

NZGA's response to Commission's email dated 9 June 2026

Introduction

NZGA's responses to the Commission's questions (in red) are below. We submit that, in reviewing these responses, the Commission must recognise five key points:

- 1. This application is in response to an SCHI 'proposal' (although proposal is an understatement, as SCHI is imposing a new market structure). NZGA wishes to negotiate with SCHI.** We framed the application on an "and/or hospitals" basis only because SCHI's proposal contemplates hospitals as head contractors, 'requiring' them to adopt or impose terms set by SCHI, and we do not know how it will impose its model. The extent of any hospital-level engagement will be solely because of, and will depend on, the model SCHI ultimately chooses and how hospitals implement it. It is not possible to assume away or ignore that aspect of the proposal (which the questions seem to do) – the key fact that hospitals are incentivised to pass down SCHI's terms as they stand to profit from the bundled fee model (which permits hospitals to take margin from gynaecologists and anaesthetists, and removes the need for hospitals to compete to attract specialists).
- 2. Regardless, the assumed separation of hospitals' market and bargaining power from SCHI's is incorrect.** SCHI and hospitals are acting in concert under a combined contractual initiative. No artificial distinction (or separate analysis) between SCHI and hospitals is required, because regardless of which entity is the immediate counterparty for whichever aspects of SCHI's proposal, the market and bargaining power is the same (ie the combined power of SCHI and hospitals). As above, hospitals favouring the proposal have 2 powerful incentives to participate – the margin from SCHI and the reduction in competition between them on terms of supply to attract surgeons, backed by SCHI. (This is critical yet not contemplated in the questions.)
- 3. The questions also seem to incorrectly assume compulsion as part of collective bargaining.** This is not true as NZGA is simply seeking to 'bring SCHI to the negotiating table' so that SCHI makes an informed decision on a proposal that will fundamentally restructure the funding and delivery of private gynaecological surgery services in NZ. Ultimately SCHI will decide what terms and contractual framework it imposes. NZGA is essentially seeking a right to be heard. It is hoped that the standstill will get SCHI to engage, so that it makes informed decisions, that is all.
- 4. That position is consistent with the Commission's (and, we understand, ACCC's) authorisation framework,** which recognises that such applications (if authorised) simply enable efficient 'submissions' (and efficient contractual terms), and accepts that there is no compulsion as counterparties can simply choose not to engage and / or 'walk away'. For example, in its most recent authorisation (NZBA) the Commission proceeded on the basis that Armourguard was not compelled to contract and retained a credible ability to refuse uneconomic terms. The Draft and Final Determinations (at [149] and [337] respectively) state that relative bargaining power depends on factors including the payoffs each party derives from walking away from negotiations and acknowledge that any collective outcome must be acceptable to the counterparty of the collective bargaining (at [97]).
- 5. Even a hospital (Forte Health Limited in Christchurch) despite opposing the application, affirms the purpose of the application:** *"If gynaecologists want to be more directly involved in those negotiations, they are free to submit a proposal to Southern Cross, become a lead provider and sub-contract to hospitals, anaesthetists and other allied health providers."*

“The information we would like in a supplemental submission concerns NZGA’s intentions to collectively bargain with hospitals, and the impact of the proposed arrangements on hospitals and anaesthetists. While aspects of this are very briefly covered in the application at paragraphs 5.49 and 11.30, we would welcome a supplementary submission from NZGA setting out its views on:

NZGA’s response

NZGA believes that our objective has been misunderstood. NZGA’s *intention* is to negotiate with SCHI and not with hospitals. In fact, this has been one of the objections to the process that has been pushed by SCHI.

Ultimately SCHI (acting with hospitals) will determine whether to engage, what to accept, and what contractual model to impose (the same is true to the extent that hospitals are expected to subcontract with gynaecologists). NZGA cannot compel any outcome.

The application simply provides a limited opportunity for NZGA to influence SCHI’s decisions:

1. about how it chooses to impose its new model (vis a vis gynaecologists) without fear of inadvertent Commerce Act breaches (as was flagged by SCHI to date as a concern).
2. to establish sustainable and transparent contracting arrangements that support ongoing patient access to private gynaecological surgery services without increasing the burden on public hospitals.

This should reduce the risks of unintended adverse consequences of SCHI proceeding as proposed.

The Commission’s questions appear based on **incorrect assumptions** that:

1. Negotiations with hospitals would be on a purely independent bilateral basis (without SCHI’s influence) which is not the case, as discussed below;
2. NZGA’s proposed arrangements would create a permanent and enduring change, where NZGA’s members act and negotiate as a single head with countervailing bargaining power. That is not the case and we reiterate that the application is to simply talk to SCHI on a coordinated basis for a limited time period, where SCHI will decide outcomes (including ‘walking away’). NZGA is not a ‘traditional’ union threatening a collective boycott and is not seeking the ability to withhold services.

The scope of the application is framed on an “and/or hospitals” basis solely because it appears SCHI is ‘requiring’ hospitals to adopt or impose SCHI’s proposal and key terms (which NZGA has not seen but appears to be asymmetric). The necessity of any hospital-level engagement is entirely contingent on SCHI’s chosen model and on hospitals’ responses.* Regardless, they are acting together in concert so, respectfully, the distinction made in the questions (regarding market/bargaining power) is a false one. Hospitals are not disincentivised participants and are aligned with SCHI’s proposal as they stand to benefit from the proposed changes (e.g. profit from the bundling of fees and removal for the need to compete with other hospitals for gynaecologists).

NZGA cannot comment on proposed arrangements between SCHI / hospitals relating to anaesthetists as outlined below.

***Note:** Hospitals are incentivised to align with and pass down SCHI’s terms, but could in theory respond differently: some may be passive adopters of whatever SCHI dictates, in which case (assuming if legal) no separate hospital-level engagement may be required; while others may seek to vary the arrangements in their subcontracts with gynaecologists (although this may be minor), in which case separate negotiations may be necessary to give effect to what is agreed with SCHI. NZGA does not control (and cannot predict) how hospitals may respond.

1. *The terms and conditions that NZGA would seek to collectively negotiate with hospitals and whether those negotiations are envisaged as separate to negotiations with SCHI.*

NZGA's response

NZGA's starting point (and intention) is to directly negotiate with SCHI, who is driving the proposed terms and restructure (rather than through hospitals, as we are not employees or independent contractors of hospitals). Gynaecologists are self-employed and/or work as part of private gynaecology group practices. Hospitals are *in competition* to attract surgeons to their facilities.

Currently gynaecology services are provided on a 'Fee for Service' whereby a quote for the surgery (comprised of separate estimates for the surgeon fee, anaesthetist fee and hospital fee) is submitted to SCHI, which SCHI reviews and then approves or declines. There is no current negotiation between the surgeon and hospitals.

SCHI proposes to replace Fee for Service with an alternative Affiliated Provider* Scheme (APS) model. Under this APS model, NZGA understands that SCHI intends to give full contracts to the hospitals (albeit with no exemplar of such a contract) which would make gynaecologists subcontractors via hospitals.

- a. *For example, would NZGA seek to negotiate the specific fees to be received by gynaecologists with each individual hospital following negotiating an overall bundle of fees with SCHI (if SCHI remains committed to its bundle of fees method of reimbursement)?***
- b. *Are there any other terms that NZGA would seek to collectively bargain about with hospitals?***

NZGA's response

NZGA's intentions are to negotiate solely with SCHI (including on terms it appears to be imposing via hospitals), rather than with hospitals.

As part of a broad structure, we would like to include the following in discussions for contracts.

1. **Revised surgical billing codes** – proposed by RANZCOG and accepted by NZGA.
2. **Risk corridors for clinical complexity**– to allow the surgeon to assess the complexity of the disease, plan the patient's surgery according to clinical best practice, with recommendations for post-operative care and duration of admission, taking into account the patient's medical and surgical co-morbidities. The SCHI proposal takes the approach of using a fixed fee for the anticipated surgical procedures, but the reality is that it is best to undertake one surgical procedure rather than return later for separate approval from the insurer for each additional procedure.
 - a. **Treatment of patients with co-morbidities** – One simple example of a co morbidity that significantly impacts on time and complexity is the BMI (body mass index) of a patient. A high BMI is almost invariably more complex and can take longer. The SCHI proposal basically ignores this major public health issue.
 - b. **Second Surgeon** – for surgical cases that are complex, require subspecialist input.

*Note: SCHI has different AP schemes with different eligibility and payout criteria across different specialties.

- c. **Surgical Assistants** – are often required to assist in many gynaecological surgeries. NZGA considers these fees should be covered by SCHI.
- d. **Combinations of procedures** – the surgical billing codes may influence this, but we would want to be appropriately remunerated for the surgery planned and completed, e.g. the fee for removal of both ovaries is higher than for removal of one ovary.

NZGA anticipates two potential and limited departures from its intent to negotiate with SCHI:

1. If hospitals depart from any terms SCHI imposes after discussions with NZGA then NZGA may need to engage with hospitals to give effect to what has been agreed with SCHI (although this is arguably no different).
2. It seems price terms would be largely dictated by SCHI, although this may involve a parallel arrangement or understanding between hospitals (which the Commission may need to consider). There may, as part of the SCHI / hospitals proposal, be some residual hospital-specific terms, which may need to be addressed.

Appendix 4 of the application identifies examples of imbalanced, asymmetric terms that should be addressed as part of collective negotiations (from the only proposed contract we have seen). That contract requires gynaecologists to agree to terms in the head contract which it has not seen.

For clarity, if (and to the extent that) SCHI / hospitals insisted on negotiations with hospitals, the counterpart (and bargaining power would in effect still be the combined SCHI / SCH or other hospital). In other words, regardless of how and who SCHI and hospitals choose to negotiate, the counterparts would likely have the combined power of SCHI and hospitals as they are acting in concert to flip the current competitive conditions (making hospitals the ‘customer’ instead). Hospitals are incentivised to align with SCHI as they stand to profit from the proposed changes. In either case, SCHI would ultimately determine the terms / proposal.

2. *The market power and relative bargaining power of gynaecologists compared to any hospital or group of hospitals that NZGA may seek to collectively bargain with under the proposed arrangements in both the factual and counterfactual. Please provide supporting evidence for your submission.*

NZGA's response

This question is not clear to us. We think it means SCHI's "proposed arrangements", rather than the proposal for which we seek authorisation, as collective bargaining seems only likely to occur under the proposed arrangements (the **factual**).

However, the question implicitly assumes bargaining with hospitals independently of SCHI. Any such assumption is wrong – this is not independent action by hospitals. The proposal can only proceed if there is an arrangement or understanding between SCHI (including SCH) and other participating hospitals. They are (or will be) acting in concert, so must be treated as one head (with the enhanced market power that brings, as explained in our application).

In other words, bargaining power cannot be artificially separated between SCHI and hospitals, because hospitals would not be independently negotiating with gynaecologists under SCHI's proposal (based on evidence to hand, the broader arrangements would include a contract).

(The alternative interpretation, ie hospitals suddenly (independently of SCHI) reversing clinical and contractual arrangements, lacks credibility and would necessarily involve cartel provisions.)

With respect, the Commission's questions on bargaining power do not align with its own analytical framework.* The countervailing bargaining power (by gynaecologists) assumed by the questions only arises where the bargaining group is an unavoidable trading partner and able to constrain the counterpart's conduct. NZGA is not in that position. We reiterate that no party is compelled to collectively bargain, and SCHI retains the ability to determine whether to engage, what to accept, and what contractual model to impose.

Hence our preference is to negotiate with the "architect" / driver, SCHI.

Current arrangements (status quo counterfactual)

1. We again reiterate that this not about hospitals but about the insurer provider.
2. Individual gynaecologists currently work under a 'Fee for Service' model.
3. Changes are proposed by SCHI – all these procedures are performed as part of the contract (APS) which are held by the private hospitals.
4. Features of the status quo counterfactual:
 - a. hospitals remain independent counterparties (this would not be the case under SCHI's proposal, where SCHI and hospitals would act in concert);
 - b. specialists can still choose different private hospitals to go to;
 - c. patients retain choice; and
 - d. hospitals continue to compete for specialists and patients which leads to the provision of better hospital facilities, operating equipment and thereby better outcomes for patients.

***Note:** As discussed, the NZGA's application is consistent with the analytical framework the Commission applied in the NZBA Authorisation which acknowledged that counterparts could always walk away and whether authorisation is granted should be considered on that basis.

Factual (ie authorised collective bargaining)

As noted, it would be incorrect to not group SCHI and hospitals when considering market power. They are essentially acting as one head under SCHI's proposal and may be a "person" for Commerce Act purposes including under ss 27 and 36 ("*person, includes ... any association of persons whether incorporated or not*").

Counterfactual under which SCHI Proposal proceeds (but no CB authorisation)

With SCHI's new contract system, individual gynaecologists would still not have bargaining power because we are a much smaller entity in comparison to hospitals or SCHI.

Gender equity concerns in the medical industry are likely to worsen under individual negotiations. As gynaecology is a predominantly female specialty, collective bargaining would promote fairer, more transparent remuneration and help reduce gender pay disparities while recognising the value of the specialty's clinical work.

However, even if authorisation is granted, SCHI and hospitals can still seek to impose their model and ignore the proposed standstill (which is a short-term measure and cannot have a material adverse impact on competition). Among other things, gynaecologists do not have the same infrastructure. For example, they do not have in-house legal, finance staff, no dedicated admin time for contract negotiations.

An important feature of the market is that access to SCHI members is critical to the viability of many private gynaecology practices.

SCHI insures a substantial proportion of privately insured patients in New Zealand. Unlike many other consumer markets, patients cannot readily switch insurers in response to changes in provider arrangements because pre-existing condition exclusions may significantly limit their ability to obtain equivalent cover elsewhere.

As a result, exclusion from, or inability to participate in, SCHI funding arrangements may effectively deny a gynaecologist access to a substantial proportion (over 60%) of the privately insured patient market. This contributes to a significant imbalance in bargaining power between individual gynaecologists and SCHI.

a. To the extent that this differs regionally e.g. based on the number of specialists in any given region, please break this down.

NZGA's response

Only if there were hospital-only negotiations independent of SCHI (which is not the case), within the major centres such as Auckland and Wellington there may be less imbalanced bargaining power between hospitals and gynaecologists, as there are several private hospitals which are owned by different businesses (Southern Cross, Evolution, Allevia), which might (in such a situation) allow gynaecologists if authorised to more fairly negotiate contracts with hospitals. However, in small centres there would remain an even more significant imbalance in bargaining power, such as in Dunedin there is only one private hospital, which would effectively remove any bargaining power from the small group of local gynaecologists.

- b. Please also touch on the impact of the standstill arrangement on the relative bargaining power.*

NZGA's response

The standstill does not shift bargaining power. As set out in the application, SCHI will still dictate outcomes and may 'walk away' and unilaterally determine its approach after the standstill ends. The standstill provides limited time pressure (with no obligation to agree) so that SCHI makes informed decisions and gynaecologists are not forced into uninformed bilateral contracting under deadline pressure and information asymmetry.

The standstill would not be for a competitively significant period. At 6 months, it is significantly shorter than under any standard competitive effects analysis (the usual analytical period ranging from 1-2 to 5 years).

If SCHI's stated reason for not engaging (competition concerns) is honest, it would enable genuine engagement. Regardless, it may lead to a faster more efficient and better national rollout, with more robust and enduring terms. This is especially the case if compared to immediate implementation of SCHI APS arrangements with unintended consequences for patient care, which could effectively be irreversible, and /or potentially avoiding the costs of revisiting arrangements later on.

3. *The market power and relative bargaining power held by anaesthetists vis-à-vis hospitals in both the factual and counterfactual. Please provide supporting evidence for your submission.*

NZGA's response

NZGA is not intending to negotiate with hospitals but with SCHI. As such this will not affect the bargaining power of anaesthetists or hospitals vis a vis one another.

Regardless, NZGA does not represent anaesthetists and cannot speak on their behalf. Anaesthetists are independent specialists with their own contractual relationships. The proposed arrangements do not involve bargaining on their behalf, and collective bargaining by gynaecologists does not prevent anaesthetists from negotiating independently with SCHI; those are separate processes.

To the extent that SCHI's proposal affects anaesthetist fees indirectly (via bundled payments), that is a feature of SCHI's proposal and a decision made solely by SCHI alone. More importantly, the Commission's question assumes hospitals retain their profit margin in conjunction with SCHI (ie implying anaesthetists would have to compete with gynaecologists for the 'rest of the pie'). That assumption would affirm the market power of SCHI and hospitals and their ability to retain their profits (to the detriment of gynaecologists and anaesthetists).

NZGA and this application should not be criticised for seeking to engage within the framework SCHI itself has imposed. Any flow on effects on the broader industry are a consequence of SCHI's chosen model, not of gynaecologists responding to it. To suggest otherwise is in effect to blame the party most affected by SCHI's conduct for trying to respond to it.

The bundled fee model also risks double marginalisation by allowing hospitals to decide the allocation of fees between itself and gynaecologists and anaesthetists. (In effect SCHI would give hospitals the power to take margin from gynaecologists and anaesthetists.)

SCHI and/or hospitals are best placed to comment on the potential impacts of SCHI's / their proposal on other specialists.

4. *It seems to us that the assessment of the potential benefits and detriments (e.g. the impact on anaesthetists and/or hospitals) could differ between collective bargaining with SCHI compared to collective bargaining with hospitals. Please provide a supplemental submission on the benefits and detriments associated with collective bargaining with hospitals.*

NZGA's response

We disagree for the reason outlined in this response and in the application.

SCHI has proposed that they negotiate the entire APS contract directly with hospitals, rather than engaging with gynaecologists (or anaesthetists). NZGA seeks to collectively negotiate with SCHI on terms that directly affect the services gynaecologists provide.

As discussed above, there is no indication that hospitals are acting independently of SCHI and its imposed terms (and in fact benefit from aligning with SCHI) and so any benefits / detriments are equivalent. Put another way, the assessment of benefits and detriments does not change depending on whether the counterparty is SCHI or SCHI via hospitals as the contractual framework and the terms imposed are SCHI's or a consequence of its actions (and any benefits/detriment that flow from collective engagement with SCHI to address them).

We envisage that this submission would be published on our website. While we appreciate there is uncertainty with what SCHI will be willing to come to the table on, we consider that answers to these questions are pertinent to our analysis and that NZGA's stance on these matters should be available for interested parties to view."

NZGA's response

NZGA thanks the Commission for this opportunity to reiterate the purpose of the authorisation application in this response.