Crisis in Access to Gynaecological Care in Aotearoa New Zealand" \(2 April 2025\).](#)

competition regulator, the Commission cannot set aside basic economics. Even small losses in supply compound over time in a workforce that takes decades to replace.

Outline for substantive sections of NZGA's submission

13. This submission expands on the above in the following sections:

- (a) SCHI cannot both dictate terms and be unable to walk away;
- (b) Other specialties are not comparable: this APS is different;
- (c) A costless counterfactual is measured against the most costly factual;
- (d) Cutting fees by ~48% will result in a loss to the supply of gynaecologists;
- (e) SCHI's monopsony (like) proposed fees cannot be assumed an efficient benchmark;
- (f) Evidence supporting SCHI is accepted without proper testing while that supporting NZGA is discounted;
- (g) Health outcomes are in fact affected;
- (h) Other detriments are overstated and the benefits understated;
- (i) Process concerns should be addressed before the Final Determination;
- (j) Other conditions can resolve any remaining concerns; and
- (k) Conclusion.

A. SCHI cannot both dictate terms and be unable to walk away

14. **The Draft Determination inconsistently treats SCHI as both strong and weak:** Where SCHI's strength inflates the detriments or reduces the benefits, it treats SCHI as strong. It accepts, on SCHI's say-so alone, that SCHI will not deal with NZGA, will not change the APS framework or depart from structured pricing, and can be relied on to protect supply and quality.¹³ Yet where SCHI's weakness inflates the price effects, it treats SCHI as weak, finding that SCHI cannot "walk away" and must fund materially higher fees¹⁴. Both cannot be true, and that inconsistency runs through the analysis.
15. **Either way, any fee gap is small:** The Commission's findings lead to one of two positions, and neither support the allocative detriments:
 - (a) **If SCHI controls the outcome:** If SCHI can set a hard date for transition, set APS pricing and refuse to deal directly with NZGA, it is an **unavoidable trading partner**. The fact that the Draft Determination contemplates SCHI imposing a hard transition date at all is itself telling of the extent of SCHI's buyer power. Any fees agreed in either scenario will be fees SCHI is prepared to accept, so the claimed fee uplift is overstated. Every outcome is then the consequence of SCHI's own choices. Engagement in the factual has only upside (a better-informed SCHI) and, at worst, no downside: if SCHI rejects NZGA's position, nothing changes from the counterfactual beyond any standstill period. This could be limited further by a condition if needed. Authorisation would also provide some countervailing bargaining power, supporting more efficient contract terms and sustainable supply. In any event, what SCHI chooses to do unilaterally in the counterfactual cannot be assumed efficient, and may itself be a source of inefficiency (we discussed this in **Section E**).
 - (b) **If SCHI cannot walk away:** If SCHI is contractually bound and needs coverage (as SCHI asserts and the Commission accepts), then on the same logic it would raise its prices in the counterfactual until it secured sufficient coverage, as the Commission's Manawatu ophthalmology example shows.¹⁵ Any gap between the factual and counterfactual is then minimal. Nor is that counterfactual quick or simple – SCHI would need to raise its fees hospital by hospital and region by region. We address the resulting cost, delay and disruption in **Section C**.
16. **That gap has not been measured:** The Commission accepts it has not reached a view on the size of any fee increase. Yet it finds that the Proposed Arrangements "will result in materially higher costs" and attributes allocative detriments to that increase, without measuring it or explaining why it would be material.¹⁶ With respect, that conclusion lacks an evidential foundation.
17. **Refusing to deal is inconsistent with needing coverage:** If SCHI must ultimately reach prices gynaecologists will accept, it would be expected to settle them in the most efficient way: directly with NZGA. Its refusal to do so is SCHI's choice (and in any event may not be the case, in the factual and counterfactual).¹⁷ It is wrong to attribute the consequences of that choice, including any additional transaction costs, to the Proposed Arrangements itself (see **Section C**).
18. **Under its proposal SCHI already controls price:** SCHI provides hospitals with an indicative split of the bundle, seeks to minimise fee variation, sets its own negotiation parameters, and treats structured pricing as a core feature it will not depart from.¹⁸ As NZGA has submitted, hospitals pass those fees down (whether willingly or passively) and are incentivised to do so as they take a margin from the bundled fee.¹⁹ The Commission also holds evidence that hospitals' price lists

Draft Determination at [163]–[166], [190], [278.1], [290]–[291] and [415.1].

Draft Determination at [147], [155.3], [177], [189] and [388].

Draft Determination at [146]–[147], [155.3], [177] and fn 193.

See Draft Determination at [31], [189] and [198]; compared with [178].

Draft Determination at [163]–[166]. The Commission then relies on that refusal to increase transaction costs and limit the contracting benefit at [26.1], [273.2] and [315].

Draft Determination at [89], [148.2], [176] and [190] respectively.

Draft Determination at [384].

are near-identical for each procedure.²⁰ That is SCHI dictating price (its “structured pricing”), not hospitals competing, yet the Draft Determination neither engages with that evidence nor gives any basis for the lack of consideration. The Commission relies on that control when assessing the factual,²¹ then sets it aside to find SCHI must pay materially higher fees.²² For example, the Commission assumes that essentially the same hospital-led negotiation process produces sharply lower fees in the counterfactual, but materially higher fees in the factual (even more so than Fee for Service (FFS)) merely because it says NZGA has developed collective benchmarks.²³ It gives no explanation for why SCHI’s control over price disappears only when NZGA is at the table (see also **Section E**). The Link Report confirms this: its review of hospital AP price lists found identical pricing across unaffiliated hospitals for many procedures, and it explains that it is the exclusivity SCHI grants to its affiliated hospitals that gives them monopsony power over gynaecologists.²⁴

19. **The Commission’s ophthalmology example supports authorisation:** The Commission relies on Manawatu ophthalmologists withdrawing cataract surgery until SCHI raised its prices as the way the counterfactual resolves.²⁵ New Zealand’s specialist medical markets are unique (and unlike other jurisdictions) where specialists face powerful purchasers in both the public sector (Health NZ and ACC) and the private sector (SCHI), with few lawful means of engaging them collectively. It is therefore unsurprising that some specialties, ophthalmology among them, have encountered Commerce Act issues in trying to navigate those purchasers. The comparison to ophthalmology is questionable. A number of enforcement action has been taken against the ophthalmology speciality including proceedings.²⁶ If the counterfactual depends on specialists withdrawing services until SCHI pays more, it involves real disruption and cost, and risks informal, unsupervised coordination. Authorisation clearly brings that engagement within a lawful, transparent framework. That is a significant benefit in itself, including to the Commission’s own compliance and monitoring functions.
20. **SCHI is an unavoidable trading partner, and the Draft Determination departs from the Commission’s usual approach:** NZGA has already submitted that ACC and Health NZ (less than 5% of a typical private gynaecologist’s cases) are no meaningful alternative to SCHI and other insurers fund only a comparatively small share of private work.²⁷ **SCHI is therefore an unavoidable trading partner.** The Commission ordinarily assesses collective bargaining in that context, recognising that collective engagement can deliver transaction cost savings and more efficient contracts where members face a counterparty with significant bargaining power. The Draft Determination itself cites *New Zealand Tegel Growers Association (Tegel)* for that proposition,²⁸ yet does not apply it here, or explain why it departs from the Commission’s established approach (see **Section C**). The Link Report reaches the same view: alternative sources of demand are not sufficiently large, timely or commercially equivalent to discipline SCHI’s purchasing terms, and the cost to an individual gynaecologist of rejecting SCHI’s terms is materially greater than the cost to SCHI of losing that gynaecologist.²⁹

Draft Determination at [384] and fn 493, citing NZGA cross-submission on SOPI (4 August 2026) at page 7.

Draft Determination at [163] and [190].

Draft Determination at [177] and [189].

Compare Draft Determination at [143]–[148] and [178]–[198]; see also the factual and counterfactual summary at [211].

Link Report at [18] and [22].

Draft Determination at [147] and fn 193.

See [Ophthalmological Society of New Zealand and individual ophthalmologists](#) in the high court; See also [RANZCO compliance advice letter \(4 February 2025\)](#).

Draft Determination at [177] and fn 231.

Draft Determination at fns 309 and 333, citing *New Zealand Tegel Growers Association Incorporated* [2022] NZCC 30 at [177]. See also NPA at [201.2].

Link Report at [15]–[16] and [23].

B. Other specialties are not comparable: this APS is different

21. **Other specialties' experience does much of the work in the Draft Determination:** The Commission is (over) reliant on other specialties' transition to other forms of APS to assume APS transition for gynaecology will be relatively costless, efficient and have minimal impact on health outcomes. The Draft Determination finds that gynaecologists will accept SCHI's terms through local relationships at minimal cost;³⁰ that health outcomes will not suffer;³¹ that procedure volumes, and therefore supply, will be maintained;³² and that SCHI's flexibility mechanisms work reliably in practice.³³ Those comparisons are not applicable and the Commission never tests this further.
22. **The APS proposed for gynaecology is not the APS other specialties moved onto:** The Draft Determination describes the APS as having "existed for several decades".³⁴ That is true only of the broader preapproval scheme in name and is not the same APS now proposed. NZGA has explained numerous times to the Commission that the hospital head-contractor model³⁵ together with applying APS coding to all surgical procedures within a specialty, differs from the narrower arrangements other specialties have. The Draft Determination does not engage with that clarification at all. Instead, it incorrectly adopts SCHI's characterisation of gynaecology as simply the next specialty to move onto a settled model and assumes the transition will "match" the approach taken in other specialties.³⁶ By contrast, APS procedures in general surgery and orthopaedics are mostly discrete, single site, high volume operations with predictable operating times (eg hernia repair, cholecystectomy, carpal tunnel release and primary joint replacement). In orthopaedics, more than half of cases are ACC funded and surgeons were involved in negotiating the codes. Gynaecologists were not involved in designing the gynaecology code set (and RANZCOG only became involved after gynaecologists pushed back and sought support).
23. **Gynaecology is also clinically different:** The Commission acknowledges that it is not uncommon for gynaecologists to find additional pathology during surgery (eg endometriosis) which requires secondary procedures and then decide mid-operation whether to proceed.³⁷ Complex gynaecological operations commonly combine procedures and can take up to 8 hours (eg severe endometriosis excision involving bowel, bladder or ureter) while cases under the same or similar codes may take under an hour. International evidence also shows such surgical procedures are already systematically undervalued in fixed-fee systems, particularly for women.³⁸ This raises particular concerns for a fixed code model (like AP coding), which relies on SCHI's discretion to grant top-ups or apply open codes (we discuss this further in **Section G**). Yet this is ignored when relying on other specialties as a comparator. No effort is made to examine the potential effect of putting an entire specialty which faces high intraoperative variability under a fixed set of codes.³⁹ Other specialties' experience of a part transition to APS does not translate to how APS will work for the entirety of gynaecology.
24. **SCHI's claim that the APS works well in other specialties is untested:** The Commission does not itself find that the APS works well in other specialties. But its preliminary views lean on SCHI's account that it does: that SCHI "has not seen a reduction in volume" as other specialties transitioned (to discount the supply benefit);⁴⁰ "the experience of other specialties within the APS" (to find health outcomes unaffected);⁴¹ and SCHI's submission that its flexibility

Draft Determination at [23], [143], [310.1] and [317].

Draft Determination at [236.5] and [243.1].

Draft Determination at [278.4] and [290].

Draft Determination at [415.1] and fn 549.

Draft Determination at [3]; see also [80] and [83].

Further, where other specialties have moved to a head-contractor model, they did so with reasonable surgeon input into those contracts and codes before implementation. That has not occurred for gynaecology.

Draft Determination at [143] and [236.4].

Draft Determination at [92].

See for example, [Jocelyn Fitzgerald & Christina Vosbikian "The Price of Care: Financial Pressures' Ramifications on OB-GYNs and Patients. Health Management, Policy and Innovation" \(HMPI.org\). Volume 10, Issue 2 \(2 October 2025\)](#) and also [M Penn, D Colley, P Koirala, L King and J Fitzgerald, "Price and Prejudice: Reimbursement of Surgical Care on Male Versus Female Anatomies" \(2025\) 34\(5\) Journal of Women's Health 665–676.](#)

It follows that any improvement from this in the counterfactual must be treated as a benefit in the factual.

Draft Determination at [290]; see also SCHI's submission at [278.4].

Draft Determination at [36.1]; see also SCHI's submission at [236.5].

mechanisms are used “successfully and reliably” for other specialties (to dismiss concerns about complex work moving to the public system).⁴² None of this is tested. The party imposing changes saying its own scheme works well is not evidence that it does. Nor do stable volumes show whether case mix changed, whether complex work moved to the public system, or whether quality was maintained (and in any event may not be an effective comparator as APS is currently limited to a confined set of procedures for most specialties). The evidence from specialists who have APS points the other way:

- (a) New Zealand Society of Anaesthetists (**NZSA**), whose members work under the APS across surgical specialties, reports member feedback that the AP model is “no longer fit for purpose”.⁴³
- (b) Ophthalmology New Zealand (**ONZ**) raises quality-of-care concerns about how the APS works in practice. It describes AP arrangements as offered on a standard-form, “take-it-or-leave-it” basis that leaves individual specialists little ability to influence remuneration or terms, and warns that downward pressure on remuneration may affect consultation length, service intensity and resource allocation, delay treatment and constrain clinical decision-making, with the effects most pronounced for rural and regional patients and those needing complex care.⁴⁴ ONZ supports the application, describing collective negotiation as “an important safeguard supporting patient access, clinical independence, and the sustainability of specialist services”. Yet the Draft Determination cites ONZ’s submission only on market definition.⁴⁵
- (c) Even in general surgery, where surgeons had input into their APS, SC HI’s criteria have raised a number of conflicts with clinical outcomes. More recently, [

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- (d) Nor can anything be drawn from the absence of earlier authorisation applications by other specialties:⁴⁷ as the ophthalmology experience shows, specialists facing a dominant purchaser have had few lawful avenues to engage it collectively. Instead, different business models have emerged across specialties in an attempt to resist SCHI’s market power (that is likely to be the case for gynaecology, not a counterfactual where gynaecologists all just accept SCHI’s terms. See **Section C**).

25. **SCHI's wider plans should carry no weight, and if anything favour engagement:** SCHI resists engaging with NZGA partly because of the precedent it may set across the more than 30 specialties it funds under the APS, and it intends to extend the APS to other services.⁴⁸ That is SCHI's wider commercial strategy, and the Commission should put no weight on it. As the Commission rightly recognises, effects on other specialties fall outside this application and cannot be considered without predetermining future applications.⁴⁹ The same must apply to SCHI's concerns about precedent. In any event, the point supports the opposite conclusion. If SCHI intends to roll the head-contractor model out across the sector, it is all the more important that the model is clinically informed and workable, or SCHI will face the same pushback in each specialty. Indeed, where head contractor models have been introduced in other specialties,

Draft Determination at [415.1] and fn 549.

NZSA submission on SOPI (3 July 2026) at [27]; see also Draft Determination at [399].

ONZ submission on SOPI (12 June 2026).

Draft Determination at fn 158.

Draft Determination at [83].

Draft Determination at [166].

Draft Determination at [197] and [294].

surgeons were given reasonable opportunities to provide input into those contracts before implementation. The problem stems from SCHI's refusal to work with the specialists who treat its members. More engagement is needed, not less (and that can come without the authorisation process if SCHI engages, but it has refused) and any precedent set would be a positive one. NZGA reiterates that the Commission should also have its own concerns about SCHI imposing this model unilaterally across specialties and its wider impact on the medical profession (including whether it raises competition concerns in specialty markets).

C. A costless counterfactual is measured against the most costly factual

26. **A costless counterfactual is compared with the most costly factual, and the result is counted twice:** The Commission's counterfactual is one in which gynaecologists individually accept SCHI's terms through local negotiations with hospitals, with little resistance and at minimal cost.⁵⁰ Against that, it measures the most elaborate, and most costly, version of the factual. The resulting transaction cost detriment is rated "medium", given greater weight because of its "high likelihood of eventuating", and weighed again when the detriments are balanced.⁵¹ But its size and its likelihood rest on the same assumption. Having assessed only one counterfactual against one factual, the Commission treats the gap between them as near-certain and weights it twice, without accounting for the messiness likely to follow if authorisation is declined. Properly assessed, the counterfactual carries real costs the Commission has not counted: staggered refusals, hospital-by-hospital renegotiation, alternative practice structures and continued disputes (see paragraph 25). The factual can replace them with one structured engagement, producing reference terms with greater buy-in and more durable implementation (see also **Section H**). On a like-for-like comparison, transaction costs are small and likely a net saving.⁵²
27. **The Commission has selected the most costly version of the factual:** The Commission relies on NZGA's description of a detailed, multi-round process with feedback loops to members.⁵³ That description was given in response to the Commission's request to explain how negotiations could play out if they became formal and structured. NZGA made clear it was "not an exhaustive statement of what NZGA would likely negotiate or how negotiations may play out in reality", and that the process may be refined with SCHI.⁵⁴ How simple the process is depends on SCHI's willingness to engage. With respect, the Commission should not adopt the most elaborate version of the factual to generate a transaction cost detriment when it is on notice that the likely factual is far simpler. If SCHI declines to engage, nothing changes beyond any standstill period.
28. **Properly understood, the factual can be light-touch:** NZGA has consistently explained that its application seeks a lawful mechanism for collective advocacy, so that SCHI's proposal is clinically informed and the specialty remains sustainable. If SCHI engages, the factual can be a simple and largely low-cost exercise, eg an exchange of information so that each side can understand and verify the other's position and reach a mutually acceptable arrangement. Indeed, NZGA remains open to working with SCHI on a transparent basis, including broader willingness to reduce fees should SCHI provide evidence / the basis to support the level of reductions it proposes. SCHI also remains free to reject any proposal it considers uneconomic. That is consistent with the Commission's reasoning in *Tegel*, where it considered collective bargaining more likely to produce a net efficiency benefit than individual bargaining, in part because the counterparty "would not be compelled to negotiate" and growers "would not be permitted to arrange a boycott". NZGA's standstill is limited and time-bound, and members would continue to provide services during it. If the Commission nonetheless sees it as a material point of difference from *Tegel*, NZGA would be open to discussing conditions (including removal).
29. **The counterfactual is likely to be partial, staggered and slow:** Even SCHI's current attempt at transition has been disorderly. SCHI has discarded its original indicative timeline of around seven months and extended the transition several times, hospitals report an impasse because the

Draft Determination at [143]–[148], [304] and [317].

Draft Determination at [28], [38], [328] and [425].

Draft Determination at [296].

Draft Determination at [26.3], [299] and [313].

NZGA's RFI Response (18 August 2026).

fees offered fall below their clinicians' expectations,⁵⁵ and only two providers have implemented the APS for gynaecological surgery.⁵⁶ On that record, there is no basis to conclude that the transition would be orderly in the counterfactual. The Commission's own ophthalmology example confirms NZGA's view that uptake is likely to be drawn out and staggered, with pushback until SCHI raises its prices.⁵⁷ Yet the Commission collapses the counterfactual into a single scenario because SCHI prefers the APS and NZGA accepts it.⁵⁸ That misses the point. The issue is not whether the APS is ultimately implemented, but the cost, delay and disruption of getting there. If SCHI must ultimately raise its fees to secure coverage, as the Commission finds,⁵⁹ it is more efficient to get there through one structured engagement than through a series of local impasses. Faced with a fee reduction of around ~48%, gynaecologists are also likely to respond in ways that add costs the Commission has not counted and gives no basis for setting aside, including:

- (a) Individual refusals to sign, like the Manawatu ophthalmologists, causing staggered and delayed uptake and wasted time, money and effort for gynaecologists, hospitals and SCHI;
- (b) Local or regional practice structures formed to achieve some countervailing bargaining power against SCHI, as other specialties have done;
- (c) NZGA and its members continuing to contest SCHI's proposal through available regulatory and legal processes (including appeal), prolonging uncertainty for all parties; and
- (d) NZGA continuing to engage SCHI on behalf of its members within the limits of the Commerce Act. NZGA is set up to operate in a Commerce Act compliant way and, as the Commission itself recognises, it could continue to advocate for members who individually resist SCHI's terms and do not sign. That engagement would continue in the counterfactual, but in a less structured and less efficient form than the factual allows, adding further time and cost for NZGA, its members, hospitals and SCHI.

30. **SCHI's refusal to deal cannot be counted against the Proposed Arrangements:** The Commission attributes much of the additional transaction cost to hospital-by-hospital negotiations that follow from SCHI's refusal to negotiate with NZGA. With respect, that adopts SCHI's circular and self-serving reasoning: SCHI's refusal creates the inefficiency that is then counted against NZGA (see **Section A**). The Draft Determination even treats that refusal as adding to, rather than mitigating, the detriment. On SCHI's own model, there will be multiple negotiations in either scenario: between SCHI and each hospital, and between each hospital and its gynaecologists. Settling common terms once, through a single forum, rather than many times over is a clear efficiency benefit (see **Section H**).
31. **Heterogeneity cuts both ways:** The Commission finds members too heterogeneous to bargain efficiently,⁶⁰ yet cohesive enough to extract materially higher fees and to maintain an informal standstill after the authorised standstill expires.⁶¹ Equally, it finds them too heterogeneous to agree a position in the factual (inflating internal transaction costs), yet expects them to act uniformly in the counterfactual, each content to sign "if colleagues do".⁶² The Commission cannot shift how members behave to make one scenario look costless and the other costly.
32. **Low counterfactual costs rest on untested assumptions:** The Commission records NZGA's estimate that collective negotiation would cost less than individual advice,⁶³ but sets it aside because doctors in other specialties rarely engaged advisors when moving to the APS, and because some surgeons are "ambivalent" about their contracts or are taken to accept terms simply

Draft Determination at [84], [146] and [186].

Draft Determination at [145].

Draft Determination at [147] and fn 193; Application at [10.4] (Table 2), [11.24] and [11.28].

Draft Determination at [137.1] and [149]–[150].

Draft Determination at [146] and [180].

Draft Determination at [26.2] and [311]–[312].

Draft Determination at [183] and [188].

Draft Determination at [304.1].

Draft Determination at [296].

by operating.⁶⁴ That relies on the same untested comparison with other specialties which as discussed is highly flawed (see **Section B**). If anything, that evidence shows surgeons being bound to terms simply by operating, with no real opportunity to negotiate them (see **Section H**). And because specialists are “time-poor”,⁶⁵ time spent individually on contract terms is time taken away from patients. Shared resourcing in the factual avoids that, as NZSA submits.⁶⁶

33. **Most of the cost falls on those choosing to bear it:** The Commission finds SCHI would face only “marginally more” or “minor” additional transaction costs, and hospitals only “minimal” additional costs on non-price terms.⁶⁷ The greatest additional cost falls on gynaecologists, whose participation is voluntary and who, the Commission accepts, “may be willing to bear those costs” where the benefits outweigh them.⁶⁸ A cost borne largely by the applicant’s own members, by choice, should not be the detriment given the greatest weight. As the Link Report notes, transaction costs are not usually critical to economic efficiency unless they are so large as to prevent otherwise efficient contracting, which is not suggested here. NZGA’s and its members’ willingness to bear their side of these costs indicates they are small.⁶⁹ Link also considers it plausible that, without authorisation, gynaecologists would seek detailed engagement with hospitals (and likely SCHI) anyway, given the scale of the changes members say they would make.⁷⁰

D. Cutting fees by ~48% will result in a loss to the supply of gynaecologists

34. **The reasons given for a “small and theoretical” supply benefit do not withstand scrutiny:** The Commission accepts that, all else being equal, higher fees would be expected to increase the supply of gynaecologists (indeed, this is conventional economic theory).⁷¹ Link’s independent comparison of current FFS prices with hospital AP price lists found the proposed AP pricing to be on average around 52% lower than FFS, broadly consistent with NZGA’s ~50% estimate.⁷² It follows then that a ~48% cut would be expected to reduce supply. SCHI-funded work makes up around ~50–60% of a typical private gynaecology practice, so SCHI’s proposal would likely remove roughly 25–30% of a private practice’s total revenue. The Draft Determination nonetheless assesses the supply benefit as “small and theoretical” on three main grounds:⁷³
- (a) the evidence that fees are higher in Australia is “unclear”;
 - (b) “financial and non-financial frictions” may reduce gynaecologists’ incentive to leave; and
 - (c) SCHI is incentivised to keep fees at a level that maintains adequate supply for its members. It also relies on several other factors to suggest the supply lost in the counterfactual would be less.

With respect, none of those reasons holds and such a reduction in fees cannot simply be assumed to leave supply largely unchanged. We address each in turn.

35. **The gap in overall remuneration is evidenced on the Commission’s own record:** The Commission first discounts the supply benefit because the evidence that fees are higher in Australia is “unclear”,⁷⁴ and finds remuneration comparisons with Australia not “particularly relevant” to whether gynaecologists will leave.⁷⁵ With respect, that asks the wrong question and overlooks the answer already in front of it (and fees are not earnings). The correct question is what can a gynaecologist earn overall in New Zealand compared with Australia, and how does

Draft Determination at [304], [310.1] and [317].

Draft Determination at [317].

Draft Determination at [306] (NZSA).

Draft Determination at [319], [323] and [327].

Draft Determination at [169] and [328].

Link Report at [72].

Link Report at [70].

Draft Determination at [35] and [283].

Link Economics Report at [105] and [110].

Draft Determination at [283], [291] and [423.1].

Draft Determination at [291]; see also [284].

Draft Determination at [286].

SCHI's proposal change that (in other words, the delta (change)).⁷⁶ On the Commission's own record:

- (a) **The gap is large and acknowledged:** RANZCOG told the Commission that its qualifications are trans-Tasman, that there is "significantly higher income potential in Australia", and that more than 50% of New Zealand-trained gynae-oncologists have not come back after rotating to Australia.⁷⁷ Health NZ agrees that New Zealand public pay is significantly lower.⁷⁸ The Commission also records the figures:⁷⁹ New Zealand public specialists earn NZ\$198,386–NZ\$282,645, against Australian advertised salaries of AU\$350,000–AU\$679,000 plus benefits. Even at a conservative exchange rate of AU\$1 = NZ\$1.20, the bottom of the Australian range (around NZ\$420,000) is more than double the bottom of the New Zealand scale, a gap of over NZ\$220,000. Notably, the top of the New Zealand scale still sits around NZ\$137,000 below the bottom of the Australian range. At the top end (around NZ\$815,000), the gap exceeds NZ\$530,000, nearly three times the top New Zealand salary. That is before any additional earnings through private earnings in Australia. As NZGA has told the Commission, a gynaecologist can move to Australia and immediately earn more.
 - (b) **Private practice is what closes the gap:** RANZCOG and Health NZ both explain that private work is how New Zealand specialists "top up" lower public pay "to make things at least a little bit more even"⁸⁰ given most gynaecologists work across both sectors.⁸¹ The Commission nonetheless separates public from private remuneration, comparing SCHI's proposed APS fees only with Australian private remuneration, which entirely misses the point.⁸² New Zealand private income is not an alternative to Australian private income, as it cross-subsidises lower New Zealand public pay. On a like-for-like basis, it must make up a gap at least as large as the New Zealand base salary itself just to match Australian public pay.
 - (c) **SCHI's proposal removes the top-up:** A ~48% cut to SCHI-funded fees affects the income that offsets the trans-Tasman gap and keeps many gynaecologists in New Zealand. Once that cross-subsidy is removed, the gap enlarges and the effect on supply is likely to be far greater than the Commission assumes. The Draft Determination does not consider this at all. Its own finding that higher Australian public pay is a "drawcard" for younger gynaecologists only reinforces the point.⁸³
36. **The claimed frictions to exit do not hold:** The Commission next finds that "additional financial and non-financial frictions" may reduce gynaecologists' incentive to leave (again, these are not a measure of the delta). It lists family and other non-financial reasons, referral relationships and clinic ownership as examples, but those do not hold:
- (a) **Family and other non-financial reasons:** The Commission relies on two anecdotes that some gynaecologists have stayed in New Zealand for family or other non-financial reasons. Those anecdotes more likely describe those who stay whatever the fee and are inframarginal and are negligible to the analysis. The relevant question is how many gynaecologists are at the margin: those whose decision to enter, stay or return would

While the comparison is between the factual and counterfactual, the analysis here hinges on what SCHI's proposal as any agreed negotiated outcome in the factual would likely prevent the current risk to gynaecologist supply by SCHI's proposal. Draft Determination at [280].

Draft Determination at [281].

Draft Determination at fn 365. The Commission notes that the AU\$679,000 salary was advertised for a position in an "outback community". It is not clear why that aspect of the position matters. It is a real salary, on offer now, to a gynaecologist willing to move. Whether the location suits is for the individual to weigh and it is not a valid reason to discount the figure. It is not clear what purpose that qualification serves other than to diminish the one figure that most clearly shows the scale of the gap. In any event, even the bottom of the Australian range sits well above the top of the New Zealand scale.

Draft Determination at [280]–[281].

Draft Determination at [281]. NZGA's survey evidence of 129 private gynaecologist members finds: 41 do 60% or more of their work privately, 17 more than 40%, 38 more than 20% and 33 less than 20%.

Draft Determination at [284].

Draft Determination at [288].

change because of a ~48% cut. The Commission never asks that question.⁸⁴ If its reasoning were right, no change in price or quality could ever affect supply. NZGA does not accept that many would stay after a cut of this size, and the survey indicates otherwise (see paragraph 35). These anecdotes are given weight despite contradicting evidence pointing the other way to support exit (which the Commission sets aside, see paragraph 37). Link makes the same point: the Commission does not address behaviour on the margin, and entering, newly established and overseas-origin trainee gynaecologists have much greater incentives to leave than established practitioners. Gynaecologists who had narrowly decided to stay may also change that decision after a material change in expected remuneration.⁸⁵

- (b) **Referral relationships:** The Commission assumes that having to rebuild GP referral relationships would deter gynaecologists from practising in Australia (assuming New Zealand's patient pathway applies there). Australia's private market is far larger, with around 46%⁸⁶ of Australians holding private hospital cover, and its own O&G workforce is projected to remain in shortage, so demand for incoming specialists is strong.⁸⁷ Specialists can build a private patient base through public hospital and visiting appointments, and as discussed, salaried public roles advertised at AU\$350,000–AU\$679,000 (which bridge a significant gap for private work) do not depend on private referrals at all.
 - (c) **Clinic ownership:** The Commission wrongly treats clinic ownership as a barrier to exit. The cost of closing a clinic matters only if the practice remains viable. NZGA has given the Commission evidence that clearly indicates that this will not be the case – practice costs have risen sharply (eg nursing salaries have increased by around 60%, and medical CPI of 14.5% in 2025) without comparative fee increases, and as discussed, SCHI's proposal would cut total practice revenue by around 25–30%. An unviable practice is precisely a reason to leave (owning a clinic under those circumstances is no reason to stay). In any event, these frictions do nothing to prevent early retirement or reduced private work.
37. **Clear evidence of exit is recorded, then set aside without explanation:** The Commission has also been selective in how it uses evidence:
- (a) Four gynaecologists wrote to the Commission describing early retirement, practice closures and relocation overseas if private practice becomes unviable.⁸⁸ One has already closed their practice.⁸⁹ The Draft Determination documents these issues and does nothing further.
 - (b) We understand an anonymous gynaecologist has made a submission on the Draft Determination raising concern that the parts of their interview evidence most critical of SCHI were omitted. They told the Commission they would not sign the contracts on offer, would likely move their work to Australia because the proposed cut threatens their livelihood and family, and expected many colleagues to do the same. None of that appears in the Draft Determination. Their interview is cited where it points against authorisation and left out where it supports it. For example, the Draft Determination relies on anecdotes that gynaecologists stay in New Zealand for family reasons while not weighing evidence that the fee cuts threaten a gynaecologist's livelihood and family.⁹⁰
38. **SCHI's incentives do not protect national supply:** Finally, the Commission considers that SCHI, as a member-focused friendly society bound to provide cover, is incentivised to keep fees

Draft Determination at [283.2] and [287].

Link Report at [58].

[Australian Prudential Regulation Authority, *Quarterly Private Health Insurance Membership and Benefits Summary – June 2026 \(27 August 2026\)*.](#)

See [Australian Government - Department of Health, Disability and Ageing \(Cth\), *Obstetrics and Gynaecology Supply and Demand Compendium Report \(April 2026\)*](#) at p.4; see also [RANZCOG, *Women's Health Roundtable: Strengthening the O&G Workforce Report \(August 2026\)*](#) at p.5–6.

Draft Determination at [276.5].

Draft Determination at fn 341.

Draft Determination at [287.3].

at a level that maintains adequate supply for its members. It cites no evidence for this beyond SCHI's own submission,⁹¹ and in doing so assumes SCHI alone knows what a sustainable fee is. That assumption does not hold. NZGA, representing around 92% of private gynaecologists, has told the Commission the proposed cuts are not sustainable. The Commission records NZGA's point that SCHI cannot identify a sustainable fee without engaging with the workforce but then does nothing further.⁹² SCHI's incentive is to secure *sufficient* coverage for its own members, which may not require all gynaecologists and SCHI acknowledges that it will target lower-charging surgeons,⁹³ while complex and unfunded work moves to the public system. That is not the same as the supply New Zealand needs.⁹⁴

- (a) SCHI covers around 60% of insured New Zealanders.⁹⁵ At most, SCHI is incentivised to protect supply for those members. As such, it has no (or minimal) incentive for the remaining 40% or more of insured patients, or for patients funded in other ways.
 - (b) Nor does the Draft Determination point to any evidence that SCHI is making a concerted effort to protect subspecialty numbers, which are already below the levels needed (see paragraph 48(b)). Losing one or two subspecialists may make little difference to SCHI's coverage in the short term, but in segments this small it would be a significant proportionate loss and would materially reduce national capacity.
 - (c) The most significant loss of supply is likely to be felt over the medium to long term, and none of it has been measured. As noted above, SCHI's incentives favour the short term. Even if SCHI maintains sufficient cover after moving to the APS, its incentives do not extend to the longer-term sustainability of the workforce: earlier retirements, the training and mentoring of younger specialists, and the return of specialists from Australia.
39. **NZGA's member survey shows what the delta looks like:** In an anonymous survey of 129 private gynaecologists (and then a subsequent 49-member survey⁹⁶). []% ([] out of 129)] of respondents indicated they expect to change their practice under SCHI's proposal (the counterfactual): []% indicated they would likely stop complex procedures, []% would reduce their workload by around 30%, []% would retire and []% would move overseas ([]% indicated no change). See below.

TABLE 2: WHAT MEMBERS (N=129) WILL LIKELY DO IN THE COUNTERFACTUAL

40. Evidence from Table 2 was then further tested with additional options to test the robustness of the earlier survey question, splitting between overall work and complex work (as members may reduce work overall but this may disproportionately affect complex work).

Draft Determination at [278.1].

Draft Determination at [335].

Draft Determination at [187].

Draft Determination at [147], [155.3] and [290]–[291].

See [SCMCS 2026 Annual Report – Summary at p.4](#).

Not all members were surveyed in the subsequent survey due to time constraints.

FIGURE 1: WHAT ARE MEMBERS'S LIKELY RESPONSE TO THEIR OVERALL WORK UNDER SCHI'S APS FEE – FURTHER SURVEY OF MEMBERS (n=49) TO TEST TABLE 2 RESULTS

FIGURE 2: WHAT ARE MEMBERS' LIKELY RESPONSE TO THEIR OVERALL COMPLEX PROCEDURES UNDER SCHI'S APS FEE – FURTHER SURVEY OF MEMBERS (N=49) TO TEST TABLE 2 RESULTS

41. Figures 1 & 2 largely corroborate Table 2 showing that in some cases, members will go further than the earlier ~30% reduction benchmark and that members are unlikely to increase work in response (as suggested by the Draft Determination). Figure 2 shows on a mid-point assumption⁹⁷ that [] of all complex procedures would no longer be provided.
42. The further survey also indicates an even more pronounced effect on complex work. Excluding the [] respondents who do not currently perform complex procedures, [] of those currently undertaking complex work would stop or reduce it. [] indicated no change.

FIGURE 3: WHAT ARE MEMBERS' LIKELY RESPONSE TO THEIR OVERALL PRACTICE UNDER SCHI'S APS FEE – FURTHER SURVEY OF MEMBERS (n=49) TO TEST TABLE 2 RESULTS

43. Only [] of respondents indicated that they would retire or move overseas immediately in response to SCHI's proposal being implemented in the counterfactual. However, when tested more carefully in the subsequent survey, it was revealed that closer to []

Assumes that more than 50%+ averages to .75 and less than 50% averages to .25.

44. **Age and private-work profile:** Retirement and reducing work are real and immediate options for many gynaecologists given the ageing private workforce: []

FIGURE 4: HOW OLD ARE MEMBERS (N=129)

45. **Overall reduced hours, retirement and emigration effectively equate to around a [] FTE loss ([] % of the private workforce).** This is before considering that []% of respondents indicated they may stop offering complex procedures.⁹⁸ Applying a conservative 75% follow-through rate to these survey responses, Link estimates that the capacity to perform around 8,200 procedures a year would be lost (around 6,600 of them private).⁹⁹
- (a) These effects are unlikely to fall evenly. As mentioned, nearly [] of private gynaecologists are aged 50 or over [] and only [] are under 40.¹⁰⁰ A cut of this size is more likely to bring forward retirement or reduce private work for senior gynaecologists. They are generally the most experienced, carry much of the complex work, and include many of the subspecialists whose numbers are already critically low.
 - (b) They also train and mentor the next generation. The chance to learn from an experienced senior colleague is an important factor for why younger specialists stay in (or return to) New Zealand. Losing senior gynaecologists would reduce critical complex and subspecialty capacity (exacerbating adverse health outcomes and exit risk by younger specialists).
46. **The effect should be assessed, not assumed:** As such, NZGA asks the Commission to carefully assess and test, using the data available, the effect of different fee scenarios on total gynaecology claims, total claims, average premiums (where this can be reliably estimated) and coverage or utilisation, and to weigh any effect against the access consequences of a payment model that reduces specialist supply (see **Section D**).
47. **The wider evidence supports a real supply risk:** Alongside the higher income potential in Australia for the public sector as identified by RANZCOG, Health NZ confirms that the shared college lets specialists move to Australia without further training.¹⁰¹ Its own workforce plan records obstetrics and gynaecology as already around 60 FTE (13.8%) short.¹⁰² AGES warns that smaller centres relying on one or two gynaecologists risk losing services altogether.¹⁰³ Link adds that more than 50% of private gynaecologists also work in the public system, so attrition would also reduce specialist availability in public hospitals, and the gynae-oncology experience shows that losses overseas may be long-term.¹⁰⁴

NZGA anonymous workforce survey (n=129): [] surgeons reducing workload by around 30% [], plus [] retiring and [] moving overseas [].
 Link Report at [60].
 NZGA anonymous workforce survey.
 Draft Determination at [281].
[Health New Zealand | Te Whatu Ora, Health Workforce Plan 2024 – medicine analysis \(last updated 22 July 2026\)](#), see “Current shortages and long-term estimates”.
 Draft Determination at [282].
 Link Report at [64]–[66].

48. **The other factors relied on to discount supply do not hold:** The Commission also relies on several other factors to weaken the supply benefit in the factual or limit the loss of supply in the counterfactual:
- (a) **The supply analysis is framed too narrowly:** The Commission frames supply almost entirely around whether gynaecologists would leave for Australia, although it accepts that supply also turns on early retirement, the return of specialists from overseas and decisions to train.¹⁰⁵ Yet it does not assess those factors, or the reduction in complex and private work NZGA has raised, and gives no reason for leaving them out.
 - (b) **Small movements matter, especially at subspecialty level:** In a specialty this small, the delta does not need to be large to matter. New Zealand has only around 10 gynaecologists (against an estimated need of 18), three urogynaecologists and 20 advanced laparoscopic gynaecologists. More than twice as many New Zealand urogynaecologists have stayed in Australia after their fellowships (versus practicing in New Zealand). Losing a single urogynaecologist would remove a third of national capacity, and each subspecialist takes well over a decade to train. The Commission accepts that market boundaries may depend on surgical specialty,¹⁰⁶ and each subspecialty is arguably a distinct segment (if not a separate market) in which a handful of exits would materially reduce women's access to care. The Commission need not formally define these segments, but it must assess supply within them, and the Draft Determination does not.
 - (c) **SCHI's "better off" estimates:** The Commission relies on SCHI's confidential estimate that some gynaecologists will be better off under the APS,¹⁰⁷ while accepting that most are likely to receive a lower fee per procedure.¹⁰⁸ That some may be better off says little about how the majority will respond, and the estimate has not been tested (see **Section F**).
 - (d) **Volume cannot offset a ~48% cut:** The Commission suggests remaining gynaecologists may partly offset any loss of supply by increasing their volumes.¹⁰⁹ That assumes spare capacity that does not exist. Private gynaecologists already carry high volumes: in 2025, [] private hospital completed [] gynaecology cases with [] surgeons, and [] private practice completed [] cases with [] consultants, compared with [] cases at [] public unit with [] consultants and [] registrars.¹¹⁰ On those figures, private gynaecologists already handle around four to six times as many cases per consultant as the public unit, so it is unclear on what basis the Commission assumes they have room to do more. Nor can surgeons simply add lists, as credentialing does not guarantee theatre time.¹¹¹ The suggestion rests on submissions from interested parties, including an insurer and Southern Cross Hospitals,¹¹² and the survey responses point the other way (see paragraph 39).
49. **Given the lack of capacity, any change in supply is significant:** Private capacity that is lost moves to a public system the Commission itself records as having waiting lists and a shortage of surgeons.¹¹³ Gynaecology waiting lists are already among the longest in the health system: many public units no longer accept GP referrals, and women often wait more than 120 days for a first specialist appointment, and again for surgery. A conservative estimate of around [] cases/year¹¹⁴ and disproportionately [] complex cases/year,¹¹⁵ would need to be absorbed elsewhere, around five times the annual output of the public unit referred to above. This highlights that even a modest difference in supply between the factual and counterfactual is

Draft Determination at [35] and [284].

Draft Determination at [119].

Draft Determination at [144] and [287.4].

Draft Determination at [171].

Draft Determination at [289].

Draft Determination at [71].

Draft Determination at [289], fns 381–382.

Draft Determination at [376].

Calculated based on NZGA anonymous workforce survey, where [] is lost. This is then multiplied by around [] cases per surgeon which results in [] cases lost per year.

Based on NZGA anonymous workforce survey where [] surgeons selected that they would stop all complex work. With complex work estimated to make up 11% of a gynaecologist's caseload, []].

therefore significant. Even modest annual losses compound. in a workforce that is already short and takes over a decade to replace. Given existing waiting lists, any reduction in supply in the counterfactual is a significant detriment, and preserving supply in the factual a significant benefit. Link also notes that withdrawn private capacity is unlikely to be fully replaced by the public system in the short term and, over the longer term, only with additional government funding.¹¹⁶

E. SCHI's monopsony (like) proposed fees cannot be assumed an efficient benchmark

50. **SCHI's proposed fees are treated as the efficient benchmark without testing:** The Commission accepts that higher fees are a transfer and not a detriment in themselves. But it then counts the “resulting” effects of that transfer (higher premiums, and members reducing or dropping cover) as an allocative efficiency loss, which on its own definition arises only from “inefficient (higher) prices”.¹¹⁷ Every allocative detriment therefore assumes that any fee above SCHI's proposal is inefficient: the more NZGA achieves, “the greater these allocative efficiencies losses will likely be”.¹¹⁸ SCHI has monopsony (like) buyer power – it holds 68% of gross written premiums, and the Commission accepts that gynaecologists depend on SCHI and face significant financial risk if they do not sign up.¹¹⁹ That should not be controversial. NZGA set out SCHI's buyer power and the relevant markets in its application, which the Draft Determination largely sidesteps.¹²⁰ No formal market definition is needed to recognise it. Yet the Commission treats SCHI's proposal to cut fees by ~48% as the efficient level, without ever asking whether SCHI's proposed fees could sit below competitive levels, and so inefficiently reduce entry into / increase exit from gynaecology (supply).¹²¹ If they do, higher fees in the factual move towards the efficient level and are a gain, not a detriment, and any resulting rise in premiums reflects the efficient cost of care rather than an efficiency loss. As discussed, SCHI's own incentive is only to secure *sufficient* coverage for its members. Paying only enough to secure that coverage is consistent with a monopsony outcome, not evidence of an efficient one. Where a purchaser holds that power, countervailing bargaining power is pro-competitive and efficiency-enhancing, as the Commission has recognised in other collective bargaining authorisations. Link's analysis supports this. It finds that SCHI is a near-monopsonist, which implies that at least moderately higher prices in the factual would be efficient, and that prices in the factual are likely to remain below efficient levels even with authorisation.¹²²
51. **A lower fee is not automatically an efficiency:** A lower input price may reflect genuine efficiency, the removal of seller rents, a transfer of surplus to the purchaser, or monopsony depressing supply and quality. A purchaser using bargaining power to remove seller rents is different from a powerful purchaser depressing reimbursement below competitive levels, which reduces the availability and quality of care. Assuming one over the other requires evidence-based assessment, which has not been done. The Commission also applies its transfer approach in one direction only: it counts the allocative losses from higher fees in full but treats the supply loss from SCHI's lower fees as “small and theoretical” and the quality loss as nil. Any efficiency must also be assessed across the whole treatment pathway, not the specialist fee in isolation. A lower fee is not a net efficiency if it delays care, or patients can no longer access their preferred surgeon or treatment privately, they will likely turn to the public system instead.
52. **Nothing shows the lowest price is the most efficient:** In healthcare, the lowest price will rarely be the efficient one. Surgical services are highly differentiated: surgeons differ in skill, experience and subspecialty, and what may appear as identical procedures differ in complexity from one patient to the next. Most surgical services must also recover fixed costs (training, equipment, staff and indemnity). Some surgeons may accept less than that in particular cases, for example early in their career, where those costs are met elsewhere or even goodwill, but this cannot be expected of an entire workforce. Price differences therefore often reflect real

Link Report at [62] and [67].

Draft Determination at [20], [218], [223] and [329]–[330].

Draft Determination at [422]; see also [31] and [432].

Draft Determination at [59], [177] and [186].

NZGA authorisation application (19 May 2026) at [5.20]–[5.35] and [7.1]–[7.11].

Draft Determination at [29]–[31] and [422].

Link Report at [45] and [49].

differences in what is supplied, not inefficiency. As Link explains, under the AP scheme price is easy for SCHI to set and monitor, but quality (surgeon skill, procedure length, the need for out-of-the-ordinary procedures and patient interaction) is not. Gynaecologists have better incentives and information on quality, so SCHI's monopsony power in the counterfactual is likely to lead to inefficiently low quality.¹²³

- (a) The Commission accepts that gynaecologists differ in experience, subspecialty and costs when assessing transaction costs, and records evidence that fee variation partly reflects skill and experience.¹²⁴ Yet it assumes a lower, more uniform fee ("structured pricing" as SCHI calls it) as the efficient benchmark. In private care, patients and their GPs look for a surgeon they trust to deliver the best outcome. For an invasive procedure, that choice turns on expertise, experience and reputation sometimes more so than on price,¹²⁵ and a lower common fee rewards none of them.
 - (b) As the Commission notes, GPs have no visibility of surgeons' fees or outcomes, so there is no market mechanism to show that the lowest-priced surgeon is the most efficient, or that a lower price delivers equivalent quality.¹²⁶ The evidence on the record points the other way. Anglesea Gynaecology submitted that the APS creates a bias towards lower-cost and lower-expertise care, affecting outcomes, complication rates and patient satisfaction. Intus said pricing pressure is already driving wraparound support towards the minimum, and NZSA warned that financial incentives may not align with optimal clinical decision-making.¹²⁷ The Commission records this evidence but never assesses this properly because it does not ask whether SCHI's lower fee is the efficient one.
53. **In any event, even if SCHI's mission is to fund care efficiently, it may well fail to do so:** It lacks the clinical and workforce information needed to identify a sustainable fee and, like any large organisation, it cannot ensure every level of management acts in line with that mission. Management incentives favour the short term: cutting specialist fees holds down premiums now and minimises immediate pushback from members, while the costs (lost supply, and delayed and more complex care) emerge later and, given the complexity of healthcare, can rarely be traced back to any particular decision. SCHI may therefore prefer inefficiently low fees, even with the best of intentions. Link reaches the same view: SCHI's managers are neither all-knowing nor unbiased, the easiest thing for them to set and monitor is price rather than quality, and after two years of deficits they face strong pressure to cut costs quickly. This can lead to inefficient cost-cutting through monopsony power, even without ill intent.¹²⁸
54. **The APS shifts administrative cost rather than removing it:** SCHI says the APS creates administrative efficiencies through standardised coding, automated claims and less manual processing.¹²⁹ Productive efficiency concerns the total cost of delivering care, not SCHI's share of it. The flexibility the Commission relies on to dismiss clinical concerns (open codes, risk corridors, add-ons and top-ups) works through case-by-case applications, insurer-defined criteria and documentation requirements.¹³⁰ The work SCHI saves falls on hospitals, gynaecologists and their practices, and takes time away from surgery and patients. That is a productive efficiency loss in the counterfactual which the Commission has not counted. Negotiated, objective criteria for those mechanisms in the factual would reduce it.
55. **The Commission has previously recognised the risk of SCHI operating inefficiently:** When SCHI sought to acquire Aetna Health (NZ) Limited, the Commission's own inquiries recorded that SCHI did not face the same commercial incentives as its corporate rivals, that it "[doesn't] have to operate all that efficiently to compete" and that it "could operate at inefficient levels".¹³¹

Link Report at [27]–[28].

Draft Determination at [279.2], [297] and [312].

Draft Determination at [68]–[69].

Draft Determination at [70].

Draft Determination at [238], [239.2] and [239.3].

Link Report at [26]–[27] and [31].

Draft Determination at [88] and [139].

Draft Determination at [90]–[91], [231], [246.3], [256.2] and [415.1].

Commerce Commission v Southern Cross Medical Care Society CA89/01, 21 December 2001 at [31], [108] and [112] per Keith J (dissenting).

The Commission, through counsel, also raised the risk of “concealed inefficiencies” before the Court of Appeal.¹³² The majority considered that risk fell outside the then old dominance test (and not the current SLC test), but under the public benefit test efficiency is the central question.¹³³ SCHI’s position is essentially unchanged: 60% of lives and 65% of earned premiums in 1999, against 60% of insured New Zealanders and 68% of gross written premiums now.¹³⁴ By comparison the duopoly supermarkets in the concentrated and regulated grocery markets own 82% (while SCHI holds at least 60% on its own). Yet the Draft Determination assumes SCHI’s proposal is efficient.¹³⁵ Not-for-profit status is no guarantee of efficiency, and SCHI’s members will differ in their preferences for premiums, access, choice and clinical quality. With respect, it is a significant omission for the competition regulator to set that history aside.

56. **SCHI’s deficit narrative is not evidence:** The Commission accepts SCHI’s account that rising specialist fees drove its recent deficits, and on that basis finds SCHI would not absorb any cost increase.¹³⁶ SCHI has since reported a \$146.9 million surplus for FY2026, with claims cost escalation falling to 7.1%, before any transition of gynaecology to the APS.¹³⁷ SCHI may say this reflects its cost-management programme. If so, it shows SCHI can manage claims costs without a ~48% cut to gynaecology fees. The reasoning is in any event a non sequitur – as a not-for-profit, SCHI should always pass on efficient costs and avoid inefficient ones, whether in deficit or surplus, and its return to surplus before gynaecology fees had materially changed shows those fees had little to do with its losses. SCHI cannot simply assert, and the Commission cannot simply accept, that any cost increase must be passed on to members. Like all insurers, SCHI routinely runs unders and overs, and manages them through its reserves and investment portfolio. That premise must be tested against evidence before it is relied on.
57. **Whether SCHI’s conduct is itself anticompetitive has not been assessed:** As set out at paragraph 18, NZGA has explained that under the head-contractor model hospitals no longer compete with one another for surgeons, and pointed to near-identical hospital price lists as evidence. Despite this, the Commission adopts the view of SCHI and hospitals that hospitals still compete “vigorously” for surgeons, including through a greater share of the bundle, better facilities or new technology, on those parties’ word alone.¹³⁸ The more likely outcome is that hospitals (whether willingly or passively) adopt SCHI’s indicative split, knowing other hospitals will do the same, so that fees settle within the narrow range SCHI sets and seeks to keep uniform.¹³⁹ The Commission has not assessed whether the specific conduct by SCHI moving gynaecologists from FFS onto that narrow range of unilaterally set fees is itself anticompetitive. That is the necessary starting point. If the counterfactual is itself an anticompetitive outcome, any movement away from it in the factual is a benefit, not a detriment.

F. Evidence supporting SCHI is accepted without proper testing while that supporting NZGA is discounted

58. **The evidential burden is applied unevenly:** NZGA accepts that it bears the practical burden of persuasion. That burden does not displace the Commission’s duty to scrutinise all evidence consistently.
 - (a) NZGA’s evidence is discounted as unquantified or “not strong”.¹⁴⁰
 - (b) Evidence from SCHI and other interested parties is accepted without further testing, despite the clear interest of those submitters in aligning with SCHI (hospitals and other

At [61].

Draft Determination at [107] and [218].

Commerce Commission v Southern Cross Medical Care Society, above, at [26]; Draft Determination at [59].

Draft Determination at [147], [278.1] and [290].

Draft Determination at [60] and [200].

SCMCS 2026 Annual Report – Summary.

Draft Determination at [382], [384], [386], [395] and [418].

Draft Determination at [89], [148.2] and [190].

Draft Determination at [245] and [283].

funders benefit from lower fees), and even where the Commission itself has found SCHI's assumptions unsupported.¹⁴¹

- (c) Evidence supporting NZGA is recorded and then left out of the analysis without explanation.

With respect, this is not a popularity contest in which the Commission can simply choose the evidence it prefers. It must test the evidence on each side on its merits, and explain why it prefers some qualitative evidence over other evidence.

59. The same uneven approach applies to the “likely” threshold. A benefit or detriment is likely if there is a real and substantial chance it will occur. It must be more than a mere possibility but need not be more likely than not.¹⁴² The Commission finds the allocative detriments likely while accepting that their size and the causal chain behind them are unclear. Yet it treats the supply benefit as “theoretical” for want of “strong evidence” and discounts the health benefit for lack of quantitative evidence of its likelihood.¹⁴³ If uncertainty does not stop a detriment from being likely, it cannot stop a benefit from being likely. Where an adverse (untested) proposition will be relied on in the Final Determination, NZGA asks that it first be put to NZGA so that it can respond.
60. **Key findings rest on evidence no one else can see or test:** Several central findings rely on SCHI's confidential information, including that some gynaecologists will be better off under the APS, the comparison with Australian remuneration, and the effect on premiums and coverage.¹⁴⁴ Those findings concern the fees and practices of private gynaecologists, who are best placed to identify any error, yet they cannot see the material. The Commission does not appear to have tested any of it independently before relying on it.
61. **The clinical evidence has not been properly tested:** As NZGA submitted on 27 August 2026, much of the evidence relied on (including SCHI's clinical rebuttals, the code set and the treatment of surgical complexity) sits within a highly specialised clinical context. Testing it properly requires expertise in gynaecology as a clinical discipline, which the Commission does not have. Until it is tested, it should be treated as assertion rather than evidence. By declining access for NZGA's independent clinical adviser to SCHI's confidential information, the Commission has prevented NZGA from testing SCHI's assertions, contrary to natural justice.¹⁴⁵ NZGA urges the Commission to engage its own independent clinical specialist to test all of the clinical evidence (from SCHI, hospitals and NZGA alike) and the likely clinical effects of the factual and counterfactual before reaching any conclusions. That would avoid the confidentiality concerns the Commission relied on to decline NZGA's request, go some way to addressing the natural justice concerns, and give the wider public assurance that the evidence has been critically assessed.
62. **The interview record was not corrected:** Before the Draft Determination was released, an individual gynaecologist asked the Commission to correct how a statement in the Draft Determination was being attributed to them. The statement was left unamended and is incorrectly relied on to discount the supply benefit.¹⁴⁶ No reason was given for why the correction was ignored. Conversely, other relevant evidence from the same interview (including on loss of trust in SCHI and the effect of the proposed fee reduction on their practice) has not been given any consideration in the Draft Determination.

See, for example, Draft Determination at [246.1], [278.4], [287.4] and [289]; compare [194].

NZME Ltd v Commerce Commission [2018] NZCA 389 at [86(a)], citing *Port Nelson v Commerce Commission* [1996] 3 NZLR 554 (CA) at [562]–[563].

Compare Draft Determination at [336.2], [337], [344] and [379] with [245] and [291].

Draft Determination at [144], fn 185; [187], Figure 1; [278.3], Figure 3; [285]; [287.4]; [332]; and [340].

Commission letter to Matthews Law (5 October 2026).

Draft Determination at [279.2], fn 358.

G. Health outcomes are in fact affected

63. **Health benefits cannot be discounted for lack of quantification:** The Commission discounts the health benefit because NZGA has not provided quantitative evidence of better outcomes.¹⁴⁷ Forward-looking quantification of patient harm is often difficult (and even if attempted, is inaccurate, requiring a number of assumptions) and is not required. As the Commission itself notes, qualitative factors can be given independent and, where appropriate, decisive weight.¹⁴⁸ Regardless, the detriments have not been quantified either.¹⁴⁹ The Commission has not attempted the first step of the analysis to health outcomes – it must assess the potential harm under SCHI’s code set in the counterfactual, and compare it with a factual in which clinical input produces a more clinically appropriate code set.
64. **Health outcomes are not “unaffected”:** The Commission treats health outcomes as unaffected on the basis that clinical issues will be resolved in the same way in both scenarios.¹⁵⁰ That assumes away the mechanism NZGA relies on. In the counterfactual, gynaecologists bear the risk of unfunded complexity and depend on SCHI’s discretion. Incentives matter and the combination of reduced fees and funding complexity will lead to gynaecologists stopping complex private work, reducing their private work or stopping working altogether, as discussed. That work moves to an already stretched public system with long waiting lists, creating a real detriment to patient outcomes in the counterfactual.¹⁵¹ Link explains why: a standardised or bundled price transfers risk to the provider, and where payment does not adjust for complexity, providers may avoid high-cost patients, narrow the services supplied or reduce unmeasured quality, with some patients switching to the public system or not receiving adequate treatment, and wait times rising in both systems.¹⁵² Authorisation provides a means for NZGA and SCHI to collaborate on complex procedures, controlling cost while giving gynaecologists reassurance that they will not unnecessarily bear the financial risk.¹⁵³
65. **The code set is not “largely settled”:** The Commission prefers SCHI’s statement that the code set is “largely settled” (which NZGA disagrees with), while inconsistently acknowledging that it will “evolve over time as SCHI acquires more data”.¹⁵⁴ That is an acknowledgement that gaps remain and SCHI cannot get it right immediately with data alone. These are clinical issues which are best resolved directly with the clinicians who perform the procedures rather than inferred over time from claims data. SCHI’s code set has around only 55 codes (only adding 2 codes following RANZCOG consultation), against the 84 codes which RANZCOG originally proposed to SCHI.
- (a) By comparison, there are more than 150 gynaecology codes in Australia. The Commission has not grappled with that gap or undertaken (or commissioned) any clinical analysis of whether gaps exist. It is not clear why RANZCOG first recommended 84 codes, or why Australia needs more than 150 if 55 codes are sufficient as SCHI says it is.
 - (b) The two most complex conditions in benign gynaecology, endometriosis and pelvic floor/urogynaecology, are particularly underserved by the proposed AP code set, despite multiple engagements and recommendations from RANZCOG.
66. **Several common procedures still have no appropriate code:** The gaps disproportionately exist in areas where complexity and combined procedures are most common (ie the serious cases are at the most risk under the counterfactual):
- (a) **Laparoscopic hysterectomy:** RANZCOG proposed three codes (simple, complex, and complex with fibroid morcellation for uteri over 500 grams). SCHI’s framework acknowledges only two (uteri under and over 250 grams) with no provision for a uterus

Draft Determination at [245].

Draft Determination at [214]–[215], citing *Godfrey Hirst NZ Ltd v Commerce Commission* [2016] NZCA 560 at [38].

Draft Determination at [18] and [419].

Draft Determination at [36.1], [244] and [246].

Draft Determination at [413]–[414].

Link Report at [55].

Link Report at [56].

Draft Determination at [246.1] and [246.3].

over 500 grams with stage 2–3 endometriosis. SCHI also provides no clarity on whether stage 4 endometriosis requiring hysterectomy is a primary code with an add-on.

- (b) **Pelvic floor surgery:** Despite multiple discussions, the pelvic floor codes remain deficient. Open or laparoscopic sacrocolpopexy with a TVT is coded as a single procedure although it treats two separate conditions. There is a combined anterior and posterior colporrhaphy code, but no code for sacrospinous fixation or any vaginal vault or uterine suspension procedure. As the Urogynaecological Society of Australasia (UGSA) submitted,¹⁵⁵ around 80% of women with advanced prolapse have occult stress urinary incontinence requiring a combined procedure, and 85% of women with stage 3 (and all women with stage 4) anterior prolapse have clinically significant apical prolapse. Repairing the anterior wall alone leaves the apex untreated, so symptoms persist and a second operation is often needed soon after: two surgeries and two recoveries for the patient, with each further operation more complex and higher risk.
 - (c) **Procedures with no code at all:** These include colpocleisis, fascial slings, vaginal suspension of the uterus or vault, Manchester repair, Burch colposuspension, bladder Botox, pelvic floor Botox and pudendal block, destruction of vulval lesions, and several gynae-oncology procedures that fall within benign practice (eg wide local excision of the vulva).
 - (d) **The open code is no answer:** These cases fall to open code AP1487, which applies only to procedures that “significantly fall outside” contracted codes and requires a detailed description and rationale before approval, with theatre time to be retained and provided on request. Given how often prolapse repair requires a combined procedure, 80% of patients would effectively need a justification letter and hospital–insurer correspondence before surgery, adding to the burden described at paragraph 68(c).
 - (e) **The code set has not moved, and surgeons cannot see what is being agreed to:** Despite RANZCOG providing codes and extensive discussion, the codes circulated by hospitals as recently as June 2026 are unchanged. Further, when SCHI and hospitals agree a fee for a procedure, surgeons receive the code description only after the agreement is made (so surgeons are bound by a fee agreed on their behalf by others, for a procedure whose scope they had no opportunity to review).
67. These gaps emphasise NZGA’s view that APS is designed for simple procedures with few variables and should not be so quickly cast over the entirety of gynaecology surgical procedures without proper engagement and clinical consultation. Applied without the necessary clinical input (particularly to multivariable conditions), it will harm women’s health in the counterfactual. Engagement in the factual is how they would be fixed. NZGA provides some further case examples to illustrate where the proposed AP coding appears to be inadequate (more examples can be provided to the Commission if needed):

TABLE 1: FOUR CASE EXAMPLES OF GAPS / ISSUES IN PROPOSED AP CODE SET

#	Procedure & complexity	What the proposed code set provides	Gap / issue	Practical consequence
1	Hysterectomy (14-week uterus), stage 4 endometriosis, 15 cm sigmoid bowel resection, cystoscopy and ureteric catheters. Multiple previous surgeries. Two surgeons (gynaecologist and colorectal). ~360 mins; 4-day stay.	Largest available code is 340 mins (stage 4 endometriosis), excluding colorectal bowel resection. 15-minute add-on, understood to be capped.	Case exceeds the longest code. No code for cystoscopy or ureteric catheters. No provision for a second surgeon for the full procedure.	No appropriate code. Multiple discussions with insurer needed; unclear how the colorectal surgeon is paid; approval delays extend patient wait times. (Even under FFS, invoices can be unpaid 8 weeks after surgery despite prior approval.)
2	Laparoscopic excision of severe endometriosis, including diaphragmatic disease. Two surgeons (gynaecologist and upper GI). 3 hrs 5 mins.	No provision.	No code for diaphragmatic disease or for a second surgeon.	Approval must be sought outside the code set through multiple insurer interactions. One surgeon has never succeeded in obtaining extra remuneration for robotic surgery over 2.5 years.

See [UGSA submission on SOPI](#), at p.3.

3	Anterior and posterior vaginal repair with sacrospinous colpopexy.	Assumed standalone pelvic floor code. Appears to operate like FFS, but is also described as a range code. No risk corridor.	Issue is not time but structure: it is unclear how this procedure fits the code set.	No clarity on coding or payment for a high-volume procedure.
4	Robotic-assisted laparoscopic hysterectomy with excision of endometriosis and in-bag morcellation of fibroid uterus. 3 hrs 28 mins.	Robotic hysterectomy code covers stage 2 endometriosis.	No provision for a longer case due to fibroid uterus. In-bag morcellation (a different technique) not in the code description. No risk corridors identified by the contracting hospital.	Case well beyond a simple hysterectomy is under-coded. Surgeons' attempts to obtain additional payment in similar cases have all failed to date.

68. **SCHI has done little to address the risk it passes to surgeons:** Gynaecological surgery is often diagnostic and unpredictable. Imaging is a screening tool, and what is found at surgery (eg extensive adhesions, endometriosis or additional pathology) often differs from what was planned, so the surgeon must decide intraoperatively how to proceed. SCHI's answer is open codes, risk corridors and top-ups, but these are considered case by case at SCHI's discretion, and the Commission acknowledges gynaecologists' hesitancy where they are not contractually guaranteed. SCHI has not shown that they work reliably in practice:

- (a) **No objective criteria:** SCHI has provided only a generic, high-level guide referring to risk corridors, combination exclusions and eligibility criteria, without objective criteria for when they apply. As NZGA has explained, clinicians are often not told in detail what criteria apply or why a request has been declined. Even SCHI's explanation of how its complex hysterectomy, stage 4 endometriosis and pelvic floor add-on codes interact was first provided in its submissions.¹⁵⁶ NZGA has consistently sought for these mechanisms to be clearly documented and contractually guaranteed before surgeons are asked to sign AP agreements.
- (b) **Surgeons absorb the cost:** Where additional treatment is identified mid-procedure but may not be funded, the surgeon must either perform it at the risk of no reimbursement or stop and return the patient for a second operation. Gynaecologists already under APS often have to 'fight' for cover or 'pay out of pocket' (eg second surgeons when an unexpected pathology is found). We have referred the Commission to various examples provided by NZGA where surgeons have chosen to just bear the costs alone as SCHI is too difficult to deal with.¹⁵⁷ Complex cases can also require a second gynaecologist as an expert assistant, and barriers to involving one put patients at increased surgical risk.
- (c) **The administrative burden falls disproportionately on surgeons:** For gynaecology procedures already under the APS, surgeons must spend scarce clinical time applying to SCHI to exercise its discretion on risk corridors and top-ups, providing clinical input to explain why the procedure changed or how cover applies (this cannot be done by administrative staff alone as it requires clinical judgment). The frequency of those applications suggests the base codes are not sufficient and require adjustments on a regular basis.¹⁵⁸ Often it is simply not worth pursuing, and the risk and administrative burden stay with the surgeon. We urge the Commission to consider these issues more carefully.
- (d) **Cover and clinical care are intertwined:** SCHI frames these as matters of cover, saying robotic top-ups were declined because they fell outside its policy terms rather than because of complexity. NZGA does not dispute that the scope of cover is for SCHI to set. But once SCHI agrees to fund a procedure, the conditions it attaches to that funding inevitably shape how the surgery is performed. Those conditions are terms on which gynaecologists supply their services, and their clinical consequences fall squarely within the health outcomes the Commission must assess. In practice, cover decisions are dictating clinical practice (see also **Table 1** above):

See [SCHI Submission on SOPI \(16 June 2026\)](#), at Appendix 2.

NZGA would be happy to provide more examples to evidence these issues further if the Commission is not inclined to give them sufficient weight.

SCHI Submission on SOPI, at [6.9(iii)(e)].

- i. SCHI says its robotic hysterectomy code covers incidental endometriosis only up to stage three, which often cannot be confirmed before surgery. Despite this, where stage three or four disease is found, top-up applications have been declined on a number of cases, leaving surgeons completing robotic surgeries unfunded.
- ii. In another example, SCHI agreed to fund a robotic hysterectomy but required the surgeon to undock the robot and complete the expected endometriosis excision laparoscopically. The robotic approach was abandoned (because the suggested approach by SCHI was not appropriate) and the patient lost its benefits to access robotics surgery. SCHI has also declined to review its terms for this surgery despite repeated requests. SCHI's only answer appears to be a case-by-case health technology application (which requires an extensive administrative process prior), which offers nothing to a surgeon who must decide how to proceed mid-operation.

Patients should not be denied a clinically appropriate approach on the basis of cover.¹⁵⁹

69. **Objective criteria require engagement:** As such, these are inherently clinical questions that affect patient outcomes. They cannot be resolved by vague mechanisms applied at SCHI's discretion. They need objective, agreed criteria for when open codes, risk corridors, top-ups, second surgeons and assistants apply. Collective engagement in the factual is the practical way for the profession to settle those criteria with SCHI.
70. **RANZCOG's engagement is no substitute:** The Commission relies on SCHI's continuing engagement with RANZCOG. But RANZCOG does not engage in the commercial aspects of its members' work, and its engagement on the code set is clinical only.¹⁶⁰ It cannot address how the funding mechanisms operate in practice, which is where NZGA's concerns lie.
71. **Professional duty of care is only a minimum:** The Commission places significant weight on surgeons' professional obligations and the regulatory framework.¹⁶¹ The concern is not that gynaecologists would fall below their duty of care. A duty of care sets a minimum standard; it does not promote higher standards or support wraparound care. Nor does it prevent a practitioner from reducing complex private work and limiting their practice to a narrower range of procedures, which pushes complex work onto the public system.¹⁶²

H. Other detriments are overstated and the benefits understated

72. **The allocative detriments rest on a chain of untested assumptions:** An allocative efficiency loss arises only where a price above the efficient level causes consumers to buy less, or switch to something they value less. The Commission's finding depends on a chain of assumptions: (a) fees will be materially higher in the factual; (b) those fees are above the efficient level; (c) they flow through to SCHI premiums or cover; (d) members respond by reducing or dropping cover; and (e) the fees spread to other funders. None of them holds:
 - (a) **The fee increase is assumed, not assessed:** As set out at paragraph 16, the Commission has not reached a view on the size of any fee increase, yet finds it is "likely to be material". It also overlooks that NZGA does not seek an increase and accepts fees may need to be lower than under FFS, and that the only estimate of the increase on the record (SCHI's) is one the Commission found unsupported.¹⁶³ Nor has the Commission established that fees in the factual would exceed current FFS fees; it says only that costs "may yet increase"

We expect that SCHI may argue that members are always free to move up and down in plans to adjust cover and therefore ultimately the member's choice. However, this is not accurate as SCHI has in recent years been narrowing the scope of cover across all medical procedures to manage its costs even within its tiered plans. While cover is for SCHI to solely determine (as that is its role as the insurer), it should be carefully managed so that it does not contradict or conflict with appropriate clinical outcomes.

Draft Determination at [56], [241] and [246.1].

Draft Determination at [246.5].

Draft Determination at [413].

Draft Determination at [191], fn 242 and [194].

compared to the status quo.¹⁶⁴ NZGA is willing to accept reasonable reductions across the board, so fees are likely to fall in the factual too. Because the allocative detriments scale with the size of that increase, if the Commission considers the size uncertain, it should conduct sensitivity analysis of those detriments rather than treating a material increase as an established premise. Link considers that access to NZGA's benchmarks would improve gynaecologists' bargaining position by less than 2–4% (the effect of full collective bargaining in the pay transparency literature), and that SCHI's claimed ~135% increase rests on an assumption of full collective bargaining that does not describe the factual.¹⁶⁵ An NZGA member survey also found that more than 95% of respondents were willing to accept some reduction on FFS rates.¹⁶⁶

- (b) **A higher fee is not necessarily an inefficient fee:** If SCHI's proposed fees sit below competitive levels, a higher fee in the factual is an allocative gain because it prevents those fees from inefficiently reducing entry into / increasing exit from gynaecology. The Commission's view that "the more successful NZGA is ... the greater these allocative efficiencies losses will likely be"¹⁶⁷ holds only if SCHI's fees are the efficient benchmark, which has not been tested (see paragraph 39). It also sits uneasily with the Commission's own supply analysis, which accepts that higher fees can produce an allocative efficiency gain by maintaining supply.¹⁶⁸
- (c) **Pass-through to premiums is uncertain:** The Commission accepts the link between gynaecology fees and premiums is not one-for-one and that the effect on premiums is unclear.¹⁶⁹ Gynaecology is only part of SCHI's claims. Nor do SCHI's own accounts support the narrative that rising gynaecologist fees are driving its losses.¹⁷⁰ SCHI's annual reports publicly attribute its FY24 and FY25 deficits to record claims volumes, sector-wide medical inflation, **a deliberate decision to draw on reserves to hold down premiums (as it has done eight times in 25 years)** and, in FY24, an accounting change.¹⁷¹ SCHI then returned to a \$146.9 million surplus in FY26, before any transition of gynaecology to the APS. As its Chair acknowledges, "periods of surplus and deficit are recurring features of the sector", with claims costs, economic conditions and investment markets all fluctuating over time.¹⁷² SCHI manages those cycles through its reserves and investment returns, rather than passing every cost increase through to premiums. That is how insurers routinely operate. The Commission cannot rely on SCHI's assertion that higher fees would flow through to premiums without testing it against that evidence.¹⁷³ As Link notes, prices that more efficiently reflect costs send the correct signals to insurance customers, and the Commission must consider whether prices in the factual are more efficient than in the counterfactual.¹⁷⁴
- (d) **Member responses are not shown to be caused by gynaecology fees:** SCHI's own retention data cannot separate cost-driven premium increases from age-related ones.¹⁷⁵ The Commission reaches no view on the relative losses from different member responses, most of which (a higher excess or a different tier) keep members insured.¹⁷⁶ It nonetheless finds the detriment likely without further reasoning.¹⁷⁷

Draft Determination at [190]–[191].

Link Report at [37] and [48].

Link Report at [39].

Draft Determination at [422].

Draft Determination at [226.3] and [275].

Draft Determination at [336.2] and [337].

Draft Determination at [60], [155.1], fn 104 and [200].

[SCMCS 2024 Annual Report – Summary](#) at p.2; [SCMCS 2025 Annual Report – Summary](#) at p.2.

SCMCS 2026 Annual Report – Summary at p.2.

SCHI's FY25 underwriting loss of \$45.8 million was largely offset by investment income \$42.8 million, with the balance absorbed through its reserves: SCMCS 2025 Annual Report – Consolidated Financial Statements at 1 and 3. Compare this with the Draft Determination at [200] which does not acknowledge that SCHI can and does cycle through deficits (and has done so frequently in the past) without an effect on premiums.

Link Report at [52].

Draft Determination at fn 426.

Draft Determination at fn 432.

Draft Determination at [344].

- (e) **Reference prices arise in both scenarios:** The Commission accepts that structured pricing will occur in both the factual and counterfactual, the only difference being the level of fees.¹⁷⁸ Other insurers can absorb costs across their wider books, and ACC and Health NZ purchase under their own frameworks and are a small share of private work.¹⁷⁹ NZGA's information safeguards already prevent member-level pricing being shared with competing members.¹⁸⁰ The Commission also dismisses waterbed effects in the counterfactual, but accepts upward spillovers in the factual, without explaining why one would apply and not the other.¹⁸¹
73. **Contagion runs both ways:** The reference price detriment assumes that what SCHI pays influences what other funders pay. On that logic, the effect runs equally in the counterfactual. SCHI is the price leader, and other insurers (and potentially ACC and Health NZ) are likely to follow any significant SCHI-driven fee reduction. The downward pressure that makes private gynaecology unsustainable would then spread across all funders, compounding the supply and access risks discussed in **Section D**. The Commission does not consider this.
74. **Two small detriments are combined into a medium one without explanation:** Of the six detriments considered, the Commission finds three unlikely (hospital facilities, innovation and anaesthetists), largely because any higher fees would be borne by SCHI rather than other providers.¹⁸² The allocative detriments therefore rest only on SCHI premiums and reference prices. Each is rated "small",¹⁸³ yet together they are treated as "medium", with no explanation for the uplift.¹⁸⁴ That further tilts the balance towards the detriments.
75. **The counting is one-sided:** The Commission counts pressure on the public system as part of the factual detriment, yet finds insufficient evidence of public system pressure in the counterfactual, despite evidence that fee cuts would directly reduce private capacity.¹⁸⁵ In each case, the consequences of a higher fee are counted in full as detriments, while the consequences of SCHI's lower fees are discounted or disregarded. That systematically overstates the detriments and understates the benefits, and the balancing exercise cannot safely rest on it.
76. **Innovation depends on clinicians, not just equipment:** The Draft Determination frames this detriment around hospitals funding equipment.¹⁸⁶ It records NZGA's evidence that new technology has no value unless surgeons invest their own time and money learning to use it, and accepts that gynaecologists and hospitals have a "joint role" in innovation.¹⁸⁷ Yet it finds that lower fees "may have limited impacts" on gynaecologists' willingness to adopt new technologies, while accepting that lower margins may affect hospitals' ability to invest.¹⁸⁸ No considered reason is given for treating the two 'investors' differently.
- (a) The only reasoning offered is that training "will likely be publicly funded" for those who also work in public hospitals.¹⁸⁹ That assumption does not hold. Advanced laparoscopic and robotic surgery, endometriosis surgery, urogynaecology, gynae-oncology and complex hysteroscopy depend on fellowships (often overseas), courses, simulation training, mentoring, research and audit, much of it self-funded and all of it taking time away from paid work. As set out at paragraph 35, it is private income that tops up lower public pay.

Draft Determination at fn 445.

Draft Determination at [353] and [373].

Draft Determination at [298.4] and [355].

Draft Determination at [378].

Draft Determination at [36.3], [388], [404] and [424].

Draft Determination at [344] and [379].

Draft Determination at [422]. Compare such findings with eg the supply and public system effects of depressed fees in the counterfactual, which are not considered or weighed at all.

Draft Determination at [37], [342], [413] and [415].

Draft Determination at [292.5] and [391]–[392].

Draft Determination at [393] and [395]; NZGA cross submission on SOPI (4 August 2026) at 8; NZGA "NZGA Q&A" (14 July 2026) at [11(j)]–[11(k)]. See also NZGA authorisation application (19 May 2026) at [2.19(d)] and [11.4(e)].

Draft Determination at [36.2] and [397].

Draft Determination at [395].

- (b) The Commission also recasts NZGA’s point that lower fees reduce the incentive to innovate as a coding issue,¹⁹⁰ and refers to its “Health Benefits” analysis section. That analysis does not address innovation at all. Nor is this a coding issue. NZGA’s concern remains that if compensation is materially reduced, so too are the incentives to invest in these skills, and as result innovation suffers.
 - i. If a specialist must do more cases to earn the same income, time spent upskilling costs more.
 - ii. A code set that pays the same regardless of complexity or advanced techniques does not reward the investment needed to perform them, and favours throughput over low-volume skills.

The Draft Determination itself accepts that earlier access to innovative technology overseas is one reason younger gynaecologists leave.¹⁹¹ That loss of dynamic efficiency in the counterfactual is not weighed.

77. **The contract benefit is understated:** The Commission accepts this benefit is likely, but rates it “very small”.¹⁹² That understates it:

- (a) **It is the core purpose of the application:** The Commission accepts that SCHI has declined to engage on some matters, citing Commerce Act risk, and that authorisation would allow those discussions to occur.¹⁹³
- (b) **Enduring reference terms:** One set of negotiations would produce an enduring set of reference terms with greater buy-in and uptake. Nothing displaces the usual efficiency benefit the Commission has recognised in other authorisations.
- (c) **Non-price concerns are wider than the NZGA Board:** The Commission finds that concerns about non-price terms were limited to NZGA Board members, based on a small number of interviews.¹⁹⁴ The Commission should not treat a lack of awareness of issues as a lack of concern. Very few members have experience of the APS in gynaecology, so their silence on non-price terms in interviews more likely reflects unfamiliarity than acceptance. A member survey on contract terms is still outstanding.
- (d) **Contractual asymmetry is on the record:** The Commission’s own record shows hospitals allocate payment risk inconsistently, and an APS contract confidentiality clause appears to prevent hospitals disclosing its terms to subcontracted surgeons.¹⁹⁵ That is precisely the kind of issue collective engagement resolves.
- (e) **Administrative burden:** Negotiated, objective criteria for open codes, risk corridors and top-ups in the factual would reduce the administrative burden the APS shifts onto gynaecologists (see paragraph 53).

Draft Determination at [394].

Draft Determination at [288].

Draft Determination at [274].

Draft Determination at [269] and [273.3].

Draft Determination at [314].

Draft Determination at [267], fn 337 and fn 318.

I. Process concerns should be addressed before the Final Determination

78. **NZGA raises these concerns so they can be addressed:** The concerns below relate to how the process has been conducted, not to any individual. NZGA has raised them with the Commission directly and records them here at a high level so they can be addressed before the Final Determination.
79. **NZGA has encountered a number of process gaps (several without any apparent or stated legal basis):** These include (a) how interview evidence has been recorded and used, including a correction requested before publication that was not made, and evidence that was omitted (see paragraph 37(b)); (b) limited clinical expertise and exploration of the clinical complexity of gynaecological surgery, with no independent testing of SCHI's clinical evidence (see paragraph 61); (c) reliance on heavily redacted evidence that NZGA has had limited ability to see or test (see paragraph 60). Even NZGA's independent economic expert, Link Economics, was unable to properly test the underlying confidential information despite providing confidentiality undertakings, as much of the data and comparators remained redacted; (d) limited engagement with NZGA's concerns about SCHI's conduct (see **Section E**); (e) deferral of the interim decision until the Draft Determination, leaving it with little practical effect; and (f) departures from recent authorisation with little guidance/explanation, including on registration, timetabling and cross submissions.
80. **These gaps have shaped the outcome:** Each gap limited how far the evidence was tested. SCHI's account was largely accepted as given, while evidence from NZGA and others was not explored or properly weighed. NZGA understands other interested parties have raised similar concerns about how their evidence has been treated. In NZGA's view, these gaps have contributed directly to the errors, inconsistencies and omissions identified in **Sections A to H**. They also risk a perception that the assessment was anchored to SCHI's framing from the outset. In a public process that will shape women's healthcare for years to come, that perception matters to the Commission as much as to NZGA, and to the medical profession's willingness to engage with the Commission in future.
81. Before the Final Determination, NZGA respectfully asks that the Commission:
 - (a) Engage its own independent clinical expert to test the clinical evidence (see paragraph 61);
 - (b) Properly test assertions or potentially skewed quantitative evidence, including with NZGA, before relying on it; and
 - (c) Give voluntary interviewees the opportunity to review and correct statements attributed to them, and address omitted evidence or explain why it is not relevant.

J. Other conditions can resolve any remaining concerns

82. **NZGA does not seek fees above the status quo:** The Commission considers the allocative detriments are "inherent to the main aims" of the Proposed Arrangements (higher fees), so that no condition could address them. That misreads the application. NZGA seeks a clinically appropriate and sustainable framework and has accepted that fees may need to be lower than under FFS. The Commission considered only the conditions in the application but it does have the power to impose conditions that remove or lessen detriments, or create or enhance benefits. While NZGA disagrees with the Commission's assessment of the benefits and detriments to date, it remains willing to engage constructively with the Commission on options of this kind if necessary.
83. **Targeted conditions answer each concern:** For example, NZGA would be open to conditions such as:
 - (a) **Fee safeguards:** No member seeking a fee above their current FFS level, with any reductions applied from each member's own starting point (eg this could be by fee band and/or agreed % reductions), so no one is lifted to a common rate.

- (b) **Information protocols:** Member-level pricing and NZGA's prepared prices are not circulated to members and are kept at the board level (board members do not compete).
 - (c) **Non-price terms first:** Coding, complexity, risk allocation and contract terms are settled and agreed before any fee discussion (staged discussions).
 - (d) **Shorter term:** A shortened authorisation period (aligned to either one or two of SCHI's usual renegotiation cycles), with a review point.
84. NZGA asks the Commission to consider them or any other conditions (if considered necessary to assuage any remaining concerns) before reaching its Final Determination.

K. Conclusion

85. **The Draft Determination rests on an untested premise:** At its core, the Draft Determination proceeds as if SCHI's proposal is the efficient, patient-centred outcome, and any departure from it a cost. That premise has never been tested. SCHI is an unavoidable trading partner with monopsony (like) power and short-term incentives to cut costs, and its proposal will reshape an entire specialty without clinical input. The real question is not whether fees may be somewhat higher in the factual, but whether New Zealand retains a sustainable gynaecology workforce able to deliver timely and clinically appropriate care, particularly for complex cases. On that question, the evidence points one way: the counterfactual risks lasting harm to supply and patient outcomes that cannot easily be reversed, while the factual offers a lawful, transparent means of getting the model right.
86. **The Commission must revise its preliminary view and grant authorisation:** NZGA does not seek higher fees or ask the Commission to prefer its evidence, only that both sides are tested to the same standard. Properly assessed, the benefits outweigh the detriments, and any remaining concern can be addressed through targeted conditions. What is at stake is a sustainable gynaecology workforce and timely access to care for New Zealand women. NZGA therefore submits that the Commission must revise its preliminary conclusion and grant authorisation.