

SOUTHERN CROSS MEDICAL CARE SOCIETY

7 OCTOBER 2026

SUBMISSION ON

THE COMMERCE COMMISSION'S

DRAFT DETERMINATION

IN RELATION TO THE

NEW ZEALAND GYNAECOLOGY ASSOCIATION INC

AUTHORISATION APPLICATION



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1. INTRODUCTION

- 1.1 This submission is made by Southern Cross Medical Care Society (trading as Southern Cross Health Insurance) ("**SCHI**") in response to the Commerce Commission's Draft Determination ("**DD**") in relation to the application by the New Zealand Gynaecology Association Inc ("**NZGA**") for authorisation to engage in collective bargaining and a collective boycott (together the "**Competitor Coordination**") with SCHI and / or hospitals (the "**Application**").¹
- 1.2 SCHI is grateful for the careful analysis that the Commission has undertaken to date in considering the Application. To assist the Commission as it works towards its final determination (the "**Final Determination**"), SCHI provides this submission with further evidence that it considers is important for the Commission to take into account.

2. EXECUTIVE SUMMARY

- 2.1 SCHI agrees that the Commission's preliminary decision to decline authorisation is correct. The Commission has (preliminarily) found that the detriments of the Application are likely to significantly outweigh its benefits, and that the evidence for those detriments is stronger and more comprehensive. SCHI agrees.
- 2.2 In simple terms, NZGA's Application asks the Commission to permit around 130 competing surgeons to agree collectively what they will charge, and to refuse jointly to contract while they do so. Under the Commerce Act 1986 ("**Commerce Act**"), that conduct would ordinarily be prohibited as cartel conduct (a criminal offence).
- 2.3 The Commission has (preliminarily) found that such cartel conduct would result in "materially higher costs for gynaecology surgery on an ongoing basis". SCHI's evidence shows just how large those additional costs would be. Namely, if the Competitor Coordination were authorised:
- (a) Annual gynaecology surgeon costs to SCHI are forecast to reach about \$243 million by FY2036, compared to \$105 million under a competitive transition to SCHI's Affiliated Provider scheme ("**APS**"). That is a difference of at least \$138 million a year, or approximately \$380,000 every day by FY2036.
 - (b) A 30-year-old [] SCHI member on the Wellbeing 2 policy would pay [] more in premiums over the next decade. That is a difference of more than \$535 per year on average for that member over a decade (or on a daily basis, that equates to approximately \$1.50 per day).
 - (c) Female members on co-payment plans who need gynaecological surgery would, on average, face co-payments up to 133% higher than co-payments would otherwise be for the same procedure.

¹ As the Commission is aware, SCHI filed its primary submission on the SOPI on 16 June 2026 (the "**Submission**"), its cross-submission on 3 August 2026 ("**Cross-Submission**"), and an economist report prepared by NERA on 3 August 2026 (the "**NERA Report**"). SCHI does not repeat those submissions (or the NERA Report), but will cross-refer to them where relevant in this submission. For the avoidance of doubt, SCHI wishes it to be recorded that it considers all the points it raised in its original Submission and Cross-Submission (and the evidence presented by NERA in the NERA Report) still stand.

- 2.4 These increased costs would not be limited to SCHI's members. While the Application is made to allow gynaecology surgeons to collectively negotiate in relation to SCHI, it is inevitable that the sharing of underlying pricing information would also inform the gynaecology surgeons' pricing to other funders, thereby establishing "higher reference" prices and increasing the cost of gynaecology procedures across all other private and public funders – namely, other insurers, Health NZ, ACC and self-funded patients who together fund most private gynaecology surgery. For Health NZ, that would mean fewer outsourced operations, and for self-funded patients, it would mean delayed or abandoned self-funded surgery and increased switching to the public system (in turn, placing further strain on the public health system).
- 2.5 In return, there would be no material public benefits. Even the supposed "very small" potential benefits in relation to "more efficient" non-price terms would not materialise. Any non-price concerns in relation to SCHI's proposed procedure funding code set have already been resolved without any collective bargaining through SCHI's consultation with the relevant clinical bodies,² and the Commission's own enquiries demonstrate that other non-price terms are not considered issues "in practice".³
- 2.6 Accordingly, SCHI agrees with the Commission's preliminary decision to decline authorisation.
- 2.7 That said, SCHI submits that the Final Determination's assessment of both the likelihood and extent of the detriments arising from Competitor Coordination should be much greater than indicated in the DD. SCHI's reasons for that are set out in this document, and include the following:
- (a) The significant and enduring financial transfer that would arise from the Competitor Coordination (namely, the millions of dollars that would flow from approximately [] [] SCHI members to around 130 highly-paid surgeons) should not be treated as "neutral". That is a real and independent detriment to the people of New Zealand, and should be treated as such.
 - (b) Allocative efficiency losses arising from the Competitor Coordination should be assessed as "large" (not "medium"). The losses include SCHI members cancelling their insurance cover (thereby harming their ability to access timely healthcare), increased "adverse selection" pressure on SCHI (thereby harming SCHI's sustainability and ability to provide healthcare cover), pressure on the public health system (including higher public health funding costs and longer wait-lists) and higher costs to other health insurers (thereby harming all New Zealanders access to healthcare and health outcomes).
 - (c) The increased transaction costs that would arise from the Competitor Coordination are even higher than estimated in the DD. The increased transaction costs would fall not only on NZGA and its members, but also on SCHI and hospitals / facilities. These increased transaction costs

² The Royal Australian and New Zealand College of Obstetricians and Gynaecologists ("**RANZCOG**") and the Aotearoa New Zealand Society of Urology ("**ANZSU**").

³ Para 205, DD. See also para 259, DD.

would be significant and repeated in every negotiating round over the 10-year authorisation period.

- 2.8 For these reasons, SCHI agrees with the Commission's preliminary decision to decline the Application, but considers that the grounds for declining the Application are even stronger than indicated in the DD.

3. THE COMMISSION'S ASSESSMENT OF THE DETRIMENTS SHOULD BE STRONGER

- 3.1 SCHI agrees with the Commission's core findings that:

- (a) the "magnitude of the detriments [of Competitor Coordination] is likely to significantly outweigh the benefits";⁴ and
- (b) the "evidence in support of the detriments is stronger and more comprehensive"⁵ than the assertions made by NZGA in support of its Application.

- 3.2 That said, SCHI considers that the Commission's assessment of both the likelihood and extent of the detriments arising from Competitor Coordination should be much greater than indicated in the DD. SCHI also considers that even the purported "small" potential benefits of Competitor Coordination were overstated. SCHI's reasons for these views are as follows.

4. THE INCREASES IN PREMIUMS WOULD BE SIGNIFICANT - WEALTH TRANSFERS TO SURGEONS SHOULD NOT BE TREATED AS "NEUTRAL"

- 4.1 The Commission says that the Competitor Coordination "would result in materially higher costs for gynaecology surgery on an ongoing basis".⁶ SCHI agrees with that assessment.

- 4.2 However, the Commission says it has "not given independent weight to the materially higher cost of gynaecology surgery paid by funders/purchasers and charged by surgeons... because the changes in cost themselves represent a transfer of wealth".⁷ That is despite the fact that the Commission found that increases in gynaecology surgical fees:

- (a) "will largely be borne by SCHI and its members";⁸
- (b) "place upward pressure on premiums charged to SCHI members."⁹

⁴ Para 38, DD.

⁵ Para 38, DD.

⁶ Para 16, DD. See also para 178, DD.

⁷ Para 20, DD.

⁸ Para 177, DD.

⁹ Para 336.2, DD. The Commission identified that SCHI would "respond to any material increase in bundled gynaecology surgery fees relative to the counterfactual by increasing its member premiums, decreasing its member benefits, or some combination of both" (para 201, DD).

- 4.3 SCHI has quantified the extent of this transfer and the likely impact on premiums and co-payments.¹⁰ That analysis demonstrates that it would be significant and enduring. Specifically:
- (a) SCHI forecasts that a competitive and efficient transition of gynaecology surgery to SCHI's APS will result in annual gynaecology surgeon costs to SCHI of \$105 million by FY2036, compared to annual costs of \$243 million by FY2036 if NZGA and gynaecology surgeons are authorised to engage in Competitor Coordination.¹¹ That is at least a \$138 million transfer from SCHI and its members to gynaecology surgeons each year – in aggregate, approximately \$380,000 per day by FY2036.
 - (b) Translating this into premium impacts for a member, SCHI has modelled that a [] SCHI member (on a Wellbeing 2 plan) currently aged 30 (in 2026) would over the next 10 years have to pay [] (12.4%) more in premiums than if the Competitor Coordination does not occur. That equates to more than \$535 per year on average in additional premiums for such a Wellbeing 2 plan member (or [] (12.4%) more in premiums, or more than \$310 per year on average, for a [] RegularCare member aged 30). See **Figures [1] and [2]** below.
 - (c) Furthermore, there are co-payment impacts for a member on a plan that involves a 20% co-payment (RegularCare). In addition to paying higher premiums on an ongoing basis, the co-payment that a female requiring gynaecology surgery would need to pay would, on average, be [] (133%) higher than it otherwise would be in 2027 for the gynaecology surgeon component alone for the same procedure, increasing to being [] (133%) higher on average by 2036. For clarity, this is only the *increase* in the co-payment resulting from the Competitor Coordination (on top of a total co-payment that can itself be material), and could be expected to put gynaecology surgery out of reach for a number of female RegularCare members.
- 4.4 Furthermore, SCHI does not agree that such a transfer of money from SCHI members to gynaecology surgeons can be regarded as "neutral" in a public benefits and detriments assessment. That is for the following reasons:
- (a) The transfer from members to surgeons is significant – more than \$535 a year on average over 10 years for certain [] members. As outlined above, SCHI has modelled that if Competitor Coordination were to be authorised, the increased premiums to members would be significant (more than \$535 a year on average over 10 years for certain [] members),¹² as well as the Competitor Coordination requiring significantly higher co-payments for female members on shared cover plans who require surgery. That cannot be considered "neutral" given the significant ongoing impacts that would have for everyday SCHI [] members. It would be a lasting redistribution from SCHI's members to highly-paid

¹⁰ This analysis also responds to the DD's statement that "[i]t is unclear precisely how large of an effect these higher fees would have on insurance premiums" (para 337, DD).

¹¹ See also at paragraph 2.8 of SCHI's Cross-Submission in relation to SCHI's previous forecasts to FY2031.

¹² SCHI has performed its modelling based on a specific member cohort – namely, [] member who is on the Wellbeing 2 policy and aged 30 to 40 years old.

gynaecology surgeons for the duration of the 10-year authorisation period sought.

- (b) The "modified total welfare" standard should be applied. In treating a wealth transfer as neutral, the DD adopted a "total welfare" approach. SCHI submits that the Commission should adopt a modified "total welfare" approach.¹³ The reason the Commission has the discretion to apply the "modified total welfare" standard is so that it can "adjust the weight given to benefits and detriments to reflect their distribution within the wider community" and "consider broader wider economic and social impacts of conduct".¹⁴ The Commission's own guidance recognises that it "may give less weight to benefits flowing ... to a limited number of shareholders through dividends or higher profits", and "more weight to benefits that are realised by the wider community and sustained over a period of time".¹⁵ Those considerations are relevant here:
- (i) The proposed Competitor Coordination would result in a significant transfer of value from a large pool of everyday SCHI members (approximately [] [] members) to a small number (~130) of highly-paid gynaecology surgeons. That will inevitably have detrimental distribution, equality, and social impacts that the Commission needs to account for.
- (ii) Furthermore, the starting point matters. As outlined in the NERA Report, the available evidence indicates that current gynaecology surgery fees are already above workably competitive levels.¹⁶ Where prices already exceed competitive levels, any further increase causes a greater welfare (social surplus) loss than an equivalent increase from a competitive starting point. This is because the additional cost is not offset by any efficiency gains, quality improvement, or increased investment. In these circumstances, the transfer of wealth from consumers to providers warrants particular weight in the Commission's analysis. SCHI therefore submits that the Commission should adopt a "modified total welfare" approach, consistent with the courts' analogous treatment of "functionless monopoly rents" in relation to overseas shareholders in *AMPS-A*.¹⁷
- (c) The price increase would not be "neutral": In other contexts, the Commission does not treat wealth transfers resulting from competitors

¹³ In response to para 221, DD.

¹⁴ New Zealand chapter. (15 June 2023). Advantages and Disadvantages of Competition Welfare Standards – Summaries of Contributions. OECD. [https://one.oecd.org/document/DAF/COMP/WD\(2023\)68/en/pdf](https://one.oecd.org/document/DAF/COMP/WD(2023)68/en/pdf)

¹⁵ See paragraph 9.6(k) of our Submission.

¹⁶ NERA's assessment is consistent with the evidence that many of the gynaecologists have provided the Commission, including, for example, acknowledgement from gynaecologists (at para 279.1 and 279.2, DD) that:

- some gynaecology surgeons' fees are "unacceptably high";
- "private gynaecology fees are currently approximately 25% higher in New Zealand than Australia";
- the very high fees charged by some surgeons are "unsustainable for SCHI"; and
- "current private remuneration in New Zealand compared very favourably to other jurisdictions".

¹⁷ *Telecom Corporation of New Zealand Ltd v Commerce Commission* (1991) 4 TCLR 473 (HC) ("**AMPS-A**") at 531. While that statement of the High Court was made in relation to overseas shareholders, the same point stands in relation to the current case – a transfer of "functionless monopoly rents" to a small group of highly-paid gynaecology surgeons would reflect "an exploitation of the [broader] New Zealand community".

coordinating their conduct as neutral – it says such price increases are "harmful". That includes where the coordinating competitors are New Zealand-based: "Cartels are a priority for the Commission because they harm New Zealand consumers and businesses. International studies show cartels can cause prices to rise by (on average) between 18–20%. Both **domestic** and international cartels are a priority for the Commission – whether they are based in New Zealand or involve international parties that participate in, and/or affect markets in New Zealand."¹⁸ It is inconsistent with the Commission's approach elsewhere to treat "one group gain[ing] at the expense of another"¹⁹ as neutral. Further, in confirming that the Commission had discretion to adopt the "modified total welfare" standard, the Court of Appeal in *NZME*²⁰ reiterated the seminal statement that the Commerce Act "is based on the premise that society's resources are best allocated in a competitive market where rivalry between firms ensures maximum efficiency in the use of resources",²¹ in other words that "competition is the mechanism through which efficiency gains will be delivered to consumers."²² The proposed Competitor Coordination would involve displacing competition with collusion – meaning that society's resources would no longer be "best allocated", but rather would be misallocated. A misallocation of resources should not be treated as neutral. That misallocation leaves overall society worse off. The extent of that detriment is significant – as outlined at paragraph 4.3 above. See further also in relation to allocative and productive inefficiencies at sections 6 and 7 below.

Figure [1] – Cumulative difference in the premium paid by [] currently aged 30 on a Wellbeing 2 plan if Competitor Coordination were authorised compared to SCHI's APS proposal

[]

Figure [2] – Cumulative difference in the premium paid by [] currently aged 30 on a RegularCare plan if Competitor Coordination were authorised compared to SCHI's APS proposal

[]

- 4.5 SCHI therefore invites the Commission to treat the "materially higher costs for gynaecology surgery on an ongoing basis"²³ as an independent detriment (not a "neutral transfer") that is weighted to reflect its distribution under a "modified total welfare" approach. These increased costs also need to be taken into account as the (significant) measure of the price increases from which the allocative and productive efficiency losses discussed in sections 6 and 7 arise.²⁴

¹⁸ Cartel Leniency and Immunity FAQ. <https://www.comcom.govt.nz/business/avoiding-anti-competitive-behaviour/what-is-a-cartel/cartel-leniency-faq/> [Emphasis added]

¹⁹ Para 223, DD.

²⁰ *NZME Ltd v Commerce Commission* [2018] 3 NZLR 715 (CA) ("**NZME**") at [53].

²¹ *NZME* at [53]

²² *NZME* at [53]

²³ Para 16, DD. See also para 178, DD.

²⁴ For the avoidance of doubt, SCHI does not ask the Commission to "double count" the same dollars under both approaches.

5. THE INCREASES IN GYNAECOLOGY SURGERY FEES CAN BE ESTIMATED, AND WOULD BE SIGNIFICANT

- 5.1 While the Commission found that the Competitor Coordination "would result in materially higher costs for gynaecology surgery on an ongoing basis",²⁵ the DD said that the "precise magnitude of the increase is uncertain"²⁶ including as "SCHI has not provided evidence to support [the] assumption"²⁷ that Competitor Coordination would result in average prices increasing to the [] percentile.
- 5.2 In response,²⁸ SCHI provides the following reasons why it considers that an assumption of an increase to the [] percentile is both reasonable and conservative:²⁹
- (a) In the context of collective bargaining with pricing information disclosed between competitors, there is a significant risk that higher-charging surgeons will refuse to reduce their fees and that prevailing higher prices become an effective pricing benchmark or "price floor".
 - (b) The gynaecology surgeons performing the greatest volume of surgeries and generating the greatest proportion of total fees, are concentrated in the higher billed-per-minute ("BPM") percentiles. These providers [] should collective bargaining be allowed. NZGA stated in its 26 June 2026 addendum to the Commission that they "would be prepared to accept a small reduction from the current fee for service".³⁰ Setting aside that this appears to be the expression of a collective position on price prior to any authorisation being granted, it evidences that NZGA would not likely be willing to collectively agree fees that materially reduce current fee levels. In SCHI's view, NZGA's own evidence therefore supports the reasonableness of assuming that average prices would increase toward to the [] percentile of current BPM.
 - (c) Even under this assumption, gynaecologists currently billing at or above the [] percentile, who account for approximately [] of total gynaecologist fees, would still need to accept a reduction in their fees.³¹

The assumption therefore does not reflect a worst-case outcome and should properly be viewed as conservative.

²⁵ Para 16, DD. See also para 178, DD.

²⁶ Para 198, DD.

²⁷ Para 194, DD.

²⁸ In providing this response in relation to percentiles, SCHI notes that it is only able to review data where theatre times are supplied and some facilities/gynaecologists do not routinely supply this data.

²⁹ SCHI also notes that the Commission observed that all scenarios hold volume growth at FY2023–FY2026 levels, and so assume that provider participation, patient behaviour and hospital utilisation would not be affected by the Competitor Coordination. For completeness, SCHI notes that it considers this to be a reasonable assumption in the short-term. Gynaecologist fees grew over FY2023–FY2026 while volumes continued to grow. For insured patients, the cost of surgery is largely met by the insurer rather than the patient, so higher collectively negotiated fees are unlikely to reduce utilisation in the short-term. In the medium to long-term, higher gynaecology surgery fees would flow through to higher premiums and/or reduced member benefits. That would lead members to reduce or cancel their cover, with lower-claiming members the most likely to do so. As outlined to the Commission elsewhere, the result would be a higher-risk pool with higher average claims, which would intensify adverse selection for SCHI and put further upward pressure on premiums (risking the "death spiral" that the NERA Report referenced from the relevant economic literature).

³⁰ Addendum to NZGA's 26 June response to Commission's email dated 9 June 2026.

³¹ SCHI emphasises, when it is referring to "reductions" in any fees from current fee-for-service ("FFS") levels, that the available evidence indicates that current gynaecology surgery fees are above workably competitive levels (see the NERA Report and paragraph 4.4(b)(ii) above).

- 5.3 Furthermore, SCHI does not agree that the examples identified by Professor Jaime King of increased prices from competitor coordination can be considered "of limited assistance" on the basis that "those cases involved instances where medical professionals withdrew or threatened to withdraw services from more than one insurer".³² SCHI considers that those overseas examples provide relevant empirical evidence of the potential price effects of the proposed Competitor Coordination – particularly given:
- (a) SCHI is the largest health insurer;
 - (b) the Commission considers that "gynaecologists would likely have raised their fee expectations, potentially to the rate that NZGA is negotiating at";³³
 - (c) the Commission's findings that the sharing of pricing and non-price term information between NZGA members in relation to SCHI "risks affecting the price gynaecologists seek to charge other funders of private gynaecological surgery";³⁴ and
 - (d) the proposed Standstill Agreement has the characteristics of a collective boycott,³⁵ and the Commission has found that there is a real risk that the "effect of the Standstill Agreement" could be extended "on an informal basis, after it has expired".³⁶
- 5.4 For the reasons outlined in both sections 4 and 5 above, SCHI considers that there is sufficient evidence before the Commission to conclude that the magnitude of the likely increases in gynaecology surgery fees would be significant, and that an estimate that average prices would increase to the [] percentile of existing fees is both reasonable and conservative.³⁷

³² Para 196, DD.

³³ Para 188, DD.

³⁴ Para 206, DD. See also para 373, DD where the Commission notes that "higher reference prices" would likely also "impact other insurers' customers".

³⁵ For the record, SCHI wishes to also formally record that NZGA's assertion (in its 4 August 2026 cross-submission) that SCHI's submission on ACCC's decision in *Catholic Health Australia* is "inaccurate" is not correct. The ACCC authorised a limited collective boycott by the Joint Purchasing Network in relation to certain *large suppliers* (at [5.7.1(c)]), but declined to authorise the Revenue Negotiation Network in respect of a proposed collective boycott of *private health insurers* (at [5.12]-[5.13]). The ACCC found that the proposed insurer boycott would create an imbalance in bargaining power in favour of hospital members and risk "higher private insurance health insurance premiums with no commensurate increase in quantity, quality or availability of hospital services" (at [4.130], [4.135]-[4.136]). NZGA's submission conflates these two distinct outcomes. It relies on passages that relate only to the authorised *supplier* boycott (at [4.56]-[4.61] and [5.7.1(c)]) as though they support a boycott of *private health insurers*, when those passages are in fact directed at a different proposal. By contrast, the ACCC addressed the proposed insurer boycott separately and, at [4.62], explained its concerns with that proposal before ultimately declining to authorise it (at [5.12]-[5.13]).

³⁶ Para 183, DD.

³⁷ SCHI also notes that the Commission itself accepts, in other contexts, that coordination between competitors will result in significant upward price effects. For example, the Commission has recently published materials in relation to bid rigging in public procurement, drawing on OECD literature, that assumes an average "cartel overcharge rate of 20%". See: (September 2026). Technical note: Estimated harm from bid rigging in public procurement. <https://www.comcom.govt.nz/assets/Uploads/Technical-note-Estimated-harm-from-bid-rigging-in-public-procurement-28-September-2026.pdf> In this case, the Commission has identified that the proposed Competitor Coordination can be considered to include a "cartel provision" (see paras 123 and 124, DD).

6. THE DD UNDERSTATES THE EXTENT OF ALLOCATIVE EFFICIENCY DETRIMENTS

6.1 In addition to the significant increases in gynaecology surgery fees arising from Competitor Coordination being its own independent and significant class of detriment (for the reasons outlined at section 4 above), SCHI agrees that the likelihood and size of allocative efficiency losses arising from such fee increases are "likely to be material".³⁸ However, SCHI considers that these detriments should be assessed as large, not just "medium".³⁹ That is for the following reasons:

- (a) The DD does not give sufficient weight to the allocative detriments arising from reductions in members' insurance cover: It is not accurate to assume that the allocative efficiency detriments arising from SCHI members reducing / cancelling insurance cover are "small" on the basis "it is not clear how large the difference in premium would be in the factual".⁴⁰ As outlined at paragraph 4.3 above, the difference in premiums for [] members between the factual and counterfactual will be significant. Accordingly, the extent of allocative efficiency detriments arising from SCHI members not purchasing the economically optimal level of health insurance cover should also be considered significant.
- (b) The DD does not give sufficient weight to the allocative detriments arising from adverse selection impacts for SCHI: SCHI does not agree that "it is unclear if in practice collective bargaining by NZGA would significantly contribute to adverse selection risk for SCHI".⁴¹ As set out at paragraph 4.3 above, if the Competitor Coordination were to occur, SCHI's premiums would need to increase significantly. As the NERA Report identified:⁴²

"Adverse selection in insured health care arises when rising premiums cause healthier, lower-risk members (who expect to claim less) to reduce or cancel their cover, leaving a higher-risk pool with higher average claims and creating further pressure for premium increases, which in turn may cause more members to cancel or reduce cover."

Premium increases of the magnitude identified above would (consistent with the economic literature) inevitably contribute to adverse selection risk for SCHI and, therefore, over time:

- (i) place "further upward pressure on average claims costs and premiums";⁴³
- (ii) risk the "disappearance of the most generous plans from the market over time".⁴⁴

³⁸ Para 31, DD.

³⁹ Para 32, DD.

⁴⁰ Para 344, DD.

⁴¹ Para 341, DD.

⁴² Para 130 B ii, NERA Report.

⁴³ Para 27, NERA Report.

⁴⁴ Para 48, NERA Report.

Given the economic literature, SCHI considers it is clear that the Competitor Coordination would significantly contribute to adverse selection risk for SCHI, and that this should be counted as its own likely and material category of detriments arising from the Competitor Coordination.

- (c) The DD does not give sufficient weight to the adverse health outcomes, and the adverse health impacts on the broader public health system: While the DD (correctly) finds that there would be no health benefits of the Competitor Coordination,⁴⁵ it does not give sufficient weight to the health detriments that would arise from the Competitor Coordination. These likely health detriments are identified in the DD:
- (i) "[T]he allocative efficiency losses from collective bargaining... [would] place **greater pressure on the public health system**"⁴⁶ on the basis that consumers that cancel private health insurance "would likely rely on the public health system going forward".⁴⁷
 - (ii) "Cumulatively, as SCHI's customers respond to higher premiums by switching to lower-tier plans, increasing their excess, removing optional modules, switching to another insurer (noting the barriers discussed above), or leaving the private health insurance market altogether, and as SCHI may respond by reducing coverage, **health outcomes for affected individuals may worsen. Individuals may forgo treatment altogether or delay treatment while they self-fund or seek care through the public health system.** This may, in turn, **place additional pressure on the public healthcare system. Moreover, these effects on both health outcomes and the public healthcare system may extend beyond gynaecological services to all procedures for which customers were previously insured.**"⁴⁸
 - (iii) Higher gynaecology reference prices to Health NZ and ACC could lead to **"fewer outsourced surgeries** performed within a fixed organisational budget, or **reallocation of public funding that could have been spent on additional healthcare elsewhere within the public system.**"⁴⁹
 - (iv) Self-funded patients **"may cause those patients to forfeit or delay surgery"**.⁵⁰

Accordingly, the extent of allocative efficiency detriments arising from adverse impacts on New Zealanders' health, and the broader health system, should be considered both likely and significant – and a separate category of detriments that the Commission needs to take into account.

⁴⁵ Para 36.1, DD.

⁴⁶ Para 37, DD.

⁴⁷ Para 336.4, DD.

⁴⁸ Para 342, DD. [Emphasis added].

⁴⁹ Para 376, DD. [Emphasis added].

⁵⁰ Para 377, DD. [Emphasis added].

(d) The DD does not give sufficient weight to the detriments arising from higher reference prices to other funders: SCHI does not consider it consistent with the Commission's findings that the Competitor Coordination:

- (i) "would result in materially higher costs for gynaecology surgery on an ongoing basis";⁵¹ and
- (ii) "will establish reference points that increase the likelihood gynaecologists charge higher fees to other funders",⁵²

to then conclude that "the allocative efficiency losses associated with higher gynaecological surgery fees charged to insurers, Health NZ and self-funded patients (and to a lesser extent ACC) in the factual to be small and likely".⁵³ In particular, the Commission notes that "the higher the reference prices are compared to counterfactual prices, the larger the detriment may be".⁵⁴ SCHI has provided evidence at section 5 above that the reference prices are likely to be significantly higher than in the counterfactual, and other funders have themselves raised this concern (including nib NZ, ACC, Health NZ, UniMed).⁵⁵ Given the Commission has found that the price increases are likely to be material and ongoing (and SCHI has provided evidence that those price increases are likely to be significant), the Commission cannot logically conclude that the allocative efficiency losses flowing from those increases to other funders are only small. Further demonstrating the likely magnitude of those detriments:

- (iii) those other funders account for the majority of gynaecology surgery funding in New Zealand⁵⁶ (meaning the resulting allocative efficiency losses will apply across a large volume of surgeries); and
- (iv) the Commission acknowledges that in the context of Health NZ, higher prices "would lead to fewer outsourced surgeries",⁵⁷ and that self-funded patients charged higher rates may "forfeit or delay surgery".⁵⁸

6.2 Given the above, SCHI submits that the evidence demonstrates that allocative efficiency detriments should be assessed as large (not just "medium").

⁵¹ Para 16, DD. See also para 178, DD.

⁵² Para 378, DD.

⁵³ Para 379, DD.

⁵⁴ Para 373, DD.

⁵⁵ Paras 347 to 351, DD.

⁵⁶ Footnote 231, DD.

⁵⁷ Para 376, DD.

⁵⁸ Para 377, DD.

7. THE DD UNDERSTATES THE EXTENT OF TRANSACTION COST DETRIMENTS

7.1 SCHI agrees that the Competitor Coordination would result in "significantly higher transactions costs" for gynaecologists/NZGA.⁵⁹ That is for the following reasons:

- (a) There is significant heterogeneity between gynaecology surgeons – not only on price⁶⁰ but also non-price matters;⁶¹
- (b) NZGA's proposed process would create substantial new work, including NZGA member surveys, collecting fee and cost data, benchmarking, internal consensus-building, information-sharing safeguards, legal and economic advice, and several rounds of collective negotiation. On indicative activity assumptions, SCHI estimates that these initial processes could require about 874–1,628 additional hours across NZGA, its members and advisers. That is an opportunity and adviser cost of roughly \$262,000 to \$814,000, or about \$2,000–\$6,000 for each of NZGA's ~130 members.⁶² These costs would be in addition to, rather than instead of, hospital-by-hospital negotiations and, as a matter of economic logic, these increased costs will ultimately be passed through to SCHI and then members (in the form of higher premiums).
- (c) SCHI agrees with the "consistent evidence" the Commission has received that "gynaecologists are unlikely to incur any significant transaction costs in the counterfactual".⁶³

7.2 However, despite the above, SCHI considers that the DD underestimates the extent of the transaction cost detriments that would arise from the Competitor Coordination. That is for the following reasons:

- (a) SCHI agrees with the Commission's finding that "SCHI and private hospitals are likely to experience higher transactions costs in the factual".⁶⁴ However, SCHI disagrees with the DD's finding that these arise only to a "smaller extent".⁶⁵ In particular, while the same number of hospitals / facilities would be involved in negotiations in the factual, such negotiations would be far more complex and protracted (including

⁵⁹ Para 25, DD.

⁶⁰ SCHI agrees with the Commission's findings that:

- NZGA's members are heterogeneous, and that NZGA's proposed process would be materially more intensive than current arrangements.
- "NZGA materially underestimates the variability of fees charged under FFS" (footnote 241, DD).

⁶¹ For the record, SCHI notes that NZGA members' heterogeneity extends beyond simply differing fee levels, but also in other areas as well:

- SCHI has seen significant variation in claiming, billing and procedure practices across gynaecology.
- Different gynaecology surgeons have very different approaches to surgery, which also drives different incentives (for example, faster gynaecologists complain that slower gynaecologists can get extra payments through the risk corridor).
- Different gynaecology surgeons hold differing views on basic pricing rules, such as whether secondary procedures should be discounted.
- SCHI's consultation during the current proposed APS transition has demonstrated that different gynaecology surgeons across the country record complexity differently (weeks, weight, both or neither).

These factors further emphasise that there will inevitably be significant internal transaction costs and negotiating inefficiencies within any collective bargaining group.

⁶² This has been calculated at a blended opportunity-cost rate of \$300–\$500 per hour.

⁶³ Para 304, DD.

⁶⁴ Para 27, DD.

⁶⁵ Para 27, DD.

requiring multiple additional interfaces between SCHI and the relevant hospitals / facilities, and more rounds of negotiation). On conservative assumptions, and assuming negotiations are completed within six months, SCHI estimates that for itself alone (i.e. not taking into account additional costs to hospitals / facilities), this would require about [] hours of SCHI staff time plus external advice. That is a direct cost of roughly [] calculated from an internal-time cost estimate at around [] per hour and (based on experience) would also incur costs for external legal and economic advice of between [] to []. Therefore, for SCHI alone, each round of negotiations in the factual could incur costs of between [] to [].

- (b) If authorisation were granted, hospitals / facilities (and indirectly SCHI) would have to manage at least three streams at once: negotiations in relation to NZGA's collective position; individual negotiations with NZGA members who choose to deal separately; and individual negotiations with gynaecologists who are not NZGA members. Hospitals / facilities (and indirectly SCHI) would therefore need protocols to identify which stream applies to each gynaecologist, and to manage switching between streams. Each switch by a gynaecologist could reopen terms that were thought to be settled.
- (c) As the DD identifies, NZGA members are financially incentivised to delay any agreement in relation to APS.⁶⁶ Until APS arrangements are in place, gynaecologists continue to be paid under FFS. Even if, as a collective, the NZGA members are "prepared to accept a small reduction from the current fee for service",⁶⁷ the NZGA members (in particular, the higher-charging ones) would, therefore, have incentives to prolong the process – thereby further increasing transaction (i.e. delay) costs. Based on current increases in FFS, SCHI would expect to see an additional cost to SCHI of approximately [] million from fee increases alone for a six-month delay.⁶⁸
- (d) Authorisation is sought for 10 years, and the Commission has said that "SCHI may wish to renegotiate and change terms every 3 years".⁶⁹ If so, across the 10-year period that authorisation is sought for, the additional "significantly higher transactions costs" identified by the Commission (and above in relation to SCHI and hospitals / facilities) would be incurred four times. This means that each of the additional transaction costs outlined above would need to be multiplied four-fold to establish the true extent of transaction costs that would arise from authorisation being granted.

7.3 Given the above, SCHI considers that the Final Determination should attribute significantly greater value to the likely magnitude of additional transaction costs arising from the Competitor Coordination, including in relation to the additional costs that are likely to be incurred by SCHI and hospitals / facilities across a 10-year period (and the Final Determination should reflect that, as a matter of

⁶⁶ Para 171, DD.

⁶⁷ As suggested in the Addendum to NZGA's 26 June response to Commission's email dated 9 June 2026.

⁶⁸ The reason that this figure is different to the [] million estimate that was included at paragraph 10.6 of SCHI's Submission is because that previous estimate was measuring the impact of a delay in achieving the targeted cost-savings through the APS transition, whereas this figure is calculating, based off historic FFS increases, the estimated gynaecology surgeon fee increases that SCHI would incur if gynaecology surgeons increase fees in line with prior practice.

⁶⁹ Para 94, DD.

economic logic, these increased transaction costs will ultimately be passed through to SCHI and then members, in the form of higher premiums).

8. THE DD DID NOT ATTRIBUTE SUFFICIENT VALUE TO THE COST OF THE PROPOSED CONDITIONS

- 8.1 SCHI agrees with the Commission that the detriments arising from Competitor Coordination "would not be obviated by reporting obligations, oversight by a competition lawyer or designated forum protocols".⁷⁰
- 8.2 However, on the other side of the coin, it is important that the Commission's Final Determination reflects that the conditions themselves would generate costs, and therefore are another form of transaction inefficiency that needs to be taken into account in assessing the detriments of the proposed Competitor Coordination.
- 8.3 In particular, the Commission noted that "[w]hen considering whether to impose behavioural conditions, we are mindful they can carry costs".⁷¹ However, the DD did not count the conditions proposed by NZGA as their own category of public detriment. SCHI considers that the proposed conditions should be assessed as their own category of detriment in the Final Determination, including as:
- (a) NZGA has proposed having an external competition law counsel attend meetings. That will come at a material cost, simply for competition law oversight.
 - (b) NZGA has proposed quarterly reports to the Commission. Such reports will incur costs both to NZGA and the Commission. While SCHI does not have a specific estimate of those costs, a 10-year authorisation covering about 130 surgeons, and potentially multiple hospital negotiations, demonstrates that these costs would be ongoing and non-trivial – both for NZGA and the Commission.
- 8.4 These costs can (and should) be treated as a separate category of productive inefficiency loss arising from the Competitor Coordination as they represent a use of resources that would not be needed absent the Competitor Coordination – in particular, as they would persist across a 10-year period.

9. THE DD DID NOT ATTRIBUTE SUFFICIENT VALUE TO THE COSTS OF []

- 9.1 SCHI notes that the Commission has said that it has "not considered a factual in which other specialities are permitted to collectively bargain with SCHI" as that "would potentially predetermine the outcome of any future authorisation".⁷²
- 9.2 SCHI does not suggest that the Commission should assume any future application will be authorised. However, the Commission needs to take into account the detriments that would arise from [],⁷³ []. Specifically:

⁷⁰ Para 432, DD.

⁷¹ Para 112, DD.

⁷² Para 197, DD.

⁷³ As SCHI has outlined to the Commission previously []. See paragraph 9.6 (e) of SCHI's Submission.

(a) [] [] ("although negotiations have continued between SCHI and hospitals, they have been unable to be finalised while this authorisation application process has been underway, as they need gynaecologists to agree").⁷⁴ [] (see section 7 above).

(b) [] [].⁷⁵

9.3 Accordingly, even without needing to "potentially predetermine the outcome of any future authorisation", it is important the Commission's Final Determination attributes value to these costs.

10. THE EVIDENCE DOES NOT SUPPORT ATTRIBUTING ANY BENEFIT TO "MORE EFFICIENT" NON-PRICE TERMS

10.1 The DD says that with Competitor Coordination, NZGA "would also be likely to negotiate more efficient non-price contract terms".⁷⁶ While the DD says that the potential magnitude of any such benefit would "be very small",⁷⁷ SCHI does not consider that the evidence supports the finding of any benefit arising from "more efficient" non-price terms. In particular, the DD states that the Commission:

(a) heard "from a number of stakeholders that these concerns are either addressed in the SCHI APS contractual framework or do not arise in practice";⁷⁸

(b) heard "from a number of stakeholders that negotiating these issues, particularly clinical issues, does not require the Proposed Arrangements";⁷⁹

(c) heard in "interviews with gynaecologists other than NZGA Board members" that:

(i) "they did not raise concerns about other non-price terms such as risk allocation under the APS";⁸⁰ and

(ii) "concerns about non-price terms were limited to the clinical appropriateness of coding",⁸¹ being issues that do not require collective bargaining to resolve. In particular, SCHI has already engaged in clinical consultation, including receiving and reviewing feedback on its proposed procedure funding code set from RANZCOG and ANZSU.⁸² SCHI has adopted all clinical

⁷⁴ Para 145, DD.

⁷⁵ Calculated as follows: []

⁷⁶ Para 16, DD. In so doing, the DD cites: "specifying and clarifying when additional fees would be paid, when open codes will be accepted, how risk is shared amongst the hospital, surgeon and anaesthetists when a surgery is unexpectedly complex and various other terms and conditions NZGA presently considers 'asymmetric'" (see: footnote 16, DD. See also para 204, DD).

⁷⁷ Para 34, DD. See also para 251, DD.

⁷⁸ Para 205, DD. See also para 259, DD.

⁷⁹ Para 258, DD.

⁸⁰ Para 314, DD.

⁸¹ Para 314, DD.

⁸² Clinical input on procedure funding codes already has an established and appropriate channel through RANZCOG, which does not require authorisation. RANZCOG is the accredited professional college for obstetrics and gynaecology, responsible for training, clinical standards and professional guidance for the specialty, and has been since 1998. ANZSU represents urologists, whose members also perform certain urogynaecology procedures. These are the bodies with the clinical mandate

feedback received for urogynaecology and gynae-oncology codes,⁸³ and has now communicated to both RANZCOG and ANZSU that it has settled its gynaecology surgical procedure funding code set.⁸⁴

- (d) considers that SCHI would not, in either the factual or counterfactual, "give clinicians material influence over SCHI member benefits".⁸⁵

10.2 There is a disjunct between this evidence, and the assertion in the DD that "[c]larifying and resolving these issues may be mutually beneficial to SCHI and NZGA".⁸⁶ The evidence before the Commission is that these issues are already addressed, do not arise in practice, or do not reflect matters that SCHI would negotiate with clinicians (such as member benefits). Therefore, it is not justified to attribute even a "very small" benefit to non-price terms.⁸⁷

10.3 Furthermore, for SCHI's part:

- (a) SCHI is confident that its procedure funding code set is appropriate, having undertaken a robust consultation process with the appropriate clinical bodies, RANZCOG and ANZSU, and incorporated their clinical feedback,⁸⁸ into its procedure funding codes;
- (b) SCHI is comfortable that its proposed terms and conditions for the APS agreement for gynaecological surgery are reasonable and consistent with other health funding arrangements for specialist services;
- (c) in implementing an APS arrangement, SCHI also regularly considers feedback from the specialty and changes its code set where warranted. For example, as previously outlined to the Commission, in gynaecology, SCHI has amended its procedure funding code set in response to

and expertise to advise on procedure descriptions, clinical distinctions and theatre times, and SCHI has consulted them on exactly those matters. That consultation needs no Commission authorisation because it is about clinical content, not the terms on which competing gynaecologists will supply their services. RANZCOG and ANZSU have provided SCHI clinical advice; SCHI made its own funding decisions in accordance with the terms and conditions of its policies. The recently completed gynae-oncology and urogynaecology code review shows this in practice: RANZCOG's and ANZSU's recommendations were considered and largely adopted, and changes were made to the code set, without any collective negotiation among gynaecologists. By contrast NZGA was formed in 2026. It is not a clinical standard-setting body like RANZCOG. To the extent that authorisation is sought on clinical quality or coding grounds, NZGA would duplicate RANZCOG, an appropriate channel that already exists and works. The Commission should therefore give no weight to clinical consultation as a benefit of the proposed Competitor Coordination.

⁸³ Except the request to create a standalone code for harvesting an autologous graft. That component will be included within the relevant primary procedure code, reflecting current claims data which shows the harvesting is billed as part of the primary procedure and not as a separate procedure.

⁸⁴ Refer email to the Commission of 22 September 2026. This includes SCHI having carefully reconsidered RANZCOG's request for a separate procedure funding code for laparoscopic or vaginal morcellation of a uterus or fibroids over 500g, but its position is unchanged. Morcellation is already accounted for in the average pricing of the relevant hysterectomy and myomectomy procedure funding codes. Where a case is more complex and, therefore, exceeds the agreed maximum theatre time for the primary code, the risk corridor or top-up mechanisms in SCHI's Affiliated Provider Agreements allow additional reimbursement to be claimed above the total procedure price. Additional funding for these more complex cases is, therefore, already provided for, and a separate procedure funding code is not required. This is directly relevant to the Commission's assessment. In the NZGA's Application (paragraph 68.2) and in the NZGA's response to clinical assertions document (paragraph 35), it identified pelvic floor urogynaecology concerns as a key reason NZGA sought authorisation. Those concerns have now been resolved through clinical consultation with RANZCOG and ANZSU, without collective bargaining.

⁸⁵ Para 273.2, DD.

⁸⁶ Para 205, DD.

⁸⁷ Furthermore, while the DD (correctly) references heterogeneity between gynaecology surgeons to conclude that collective bargaining over price would increase transaction costs, the DD does not appear to consider whether the same heterogeneity would limit the efficiencies achievable through collective negotiation of non-price terms.

⁸⁸ With one reasoned exception.

feedback from gynaecology surgeons during its pilot phase, with the updated codes now being used successfully; and

- (d) SCHI confirms that it will not, in either the factual or the counterfactual, negotiate policy terms and conditions with NZGA or individual gynaecologists. This includes eligibility criteria, exclusions, benefit limits, the scope of cover and how patient coverage is determined. NZGA's Application presents its proposals as clinical governance and coding issues rather than changes to policy terms, but in substance it seeks input into SCHI's policy and benefit settings. For example, it asks for eligibility criteria and exclusion rules to be subject to "ongoing review",⁸⁹ for gynaecologists to be free of "artificial constraints imposed by coding or eligibility settings",⁹⁰ and for members to receive a "broader scope of cover (reducing out-of-pocket costs for procedures currently excluded)".⁹¹ These are coverage decisions for SCHI, not matters for negotiation with providers.

- 10.4 SCHI considers that the above further reinforces its view that it is not justified to attribute even a "very small" benefit to a theoretical perspective regarding non-price terms.

11. SCHI'S RECENT SURPLUS DOES NOT ALTER THE ANALYSIS IN THE DD

- 11.1 The Commission will have seen that since the DD was published, SCHI has reported a surplus for the financial year to 30 June 2026.⁹²
- 11.2 For the avoidance of doubt, SCHI records that this recent surplus does not alter the Commission's analysis, including its assessment that SCHI's "premiums are set to meet expected claims costs, operating expenses and solvency requirements" and therefore there is a direct "relationship between expected claims costs and premiums".⁹³ Further detail on this is as follows:

- (a) The FY2026 surplus has not restored SCHI's financial position: The FY2026 surplus follows two consecutive deficits with losses of \$99.1 million (FY2024) and \$56.9 million (FY2025). Across FY2024 to FY2026, SCHI's cumulative result is a deficit of \$12.6 million. Over the same period, SCHI's cumulative operating result before investment returns is a deficit of \$148.7 million. Approximately [] million of the FY2026 surplus is investment return rather than underwriting margin. At 30 June 2026, SCHI's net assets of [] remain below their FY2022 ([]) and FY2023 ([]) levels. Over the same period, annual claims incurred have grown by approximately 66%, reflecting the increasing requirement to hold adequate reserves. The FY2026 surplus represents around 7% of premium income.

⁸⁹ Application [2.28(a)] and [11.11(a)].

⁹⁰ Application [2.28(b)] and [11.11(b)].

⁹¹ Application [11.25(a)].

⁹² (29 September 2026). Southern Cross Health Society releases FY26 Annual Report.

<https://www.southerncross.co.nz/news/2026/southern-cross-health-society-releases-fy26-annual-report>

⁹³ Para 334.3, DD.

- (b) SCHI remains below its capital target: As a friendly society, SCHI has no shareholders and no access to external capital. SCHI's only source of capital is retained surplus, from both underwriting and investment returns. Its reserves are attributable to its past and current members. SCHI's Board-approved capital management policy sets a target capital ratio (balance sheet net assets to claims incurred) with a target range of 35% to 40%. As at 30 June 2026, SCHI's capital ratio was 30.3%, still below the Board-approved target range, illustrating the importance that SCHI continue to manage claims cost to support sustainable premiums for its members. See Figure [3] below.
- (c) SCHI cannot absorb higher costs without consequences for members: As a friendly society, "absorbing" a cost means members (in effect) funding it from their own reserves. Any reduction in reserves must then be rebuilt through future premium increases (or other measures, such as benefit reductions). The cost falls on members either way; the only difference is when. Higher gynaecology fees would affect SCHI's capital ratio in two ways: they would reduce net assets, and they would increase claims incurred. By way of illustration, absorbing approximately \$4.7 million of additional annual claims costs, with no premium response, would have taken SCHI's FY2026 capital ratio below 30%. When the capital ratio is below 30%, SCHI's Interim Capital Management Policy requires []. Any surplus beyond what prudent capital requires is returned to members. Using SCHI's surplus to fund higher gynaecology fees would redirect members' reserves to providers.

Figure [3] – SCHI's internal capital ratio compared to SCHI's Board-approved target capital ratio

[]

- 11.3 Accordingly, notwithstanding SCHI's recent surplus, the points in the DD regarding the way that SCHI sets premiums and the direct "relationship between expected claims costs and premiums" remain accurate.

12. SCHI'S INCENTIVES ARE TO ACT IN ITS MEMBERS' INTERESTS

- 12.1 SCHI agrees with the Commission's identification of its incentives as a member-focused friendly society, including that:
 - (a) "SCHI is incentivised to agree terms that attract broad gynaecology surgeon participation to cover each region in New Zealand" and that it does not have the "option of simply 'walking away' if it considers surgeon fees to be too high",⁹⁴ including due to its contractual obligations to members;⁹⁵
 - (b) "SCHI has a structural incentive to ensure that fees are set at levels that maintain an adequate supply of high-quality gynaecological services for its members";⁹⁶ and

⁹⁴ Para 147, DD.

⁹⁵ Para 155.3, DD.

⁹⁶ Para 278.1, DD. The DD records that the same incentives also apply in relation to anaesthetist fees (para 403, DD).

- (c) SCHI does not seek returns for external shareholders, so premiums are set by reference to expected claims costs, operating expenses and solvency requirements.⁹⁷
- 12.2 However, for the record, SCHI notes that NZGA's assertion that "funding decisions made by management can diverge from SCHI members' long to long-term interests"⁹⁸ is incorrect, and is not borne out by SCHI's structure, governance, or conduct. In particular, due to SCHI's structure there is no separate owner whose interests management could prefer over those of members. SCHI's Board governs SCHI for the benefit of its members under the friendly society's rules.⁹⁹ In practice, SCHI has increased the prices it pays under its APS where member access has been at risk (as has occurred in the case of [] in []), and SCHI has not seen reductions in volumes in specialties that have moved to the APS.¹⁰⁰
- 12.3 The same balancing of members' interests is reflected in SCHI's approach to capital: the SCHI Board has deliberately chosen to rebuild reserves over three years, accepting a temporary position outside its risk appetite, in order to soften the premium impact on members.
- 12.4 The above demonstrates that NZGA's assertion is incorrect.
- 13. THERE SHOULD BE GREATER ACKNOWLEDGEMENT OF THE QUANTITATIVE MATERIAL THAT SCHI HAS PROVIDED THE COMMISSION**
- 13.1 SCHI records that it does not agree with the suggestion at paragraph 419 of the DD that SCHI has not "sought to quantify" the detriments arising from the Competitor Coordination.¹⁰¹ SCHI considers that it has provided significant volumes of quantitative evidence to the Commission. That includes:
 - (a) SCHI's quantification of the evidence of the current excess billing by certain gynaecology surgeons in New Zealand (with reference to comparators, such as overseas comparators and []).
 - (b) SCHI's quantification of the estimated savings of the proposed gynaecology surgery APS compared to the status quo: approximately [] million per annum (excl. GST), which equates to approximately [] million over five years.
 - (c) SCHI's quantification of the estimated increases in gynaecology surgical fees arising from Competitor Coordination (see further at section 5 above).
 - (d) SCHI's quantification of the estimated detriments from a 6-month delay in agreements in relation to APS (see further at paragraph 7.2(c) above).

⁹⁷ Para 336.2, DD.

⁹⁸ Para 335, DD.

⁹⁹ Being rules that are required under the Friendly Societies and Credit Unions Act 1982, and that can only be changed by way of a membership vote.

¹⁰⁰ See paragraph 9.6(i) of SCHI's Submission. Specifically: "the evidence demonstrates that when specialties transition to SCHI's AP programme, volumes of procedures performed continue to increase".

¹⁰¹ Para 419, DD.

- (e) SCHI's quantification of the estimated impacts on premiums arising from Competitor Coordination (see further at section 4 above).
 - (f) SCHI's quantification of the estimated insurance retention and policy downgrade impacts of such premium increases.
 - (g) SCHI's quantification of its estimated increased transaction costs.
- 13.2 SCHI considers that all this quantitative material should be reflected and acknowledged in the Commission's Final Determination.
- 13.3 Furthermore, SCHI has also responded to all questions asked of it by the Commission and in the context of the Commission considering hypothetical future scenarios, it is not apparent to SCHI that there is further quantitative evidence that it could have provided. However, if there is further quantitative evidence that the Commission would like to receive from SCHI, SCHI is available to assist the Commission further.

14. CONCLUSION

- 14.1 Ultimately, the question for the Commission is whether New Zealanders would be better off if competing gynaecology surgeons were permitted to set their prices together. The evidence answers it clearly: they would not.
- 14.2 Authorisation would replace competitive price discipline with a collectively agreed price floor, set by those with the most to gain from it. The Commission's DD has found that costs would be materially higher on an ongoing basis. SCHI has shown that those costs would reach at least \$243 million a year by FY2036. That is not a neutral transfer: it is a lasting redistribution, over the full 10-year period sought, from everyday New Zealanders to around 130 highly-paid surgeons. These increased costs would be paid by SCHI's members, and through increased reference prices and spill-over effects to other funders, there would also be increased costs and adverse impacts for other insurers' customers, Health NZ, ACC and the taxpayers who fund them, and non-insured women seeking to self-fund for gynaecological surgery.
- 14.3 In return, the Application offers no material health or quality benefits that depend on authorisation. The benefits claimed are limited, unquantified, and achievable without Competitor Coordination. The proposed conditions would not change that. They do not constrain the significantly adverse impacts on price, which are the primary cause of the detriments, and would themselves add further cost and complexity for the full 10-year period sought.
- 14.4 The DD also significantly understates the overall detriments of the Competitor Coordination. Higher gynaecological surgery prices should be treated as an independent detriment rather than a neutral transfer, and weighted under a "modified total welfare" approach to reflect who bears them. The allocative efficiency losses should be assessed as "large" rather than "medium". The transaction costs, and the cost of the proposed conditions, would fall on SCHI and hospitals / facilities as well as NZGA, would recur in every negotiating round, and (as a matter of economic logic) ultimately flow through to SCHI's members. Properly weighted, the detriments are far greater than the DD indicates.

PUBLIC VERSION

- 14.5 The public benefit test requires the Commission to be satisfied that the benefits outweigh the detriments. On the evidence, that test is not close to being met. SCHI therefore submits that the Commission should confirm its preliminary decision and decline the Application.