PUBLIC VERSION

SOUTHERN CROSS MEDICAL CARE SOCIETY

16 JUNE 2026

SUBMISSION ON THE COMMERCE COMMISSION'S STATEMENT OF PRELIMINARY ISSUES IN RELATION TO THE NEW ZEALAND GYNAECOLOGY ASSOCIATION INC AUTHORISATION APPLICATION

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1. EXECUTIVE SUMMARY

1.1 Southern Cross Medical Care Society (trading as Southern Cross Health Insurance ("**SCHI**")) opposes the application by the New Zealand Gynaecology Association Inc ("**NZGA**") for authorisation (and interim authorisation) (the "**Application**") to engage in collective bargaining and a collective boycott (together the "**Competitor Coordination**").

1.2 The Application runs directly counter to our commitment to championing affordable and timely access to women's healthcare for our members. The Application (if authorised) would make gynaecological care more expensive, reduce patient access, entrench gynaecology surgery prices that already sit significantly above competitive levels, and place further strain on New Zealand’s already stretched public health system.

1.3 Applying the required legal and economic framework, the Application must be declined:

(a) **At its core, the Application is an attempt by a concentrated group of highly-paid specialists to avoid competitive price discipline and preserve prices that already sit significantly above competitive levels**. SCHI’s evidence demonstrates that, under the current fee-for-service model,[1] gynaecology surgery prices charged to SCHI are higher than [ ] and have increased significantly faster than both inflation and [ ]. The substantial variation in fee-for-service hourly rates charged by gynaecology surgeons - ranging from approximately [ ] to [ ] per hour[2] - indicates a lack of effective competitive pricing discipline. In addition, average gynaecology surgery costs charged to SCHI in New Zealand are significantly higher than international benchmarks, reinforcing the concern that gynaecology surgery prices to SCHI are not currently being constrained by effective competitive pressures. [ ][3] [ ]. Taken together, these dynamics indicate that a number of gynaecology surgeons are charging fees to SCHI that are significantly above efficient or competitive levels.

(b) **The private health insurance market in New Zealand has experienced sustained and unprecedented claims cost escalation in recent years**. That claims cost escalation peaked at approximately 17% in FY23. In FY25 alone, SCHI paid a record 3.8 million claims, up 16% on the prior year and resulting in SCHI reporting a $56.9 million deficit from its health insurance operations, following a $99.1 million deficit in FY24. Alongside increased utilisation, this escalation has been driven by rapid and uneven growth in specialist and surgical costs, with impacts already flowing through to higher premiums for ordinary New Zealanders. In a competitive and affordability-constrained private health insurance market, these costs cannot be fully absorbed or passed on without reducing coverage and membership. If left unaddressed, this trajectory will continue to undermine health insurance affordability, drive ongoing insurance losses, erode capital resilience, and increase prudential regulatory scrutiny - ultimately posing a risk to the long-term sustainability of SCHI and the private health insurance sector.

(c) **SCHI’s Affiliated Provider ("AP") programme is not novel and delivers established, pro-competitive outcomes**. The AP programme is a key pillar in SCHI's response to the sustained and unprecedented claims cost escalation in recent years, including to respond to the well-recognised moral hazard issues that

[1] See paragraph 4.2 for an explanation of the "fee-for-service" model.
[2] GST exclusive.
[3] [ ]
- [ ]
- [ ]

can (if unaddressed) arise in insured healthcare markets. SCHI's AP programme is not novel. It has operated since 1997 and now covers more than 2,500 healthcare providers nationwide across more than 30 clinical specialties. The programme enables competitive, bilateral negotiations with hospitals/facilities, providing price certainty, moderating healthcare cost inflation, and supporting affordable premiums and healthcare coverage for members. The programme has been recognised by the Commission as producing tangible consumer benefits. SCHI's experience is that the AP programme significantly moderates cost escalation: [ ], whereas services funded on a fee-for-service basis are not subject to agreed escalation constraints and have increased far more sharply over time. For example, SCHI's claims data shows that the gynaecology surgeon fees for a number of gynaecology procedures (for example, hysteroscopy, hysterectomy, endometriosis surgery) have increased by more than [ ] cumulatively since 2013, compared with cumulative CPI[4] growth of approximately 40% over the same period. By contrast, two comparable surgeries in the [ ] that are funded through the AP programme have only faced cost increases of [ ] during that same period (i.e. broadly in line with CPI).

In addition:

(i) SCHI's AP programme does not undermine independent clinical decision-making or adversely impact patient outcomes:

(aa) SCHI's proposed gynaecology AP agreements would expressly provide that Listed Providers "remain solely responsible for all decisions relating to the medical care of the Member";

(bb) Other specialties have been successfully transitioned to the AP programme without any adverse impact on member healthcare;

(cc) SCHI's survey data shows that AP-only surgeries in other specialties receive more positive patient-reported outcomes than fee-for-service gynaecology surgery; and

(ii) there is no evidence that SCHI's AP programme has resulted in a reduction of procedures performed in other specialties. To the contrary, the evidence demonstrates that when procedures transition to the AP programme, the volumes of those procedures performed continue to increase.

The proposed transition of gynaecology surgery into the AP programme is a continuation of SCHI's well-established framework. It represents a legitimate response to unsustainable cost growth, with projected savings that would help maintain affordability and preserve access for members to these important healthcare services.

(d) **SCHI has undertaken a careful and considered consultation process in relation to its proposed transition of gynaecology surgery to the AP programme**. Since commencing the project in August 2025, SCHI has allowed more than eight months for consultation and negotiation. Throughout this period, SCHI has held multiple face-to-face and online meetings with individual gynaecology surgeons and hospitals/facilities, engaged in consultation with

[4] Consumer Price Index.

gynaecology surgeons and The Royal Australian and New Zealand College of Obstetricians and Gynaecologists ("**RANZCOG**") in developing the AP code set, made appropriate changes to the proposed AP code set in response to clinical feedback, and prepared and distributed guidance materials to assist providers with understanding the proposed AP agreements. RANZCOG has acknowledged this engagement, stating that it appreciated "the careful consideration given to our advice and the improvements made to the code set".[5] SCHI has also extended its original contracting timeline on multiple occasions in response to feedback, and no specified implementation date is currently in place. This process reflects SCHI's commitment to working constructively with hospitals/facilities and gynaecology surgeons in transitioning gynaecology surgery to SCHI's AP programme.

(e) **The immediate and inevitable effect of authorising the Competitor Coordination would be higher healthcare costs**. Allowing more than ~90% of private gynaecology surgeons to coordinate on pricing - or to engage in a collective boycott - would remove competitive constraints, undermine SCHI's ability to introduce competitive price discipline through its AP programme, and create sustained upward pressure on gynaecology surgery prices. The increased costs would flow directly to New Zealand consumers through higher insurance premiums and/or reduced scope of cover.

(f) **Those adverse impacts would be significant, widespread, and regressive – and risk the long-term sustainability of funding for gynaecology services by SCHI**:

(i) Gynaecology surgery cost escalation is not an abstract insurer issue; it flows directly to members through premium increases, affordability pressure, reduced policy cover and/or increasing strain on the sustainability of private health insurance. SCHI insures approximately 940,000 members (around 18% of resident New Zealanders). As a member-focused Friendly Society, SCHI exists solely to serve its members. It pays no dividends (and has no shareholders) and does not have access to shareholder capital or external borrowing. With approximately 94% of premiums paid in claims,[6] any increase in healthcare costs flows directly through to members.

(ii) The Competitor Coordination would reduce the affordability and availability of private insurance coverage (either through members cancelling cover as premiums rise, or through SCHI being unable to offer the same level of cover). It would, therefore, also increase pressure on the already strained public health system.

(iii) The detriments of the Competitor Coordination would be borne across a broad population of New Zealanders, while any financial gains would accrue to a small group of highly-paid specialists.

(g) **Authorising the Competitor Coordination would directly undermine the benefits of a competitive transition to the AP programme and risk spillover effects to the wider health system**. Authorisation would:

[5] [ ]

[6] During FY25. See SCHI "Southern Cross Medical Care Society Annual Report 2025" (2025) at p 3. Retrieved from: https://www.southerncross.co.nz/-/media/files/corporate/annual-reports/schi_annual_report_2025.pdf?rev=c182d27c6f734bc9be555015b2b3de7e.

(i) impair the ability of SCHI and hospitals/facilities to engage in genuine competitive bilateral negotiations, frustrating (and potentially preventing) the proposed transition of gynaecology surgery into the AP programme;

(ii) entrench existing uncompetitive prices and cost escalation (that already sit significantly above competitive levels and international benchmarks), rather than enabling competitive discipline to moderate them;

(iii) in practical terms, contribute to higher premiums for SCHI members and/or reduced scope of cover (including in relation to certain gynaecology surgeries), by contributing to claims cost escalation and the pressure that places on SCHI's capital and operation performance;

(iv) risk spillover effects across the wider system, including Health NZ, Accident Compensation Corporation ("**ACC**") and other private health insurers (in circumstances where the Reserve Bank of New Zealand ("**Reserve Bank**") already has concerns regarding the escalation in healthcare costs in New Zealand, and the pressure that is placing on private health insurer sustainability by contributing to operating losses and reductions in solvency margins); and

(v) [ ].

(h) **<u>The proposed “Standstill Agreement” carries additional and unique competitive detriments</u>**. This is a collective boycott. Collective boycotts are inherently harmful. This one would cover more than ~90% of private gynaecology surgeons. It would inflict immediate damage on consumers and the wider health system. It is also not apparent that NZGA can seek authorisation for separate forms of illegal conduct (collective bargaining on one hand, and a collective boycott on the other) under a single application.

(i) **<u>The Application does not identify any credible public benefits capable of outweighing these harms</u>**.

(i) Consultation on clinical matters does not require authorisation and does not require competing gynaecology surgeons to coordinate on price. SCHI has already engaged in extensive consultation with gynaecology surgeons (including appropriate industry bodies) on clinical code sets and has made changes in response to that feedback. SCHI has also made clear its willingness to continue to engage on appropriate specialty-wide topics (such as clinical best practice) with appropriate industry bodies. As a member-focused Friendly Society, SCHI is inherently incentivised to support clinically appropriate care, and those incentives are reflected in the consultation process undertaken to date.

(ii) The Application provides no quantified or substantiated efficiency benefits. By contrast, authorisation would result in significant anti-competitive detriments, including (as outlined above) higher health insurance premiums and reduced health insurance policy coverage, further contributing to the financial pressure facing private health insurers in New Zealand. This runs counter to the Reserve Bank’s statements that health insurers need to arrest claims cost escalation, restore capital strength, and return to sustainable performance. It would also increase pressure on the already strained public health system.

(iii) Claims of a negotiating imbalance are unfounded. The market includes multiple funders, and gynaecological surgeons are already concentrated in number. SCHI depends on having adequate specialist coverage for every region to service its members. SCHI has engaged in bilateral negotiations and consultation over a significant period in relation to the proposed gynaecology surgery AP transition. [ ].

(iv) There is no credible evidence of a material risk of "workforce exit" arising from SCHI's proposed transition of gynaecology surgery to its AP programme. SCHI is only one of a number of funders of gynaecology surgeries in New Zealand, and through the AP transition is simply seeking to negotiate competitive and efficient prices. There is no credible basis on which a single funder negotiating competitive prices could result in material workforce departure - especially in circumstances where the prices charged in New Zealand are significantly higher than in comparable overseas markets such as Australia and Ireland. Furthermore, as set out above, as a member-focused Friendly Society, 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, and the evidence demonstrates that procedure volumes continue to grow once a specialty has transitioned to SCHI's AP programme.

(j) **In the circumstances, authorisation must be declined**. Coordinated conduct between competitors is recognised as inherently harmful, leading to higher prices, reduced output, and diminished innovation. The onus lies squarely on the applicant to demonstrate substantial public benefits that outweigh these detriments. NZGA has not come close to meeting that standard. To the contrary, the evidence demonstrates that the anti-competitive detriments would significantly outweigh any claimed benefits for a small number of highly-paid specialists.

(k) **Interim authorisation must also be declined**. There are no grounds to grant interim authorisation. Interim authorisation would not preserve the status quo but instead would immediately enable coordination among competitors representing more than ~90% of private gynaecology surgeons, including the exchange of competitively sensitive information and a collective boycott. As the Commission has previously recognised, this creates a real risk of immediate and irreversible harm to the competitive process, entrenching pricing expectations and coordination before the Commission's substantive assessment is complete. There is no urgent circumstance to justify such an outcome. SCHI’s proposed AP transition for gynaecology surgery has followed extensive consultation over many months, no mandatory implementation date is in place, and gynaecology surgeons remain free to negotiate individually (or not) with relevant hospitals/facilities. The risks of interim authorisation are direct, material and enduring.

1.4 SCHI is grateful for the Commission's attention to this submission and the important matters being considered by the Commission through this process. We are committed to supporting our members' access to sustainable and affordable healthcare, including our ongoing commitment to championing affordable and timely access to women's healthcare. We are available to meet the Commission to discuss and provide further information, as helpful.

2. ABOUT SCHI

2.1 Southern Cross Medical Care Society is a member-focused Friendly Society, registered under the Friendly Societies and Credit Unions Act 1982 ("**Friendly Societies Act**"). We operate the SCHI insurance offering for the benefit of our members.[7]

2.2 As a member-focused Friendly Society our top priority is our members' health and wellbeing - our vision is a healthier Aotearoa New Zealand and this is underpinned by our purpose, which is empowering our members to live well for longer. One way we achieve this is by providing for the reimbursement of insured healthcare costs to our members.[8] Our Friendly Society structure means that we do not have any shareholders and, therefore, do not pay dividends. If we achieve a surplus that exceeds our solvency capital requirements, under our Rules, that can be used to increase our benefits or reduce our premiums.[9]

2.3 The following facts about our operations are relevant to the Commission's assessment of the NZGA Application:

(a) We have approximately 940,000 members in New Zealand, meaning we provide health insurance cover to approximately 18% of resident New Zealanders (which equates to approximately 60% of New Zealanders who have private health insurance).[10]

(b) In the year to 30 June 2025, 94% of the money we received in premiums went back to our members for their healthcare[11] (which is significantly above the market average of 76%).[12]

(c) We have one of the lowest operational costs across the New Zealand private health insurance sector[13] - with just 11.3 cents for every dollar received in premiums in FY25 going to our operational costs.[14]

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[7] SCHI "Southern Cross Medical Care Society Annual Report 2025" (2025) at p 23. Retrieved from: https://www.southerncross.co.nz/-/media/files/corporate/annual-reports/schi_annual_report_2025.pdf?rev=c182d27c6f734bc9be555015b2b3de7e.

[8] SCHI "The Rules of the Southern Cross Medical Care Society" (January 2023) at cl 3.1. Retrieved from: https://srp.companiesoffice.govt.nz/friendlysocieties/entity/filing/documents/?id=36843956-9c3b-4989-801e-af388e0fff9d.

[9] Specifically, clause 15.4 of our Rules state:

15.4 Surplus

Subject to any Applicable Law, the Board may from time to time:

(a) Determine the necessary solvency capital for the Society in consultation with the Appointed Actuary; and

(b) apply all or part of any funds that exceed the necessary solvency capital, and can be safely and equitably used, for all or any of the following purposes:

(i) An increase or extension of Benefits;

(ii) a reduction in Premiums;

(iii) medical aid, or relief of distress; and

(iv) such other Purposes or investments as may properly be permitted.

[10] Based on data provided by the Financial Services Council and including an estimate for nib, see SCHI "Southern Cross Medical Care Society Annual Report 2025" (2025) at p 3. Retrieved from: https://www.southerncross.co.nz/-/media/files/corporate/annual-reports/schi_annual_report_2025.pdf?rev=c182d27c6f734bc9be555015b2b3de7e.

[11] SCHI "Southern Cross Medical Care Society Annual Report 2025" (2025) at p 3. Retrieved from: https://www.southerncross.co.nz/-/media/files/corporate/annual-reports/schi_annual_report_2025.pdf?rev=c182d27c6f734bc9be555015b2b3de7e.

[12] SCHI "Southern Cross Medical Care Society Annual Report 2025" (2025) at p 3. Retrieved from: https://www.southerncross.co.nz/-/media/files/corporate/annual-reports/schi_annual_report_2025.pdf?rev=c182d27c6f734bc9be555015b2b3de7e.

[13] [ ]

[14] This operating cost was based on FY24 data for New Zealand health insurers excluding SCHI. The reason this 11.3 cents is different to the 94% in the sub-paragraph above is because SCHI ran a deficit (meaning it paid out more than it took in). See discussion in our annual report setting out where every $1 of premiums went in FY25. SCHI "Southern Cross Medical Care Society Annual Report 2025" (2025) at p 9. Retrieved from: https://www.southerncross.co.nz/-/media/files/corporate/annual-reports/schi_annual_report_2025.pdf?rev=c182d27c6f734bc9be555015b2b3de7e.

(d) New Zealanders have voted us the most trusted health insurer in New Zealand for ten years running.[15]

(e) Over our past financial year:

(i) we paid 3.8 million claims[16] (totalling $1.7 billion in claims); and

(ii) our health insurance operations reported a deficit of $56.9 million[17] (and the year before that reported a deficit of $99.1 million).[18]

2.4 In relation to the health insurance deficits we have reported in recent years, like other health insurers in New Zealand, we face rising healthcare claims costs that consistently outpace general inflation, and a strained public health system has also led more people to seek treatment privately, which is contributing to increased claims volumes. In response to these challenges, we have an active programme of work underway to manage our claims costs, support premium affordability, and support financial sustainability for our insurance offering. That programme includes exploring opportunities to expand our AP programme. We now have 2,500 contracted healthcare providers nationwide within our AP programme providing healthcare services to members.[19] [ ].

2.5 The health cost escalation challenges outlined above mean that premiums have been increasing across the New Zealand private health insurance sector. However, we note that our base premium increases have been lower than a number of other insurers. We consider one of the reasons for that is our AP programme, which delivers value for members and helps keep premium costs down. See further on our AP programme at Section 4 below.

[15] SCHI has been recognised as Reader's Digest Most Trusted Health Insurance Brand from 2017-2026. See SCHI " Southern Cross Most Trusted Brand across multiple insurance categories 2026 Reader's Digest Trusted Brand Awards" (4 May 2026). Retrieved from: https://www.southerncross.co.nz/news/2026/southern-cross-most-trusted-brand-across-multiple-insurance-categories.

[16] SCHI "Southern Cross Medical Care Society Annual Report 2025" (2025) at p 5. Retrieved from: https://www.southerncross.co.nz/-/media/files/corporate/annual-reports/schi_annual_report_2025.pdf?rev=c182d27c6f734bc9be555015b2b3de7e.

[17] SCHI "Southern Cross Medical Care Society Annual Report 2025" (2025) at p 5. Retrieved from: https://www.southerncross.co.nz/-/media/files/corporate/annual-reports/schi_annual_report_2025.pdf?rev=c182d27c6f734bc9be555015b2b3de7e.

[18] SCHI "Southern Cross Health Society Group annual results reflect steep increase in demand for private healthcare" (30 September 2024). Retrieved from: https://www.southerncross.co.nz/news/2024/southern-cross-health-society-group-annual-results-reflect-steep-increase-in-demand.

[19] SCHI "Southern Cross Medical Care Society Annual Report 2025" (2025) at p 3. Retrieved from: https://www.southerncross.co.nz/-/media/files/corporate/annual-reports/schi_annual_report_2025.pdf?rev=c182d27c6f734bc9be555015b2b3de7e.

3. CONTEXT ON THE NEW ZEALAND HEALTH AND INSURANCE SECTORS

Private health insurance alleviates pressure on the public healthcare system

3.1 New Zealand is due to spend $34.2 billion on its public healthcare system in the 2026/27 financial year.[20] Despite this level of expenditure, it is widely recognised that the public health system is under sustained pressure, including ongoing financial and capacity constraints.[21] That includes specifically in relation to public gynaecology care, where RANZCOG has publicly identified the strain on the public system in meeting demand for gynaecological care, including access challenges and growing service backlogs.[22]

3.2 In this context, private health insurance plays an important role in improving access to timely care and alleviating pressure on the public system. As the Financial Services Council ("**FSC**") has said:

> Health insurance is equally integral to national wellbeing, with the sector easing pressure on the public health system and ensuring timely access to care.

3.3 The Ministry of Health ("**MOH**") has similarly recognised this:[23]

> Funding from private insurers plays an important role in building private capacity which also helps deliver publicly funded care procedures and diagnostic services… [there is an] important contribution of the private health sector in expanding New Zealand's health system and enabling access to timely healthcare services for some New Zealanders, at a time when the public system is under pressure.

The public healthcare system is increasingly looking to also contract with private providers

3.4 In addition to privately funded procedures, the public healthcare system is increasingly contracting with private healthcare providers to perform medical procedures. As a recent report by the Westpac Economics Team has noted:[24]

> - Outsourcing has become a major part of elective surgery, shifting from a marginal practice in the mid-2000s.
> - According to Health Informatics New Zealand, private hospitals undertook 232k elective procedures for FY June 2025, including about 30k outsourced from the public system (up from 27K in the year prior and 14k a decade earlier)...
> - Government’s Elective Boost initiative aims to deliver 21k additional elective surgeries in 2025/26, largely through public-private partnerships...
> - For private providers, it offers consistent demand and assured cashflows.

[20] Hon Simeon Brown "Record health funding with patients at the centre" (28 May 2026). Retrieved from: https://www.beehive.govt.nz/release/record-health-funding-patients-centre.
[21] For example, see: Newsroom "Weekly data reveals scale of Govt's waiting list crisis" (29 April 2025). Retrieved from: https://newsroom.co.nz/2025/04/29/weekly-data-reveals-scale-of-govts-waiting-list-crisis/.
[22] RANZCOG "RANZCOG Raises Alarm Over Crisis in Access to Gynaecological Care in Aotearoa New Zealand" (2 April 2025). Retrieved from: https://ranzcog.edu.au/news/crisis-in-access-to-gynaecological-care-nz/.
[23] Ministry of Health "Aide-Memoire to Hon Simeon Brown: Meeting with Southern Cross Health Insurance" (26 June 2025) at [14] – [15]. Retrieved from: https://www.health.govt.nz/system/files/2025-11/H2025067729-Aide-Memoire-Meeting-with-Southern-Cross-Health-Insurance.pdf.
[24] Westpac "Healthcare in New Zealand: the changing role of the private sector" (10 March 2026) at p 16. Retrieved from: https://assets.dam.westpac.co.nz/is/content/wnzl/dist/all-of-bank/economic-reports/research-papers/Research-Papers_100326-Healthcare-report_bulletin_10Mar26.pdf.

New Zealand is facing significant healthcare cost inflation

3.5 As detailed at paragraph 2.4 above, New Zealand faces rising healthcare claims costs that consistently outpace general inflation. As the Westpac Economics Team has noted:[25]

> the private sector itself faces challenges, particularly rising medical inflation, which is reducing affordability, increasing insurance premiums and flattening insurance uptake…
>
> Rising costs are reflected in medical insurance premiums, which doubled from $1.6bn to $3.3bn between 2015 and 2025 despite flat membership of about 1.4m, with premiums on many policies rising by 20-30% in 2025.

3.6 The Reserve Bank has identified the escalation in healthcare costs in New Zealand in recent years as placing pressure on New Zealand private health insurers:[26]

> The health insurance sector has come under strain over the past 2 years, with sustained operating losses reducing solvency margins by nearly 40 percent. Insurers' capital levels remain well above regulatory minimums. However, ongoing cost pressures mean premium increases will be needed to restore profitability so that the sector can sustainably provide services to policyholders and support the wider health system.
>
> Escalating claims costs have been the dominant source of strain in the sector… By 2023, many health insurers were reporting quarterly losses. Claims cost escalation intensified during 2024. The persistence of these pressures required insurers to reprice substantially. From the second half of 2024, materially larger premium increases were implemented across the industry, both to recover earlier shortfalls and to restore profitability on a forward-looking basis. This contributed to strong growth in insurance revenue, with each of the past 4 quarters roughly 15 percent higher than the same quarter a year earlier. Despite this, the health insurance sector has continued to make losses to date. This reflects the lag between premium increases and the corresponding uplift in revenue, as policies are repriced gradually.

3.7 [ ]:[27]

> [ ]

3.8 As a result, the Reserve Bank has "intensified its supervision of the sector and is closely monitoring solvency trends. Health insurers are now being included in the Reserve Bank's stress-testing programme to assess resilience under scenarios of continued escalation of these pressures. The Reserve Bank is also engaging directly with health insurers to ensure that responses support both the long-term sustainability of the sector and the resilience of households and the broader financial system."[28]

3.9 In this context, the Reserve Bank has recognised the relevance of health insurers "implementing cost-management strategies. These measures intend to ensure products

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[25] Westpac "Healthcare in New Zealand: the changing role of the private sector" (10 March 2026) at pp 4 and 20. Retrieved from: https://assets.dam.westpac.co.nz/is/content/wnzl/dist/all-of-bank/economic-reports/research-papers/Research-Papers_100326-Healthcare-report_bulletin_10Mar26.pdf.
[26] Reserve Bank "Financial Stability Report November 2025" (5 November 2025) at p 48. Retrieved from: https://www.rbnz.govt.nz/-/media/project/sites/rbnz/files/publications/financial-stability-reports/2025/november/fsr-nov-2025.pdf.
[27] [ ]
[28] Reserve Bank "Financial Stability Report November 2025" (5 November 2025) at p 48. Retrieved from: https://www.rbnz.govt.nz/-/media/project/sites/rbnz/files/publications/financial-stability-reports/2025/november/fsr-nov-2025.pdf.

remain affordable and available in a high-inflation environment, but can result in narrower benefits or higher cost-sharing for customers."[29]

3.10 SCHI's engagement with gynaecology providers to participate in the AP programme is, therefore, one of our responses to these challenges. It is intended to promote more competitive and efficient pricing, protect affordability for members, and support SCHI sustainability over the long-term.

[29] Reserve Bank "Financial Stability Report November 2025" (5 November 2025) at p 48. Retrieved from: https://www.rbnz.govt.nz/-/media/project/sites/rbnz/files/publications/financial-stability-reports/2025/november/fsr-nov-2025.pdf.

4. SCHI'S AFFILIATED PROVIDER PROGRAMME

4.1 SCHI's AP programme has been in place since 1997 and is a central component of SCHI's operating model. It is a pro-competitive model to respond to the challenges outlined above of sustained healthcare cost inflation (including the Reserve Bank's identified need for "cost-management strategies" by health insurers), and to respond to the well-recognised "moral hazard" issues that can arise (if unaddressed) in insured healthcare markets.

4.2 For context, medical procedures that are not included in SCHI's AP programme are (to the extent they are covered by a member's policy) typically processed and funded on a "fee-for-service" basis.[30] "Prior Approval" from SCHI is recommended for fee-for-service procedures, which will confirm the member's policy cover and outline any excess or co-payments that the member will need to pay.[31]

4.3 In the fee-for-service model, SCHI (despite being the ultimate funder) has no effective ability to negotiate competitive prices to moderate healthcare cost escalation.[32] This model contributes to the well-recognised "moral hazard" issues in the insurance sectors that can arise because neither providers nor end-insurance customers have direct incentives to achieve efficiencies and cost savings in service delivery (given providers are not incentivised to moderate service costs, whilst end-insurance customers do not fund the healthcare services directly themselves). Economists recognise that addressing these "moral hazard" issues is in the long-term benefit of consumers – as has been articulated by Professor Danzon and (former Commission Deputy Chair) Susan Begg:[33]

> **In the long run consumers prefer health insurance contracts that control moral hazard**, since by definition moral hazard entails the use of services that yield benefits less than cost, and over time premiums must rise to cover these costly services. Consumers therefore choose policies with features such as co-payments, review of service utilisation, financial incentives and constraints on providers. Provider-targeted mechanisms have the advantage of controlling moral hazard without exposing the patient to financial risk. But when sick, each insured will resent the application of these constraints on their own use. Thus optimal insurance requires some short-run frustration of consumer demand, in the interests of achieving the best long-run trade-off between premium cost and access. However, it is very difficult for an external monitor to distinguish cost-effective rationing from the failure to maximise output within the budget constraint. In competitive insurance markets consumers who feel that the rationing is inappropriate can switch to an insurance scheme that relies more on co-payment or simply has fewer constraints and so costs more.

4.4 By contrast to fee-for-service procedures, the AP programme is based on negotiated agreements between SCHI and healthcare facilities (typically hospitals), under which prices are agreed for contracted procedures provided to SCHI members. Those hospitals/facilities, in turn, contract with the relevant clinical professionals (including surgeons and anaesthetists) to deliver the procedure. Surgeons practising within those facilities are recognised within the AP framework as "**Listed Providers**" to perform the surgical procedures.

[30] For "fee for service" procedures the various providers involved in performing a healthcare procedure for a member charge their chosen fee, some or all of which SCHI will reimburse in accordance with the relevant member's policy terms and conditions.
[31] Note that "Prior Approval" in the fee-for-service context is confirmation from SCHI to the member that the member has cover for the proposed procedure under their policy terms and conditions, as opposed to that being an assessment or endorsement of the proposed cost of the procedure.
[32] [ ]
[33] Professor Patricia Danzon and Susan Begg "Options for Health Care in New Zealand" (April 1991) at p 19. Retrieved from: https://www.nzinitiative.org.nz/reports-and-media/reports/options-for-health-care-in-new-zealand/document/240. [Emphasis added].

4.5 A key feature of AP agreements is that pricing (including any permitted increases over the term) is agreed upfront with the relevant hospital/facility, typically by reference to objective health sector metrics and/or economy-wide inflation measures.[34] This contrasts with fee-for-service procedures, where there is no mechanism to agree how prices change over time, resulting in greater variability and, in practice, materially higher rates of cost escalation.

4.6 Importantly, the AP programme is optional to enter and does not impact hospitals/facilities competing for specialists who deliver care within their hospital/facility.[35] Rather, through the AP programme SCHI can negotiate a competitively agreed price for the procedure as a whole, within which the relevant hospital/facility retains discretion to structure delivery, manage costs, determine the specialists who they contract with, and compete on efficiency and service quality with other hospitals/facilities.

4.7 AP agreements between SCHI and a hospital/facility are negotiated bilaterally between SCHI and the relevant hospital/facility, and they do not restrict hospitals/facilities from contracting with other funders (including Health NZ, ACC, or other private insurers) or from treating non-SCHI patients on different terms.

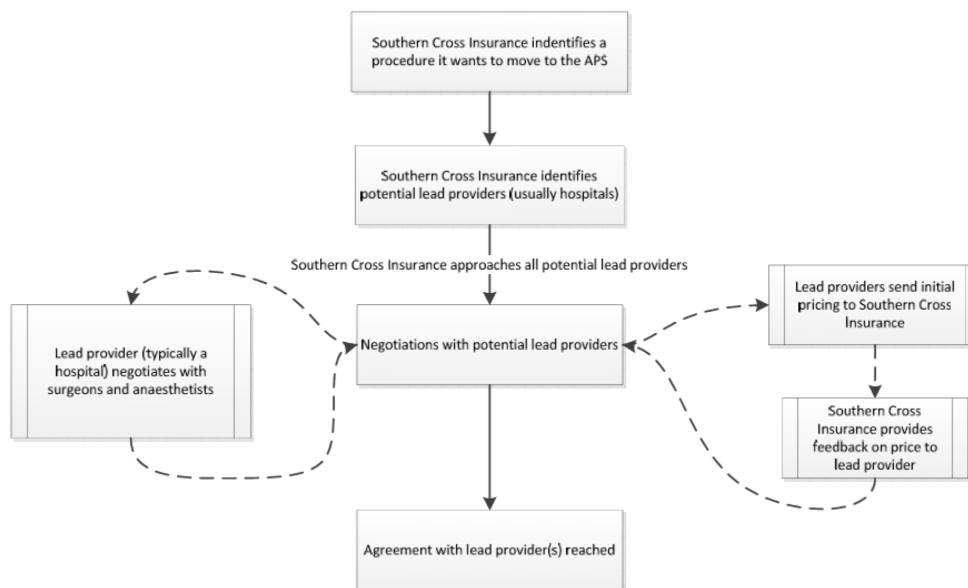
4.8 The Commission has previously (and accurately) described the operation of the AP programme in the following way:[36]

> Under the APS Southern Cross Insurance agrees a fixed price for a procedure with a lead provider. The lead provider is usually a private hospital. Southern Cross Insurance negotiates APS pricing with the hospital, with renegotiation typically occurring every two or three years.
>
> The hospital is responsible for obtaining and paying for the other services necessary to provide the procedure, such as the surgeon and anaesthetist. The negotiations between the hospitals and the surgeon and anaesthetist are held independently of Southern Cross Insurance. There are either formal contracts or verbal agreements between the hospital and the surgeon, and the hospital and the anaesthetist, which determine the price each is paid.

4.9 The Commission has usefully previously published the following diagram to illustrate the process of SCHI seeking to move a fee-for-service procedure to its AP programme:[37]

[34] Within AP agreements, SCHI typically will reach agreements with hospitals/facilities on cost increases that can occur during the term of the AP agreement [ ]. ([ ]).
[35] This demonstrates that the Application is incorrect in its suggestion that transitioning to an AP programme "implies an understanding between at least some hospitals to stop competing for surgeons to operate that their hospitals" (as suggested at paragraph 1.7 of the NZGA Application). Hospitals/facilities will continue to compete for gynaecology surgeons, in the same way that they continue to compete for other specialists.
[36] *Connor Healthcare Limited and Acurity Health Group Limited* [2014] NZCC 39 at [70] and [71].
[37] *Connor Healthcare Limited and Acurity Health Group Limited* [2014] NZCC 39 at Figure 2.

Figure [1] – Commission illustration of moving fee-for-service procedures to the AP programme



Source: Commerce Commission

4.10 As demonstrated by this Commission commentary, the AP programme is not new nor specific to gynaecology surgery. The AP programme was first introduced by SCHI in 1997, and since then SCHI has agreed AP agreements with more than 2,500 healthcare providers nationwide, spanning more than 30 clinical specialties.

4.11 In gynaecology specifically, SCHI already has [ ] contracts with [ ] providers across consultation, rooms-based and surgical services, including [ ] gynaecology surgeons working within [ ] existing surgical AP agreements. Since gynaecology consultations moved into the AP programme in 2017, the number of consultation AP contracts has increased by [ ]%, the number of unique providers by [ ]%, and the number of service locations by [ ]%. In relation specifically to [ ].

4.12 The above growth in the AP programme is inconsistent with any suggestion that the AP model suppresses supply or lacks provider support. Rather, SCHI's experience is that the AP programme supports sustainable provider participation while moderating cost growth: within AP agreements, annual price increases [ ]. By contrast, fee-for-service procedures are not subject to agreed escalation parameters and have, in practice, exhibited materially higher and more variable rates of cost growth over time.

4.13 The above also highlights that the Application's reference to a 2004 Commission decision[38] to characterise how the private healthcare sector operates today is out-dated and does not reflect current sector dynamics. As outlined in this submission, in the intervening period, the AP programme has become an established and widely adopted mechanism for funding specialist procedures, underpinning competitive pricing and provider participation across multiple specialties. The Commission's assessment of competitive effects must be grounded in current evidence of how the sector operates in practice, rather than historical assumptions that no longer reflect the sector.

[38] Application at paragraph 5.1, referring to *Southern Cross Oxford Hospital Limited and the Oxford Clinic* NZCC Decision No. 537 (2004) at [37] – [39].

4.14 There are a number of benefits to all sector participants of SCHI negotiating AP contracts with providers:

(a) For SCHI:

(i) Addressing healthcare cost escalation: SCHI has found that the AP programme assists it to address healthcare cost escalation (in particular, in comparison to fee-for-service procedures) by enabling it the opportunity to negotiate efficient and competitive outcomes with providers, to mitigate non-competitive healthcare cost escalation and to address the "moral hazard" issues described above. In the absence of negotiating AP agreements (for example, in relation to fee-for-service procedures), SCHI considers that there are insufficient incentives on healthcare providers to compete on price or innovation to reduce the overall cost of healthcare. As set out at paragraph 4.4 above, in negotiating AP agreements, SCHI will [ ], which supports premium affordability and long-term sustainability. The success of the AP programme in addressing healthcare cost escalation is shown in Figure [2] below, which compares the cost inflation in two AP-only [ ] procedures ([ ])[39] since 2012 compared to the cost inflation in a predominantly fee-for-service [ ] surgery ([ ])[40] over the same period. As the Commission will see, the cost inflation in [ ] over that period has been [ ], compared to [ ] in the two AP-only procedures. (For further comparison, as noted at paragraph 5.2(a) below, gynaecology surgeon fees charged for hysteroscopy procedures have increased by approximately [ ]% cumulatively since 2011). Figure [8] further below also illustrates this point - it shows that surgical procedures [ ]

Confidential Figure [2] – [ ]

(ii) Standardised coding and claims processing: In negotiating AP agreements, SCHI will look to agree standardised treatment codes and claims processes. Under the fee-for-service model, there is no standardised way in which surgeons describe surgery procedures in invoices that are remitted to SCHI for payment. There is also no automated system for invoices to be uploaded to SCHI. This means that, compared to the AP programme, fee-for-service claims require more manual processing and oversight, which results in inefficiencies.

(iii) Drive innovation in healthcare delivery: There are insufficient incentives or competition signals in the provision of fee-for-service procedures to drive innovation to reduce the overall cost of healthcare. SCHI sees its AP programme as the primary avenue to incentivise and encourage new technologies in the provision of healthcare for its members. Reflecting this, in the last five years SCHI has funded [ ] million on approved new health technology procedures,[41] [ ] of which were introduced through the AP programme. [ ]

(iv) Better data collection: Standardised coding also provides SCHI with better ability to gather consistent data, and benchmark costs and member

[39] For both, [ ] of procedures were performed within the AP programme in FY2025.
[40] For [ ], only [ ] of procedures were performed within the AP programme in FY2025.
[41] GST inclusive.

healthcare outcomes over time, which in turn enables the development of more refined code sets over time.

(b) For SCHI members:

(i) Mitigating premium cost increases: By negotiating competitive and efficient pricing with providers, the AP programme can mitigate the impact of healthcare cost escalation and support the affordability of insurance premiums for its members (as well support the affordability of "out of pocket" healthcare costs for SCHI members on SCHI's co-pay "RegularCare" and "KiwiCare" policies).

(ii) Supporting ongoing access to insurance cover: By supporting the affordability of insurance premiums, the AP programme supports members to maintain their health insurance cover.

(iii) Driving innovation in healthcare: As set out above, the AP programme assists in driving innovation in the provision of healthcare in New Zealand, for the benefit of our members.

(iv) Easier prior approval and claiming. Where a member uses an AP provider, the AP provider takes care of the prior approval and claiming processes on behalf of the member. This means that the member does not have to submit a prior approval request.

(v) Certainty of cost. Agreed upfront prices between SCHI and the AP provider means that, in most cases, the member knows up-front how much, if anything, they will have to pay for their treatment.[42]

(c) For AP providers:

(i) Certainty of prices. Prices for services are agreed during the contracting process, so providers have certainty of payment amounts.

(ii) Improved cash flows. Compared to fee-for-service procedures where claims and then payments can take some time to process, SCHI generally makes payment to AP providers within two business days of the provider requesting payment.

(iii) Online administration. SCHI operates an online system for AP providers, which makes applying for prior approval and requesting payments easy.

(iv) Dedicated support. SCHI offers AP providers partnership managers and relationship managers to provide a direct point of contact at SCHI.

(v) Promotion. SCHI encourages members to seek referral to AP providers where possible.

(d) For Listed Providers (such as surgeons that have contracted with an AP contracted hospital/facility):

[42] Some SCHI policies either include excesses or co-pay portions, which mean members can be required to make a certain payment in relation to healthcare treatments.

(i) <u>More certainty of cash flows</u>. Under the fee-for-service model, a specialist may experience delays in payment if the patient is slow to claim from their insurer or due to the more manual claims assessment process. Under the AP model, the hospital/facility receives payment directly from SCHI (generally within two business days of the provider requesting payment) and in turn pays the specialist under their agreed terms, which provides specialists with greater certainty of cash flows compared to the fee-for-service model.

(ii) <u>Reduced administrative burden</u>. Under the AP model, the hospital/facility (as the lead provider) manages the prior approval process with SCHI, the claims submission, and the invoicing on behalf of the specialist. The specialist does not need to manage individual claims (for example, by obtaining fee quotes from hospitals/facilities to provide fee estimates to the member to seek prior approval). This materially reduces the administrative burden on specialists and means that the specialist does not have any "bad debt" risk in relation to any portions being funded by the member (as it is the responsibility of the hospital/facility to collect those payments).

(iii) <u>Certainty of prices</u>. While SCHI is not party to agreements between a hospital/facility and a Listed Provider, SCHI presumes that those parties will reach agreement on prices for a certain period of time, which provides Listed Providers with certainty of their prices.

4.15 For its part, the Commission has recognised the pro-competitive and consumer benefits of the AP programme. For example:

(a) In *Southern Cross Hospitals / Aorangi Hospital* (2011), the Commission found that the AP scheme "provides all parties with certainty in respect of pricing" and would limit the ability of the merged hospital entity to raise prices.[43]

(b) In *Connor Healthcare / Acurity* (2014), the Commission described the AP programme as "an important development in the provision of private health insurance" and recorded SCHI's submission that "historical comparisons suggest future inflation is better moderated within a contracted procedure compared to that previously charged under a fee-for-service."[44] The Commission found that "by making the procedures AP only, Southern Cross Insurance is aiming to bring outlying prices closer to the market rate."[45]

4.16 This demonstrates that there are a number of public benefits that will be achieved from SCHI transitioning fee-for-service procedures to its AP programme through a competitive process.

[43] *Southern Cross Hospitals Limited and Aorangi Hospital Limited* NZCC Decision No. 729 at [81] and [107].
[44] *Connor Healthcare Limited and Acurity Health Group Limited* [2014] NZCC 39 at [65] and [67].
[45] *Connor Healthcare Limited and Acurity Health Group Limited* [2014] NZCC 39 at [69].

5. THE BENEFITS OF SCHI'S GYNAECOLOGY AP PROJECT

5.1 While SCHI already has reached AP agreements with a number of providers in relation to certain gynaecology related healthcare services (see paragraph 4.11 above), during 2025 it identified the need to transition its funding of gynaecology surgery to be under its AP programme as an AP-only service. This proposed transition of gynaecology surgical benefits to AP-only, would be reflected in SCHI's applicable insurance policies and see SCHI only funding gynaecology surgery when performed under an AP agreement (meaning SCHI would no longer fund fee-for-service gynaecological surgeries for its members).[46]

5.2 This proposed transition is for the following reasons:

(a) Cost escalation to SCHI over the past 10 years in relation to gynaecology surgery has become unsustainable, and has been contributing to significant upward pressure on SCHI's premiums to members. SCHI's claims data shows that gynaecology surgeon fees charged for [ ] procedures have increased by approximately [ ]% cumulatively since 2011, compared to cumulative CPI growth of approximately 50% over the same period. See Figure [3] below. The total procedure costs to SCHI (including surgeon, anaesthetist and facility fees added together) for [ ] and [ ] surgery (which both remain more than [ ] funded via fee-for-service claims), have also increased significantly in excess of cumulative CPI. By comparison, the [ ] total procedure price (which includes surgeon, anaesthetist and facility fees), and is performed within the [ ] speciality and moved to the AP programme in [ ], has had much lower cost increases that are much closer to the cumulative CPI. See Figure [4] below.

Confidential Figure [3] – [ ]

Confidential Figure [4] – [ ][47]

(b) SCHI identified that the fees currently being charged by a number of gynaecology surgeons under the fee-for-service model are significantly above what could be considered competitive or efficient prices, [ ]. Demonstrating this:

(i) Escalation in gynaecology surgery costs in recent years have been much higher [ ] See Figures [5] and [6] below. Importantly, this comparison looks at surgeon fees only (excluding facility, theatre and related costs), [ ]. On this basis, the data [ ].[48] As the Commission will see, [ ] Figure [8] below also similarly illustrates that [ ]

Confidential Figure [5] – [ ][49]

[46] Except for members covered under "UltraCare" policies - see paragraph 7.4(b) below.
[47] As noted at paragraph 5.2(a), [ ] and [ ] surgery both remain more than [ ] funded via fee-for-service claims). By comparison, the [ ] procedure moved to the AP programme in [ ].
[48] In this respect, we note that paragraph 16 of the Commission's Statement of Preliminary Issues ("**SOPI**") is incorrect. That paragraph states that "The gynaecologist incurs the facility fee and passes this onto the patient, either directly or indirectly through their service fees". However, that is not how pricing works in relation to fee-for-service gynaecology surgery fees funded by SCHI on behalf of its members. Rather, a gynaecology surgeon will bill the member (and, therefore, ultimately SCHI) their surgery fee. The relevant hospital/facility will bill the member (and, therefore, ultimately SCHI) its hospital/theatre fee and the separate anaesthetist fee. In relation to SCHI funded procedures, the gynaecology surgeon does not incur the facility fee or the anaesthetist fee. See footnote 3 for additional context.
[49] [ ]

Confidential Figure [6] – [ ][50]

(ii) Despite these significant increases in gynaecology surgery costs, SCHI cannot identify any commensurate increase/improvement in patient outcomes. For over 10 years SCHI has run a quality/outcome survey programme through which SCHI seeks to understand the value our members find healthcare treatment,[51] and (consistent with international experience) SCHI has observed no correlation between surgical price and these quality/outcome metrics. In relation to gynaecology surgery specifically, SCHI's member survey data shows that:

(aa) despite gynaecology surgery prices significantly increasing over the past decade in New Zealand, SCHI has seen no material shift in patient reported outcomes to match the rising cost of service. See Figure [7].

(bb) Despite gynaecology surgery prices being [ ] in New Zealand, gynaecology patients rate their outcome and experiences [ ].

Confidential Figure [7] – [ ]

(iii) There are significant variations in gynaecology surgery costs charged to SCHI by some gynaecology surgeons compared to others, suggesting some surgeons are charging prices significantly higher than competitive or efficient prices. This is shown in Figure [8] below. Gynaecology surgeon fee ranges from approximately [ ] per hour to [ ] per hour.[52] Those significant variations exist even within specific geographic regions. See Figure [9] below, which uses hysterectomy surgical pricing as an example of this variation within regions. Such variations are not consistent with outcomes that would be achieved in a competitive market, where prices would be expected to converge towards efficient cost levels, as providers facing competitive discipline would be unable to sustain materially higher prices than their peers for equivalent services. SCHI does not consider that there are any quality or outcome related reasons that could justify such differences. Demonstrating this, [ ], demonstrating a misalignment between cost and member value.

Confidential Figure [8] – [ ][53]

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[50] [ ]
[51] On average SCHI collects 20,000 results from across 30 hospitals/facilities and 1,000 clinics per year. The survey results represent a member perspective of value for the $1.7 billion paid out in healthcare claims each year.
[52] GST exclusive.
[53] [ ]

- [ ]
- [ ]
- [ ]

[ ]
[ ]

- [ ]; and
- [ ].

[ ]

Confidential Figure [9] – [ ]

(iv) [ ]. Reflecting this, under the fee-for-service model, the median gynaecology surgeon fee is [ ] per hour, compared to [ ][54] [ ][55] See Figure [10] below, which shows that [ ].

Confidential Figure [10] – [ ][56]

(v) On average, gynaecology surgery costs charged by surgeons to SCHI under the existing fee-for-service model are significantly higher than comparable gynaecology surgery costs in other countries. By way of example:

(aa) the published Irish Life Health 2024 fee schedule listed the participating consultant surgeon rate for a laparoscopic hysterectomy at €1,625[57] (approximately NZ$2,902).[58] By comparison, SCHI's average fee-for-service surgeon fee in 2024 for a comparable procedure (laparoscopic hysterectomy +/- BSO and Stage 3 endometriosis) was approximately [ ][59] — almost [ ] times the comparable Irish rate.

(bb) [ ][60] [ ][61] [ ].[62] [ ] See Figures [11] and [12] below.

Confidential Figure [11] – [ ][63]

Confidential Figure [12] – [ ]

(vi) Gynaecology surgery costs charged by certain surgeons to SCHI are significantly higher than gynaecology surgery costs payable by ACC for comparable procedures. For example, applying the ACC published per-minute rate calculator (at a rate of $32.24 including GST per minute) to the same laparoscopic hysterectomy procedure (based on SCHI's historical average theatre time of [ ] minutes), the equivalent ACC surgeon fee would be approximately [ ], which is less than [ ] the fee currently charged by gynaecology surgeons to SCHI in more than [ ] of claims for the same surgical procedure.

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[54] All these figures are GST exclusive.
[55] [ ]
[56] [ ].
[57] Exclusive of GST/VAT. Irish Life Health "Gynaecology – Schedule of Benefits for Professional Fees" (2024). Retrieved from: https://www.irishlife.ie/health-insurance/providers/sobfpf-2024/
https://assets-eu-01.kc-usercontent.com/ffd8d21b-ebd4-0151-55d5-297335c8f50f/eb501bf4-852f-4de6-a198-f508e60324b2/ILH_SOB_Gynae_2024_v1.pdf
[58] NZD/EUR = 0.56 as at 30 June 2024. A similar result would be reached using a PPP conversion. The world bank reports USD PPs of 1.46 and 0.74 respectively for New Zealand and Ireland. The PPP conversion rate to NZD is therefore 1.46/0.74 = 1.973, giving a conversion of NZ$3,206.08. PPPs sourced from: https://data.worldbank.org/indicator/PA.NUS.PPP?locations=NZ-IE&name_desc=false
[59] GST exclusive.
[60] [ ]
[61] [ ].
[62] [ ].
[63] [ ]

- [ ]
- [ ]

(vii) [ ]

5.3 In this context, SCHI identified that:

(a) engaging in a competitive negotiation process with hospitals/facilities to transition gynaecology surgery into the AP programme would [ ][64] [ ],[65] and therefore assist in supporting SCHI's women members to access timely and appropriate gynaecological care, while mitigating increases in premiums; and

(b) by contrast, if SCHI does not take action to address the current trajectory of gynaecology surgery cost escalation, those costs will continue to flow through to members. In practical terms, over time: either premiums would need to increase at a higher rate to absorb those costs, or the scope of cover for gynaecology services would need to be reduced to maintain affordability. Both outcomes would adversely impact members either through reduced access to insurance or reduced access to care, with disproportionate consequences for women requiring gynaecological treatment.

5.4 Accordingly, the proposed transition of gynaecology surgery into the AP programme is a proportionate and pro-competitive response to the issues identified above. It is directed at restoring competitive pricing discipline and aligning costs more closely with efficient and sustainable levels, while maintaining access to timely and appropriate care for members. In doing so, the AP model supports a balanced outcome across the system, protecting affordability for members, supporting ongoing access to insurance cover, and providing a sustainable funding framework for providers. This is consistent with the Commission's previous recognition that the AP programme delivers pro-competitive and consumer benefits, including price certainty and cost containment.

[64] GST exclusive.
[65] [ ]

PUBLIC VERSION

6. THE PROGRESS OF SCHI'S GYNAECOLOGY AP PROJECT

6.1 Given the rationale outlined above, SCHI commenced its process in August 2025 to explore the transition of gynaecology services into the AP programme. From the outset, SCHI has sought to take a structured and consultative approach, including engaging with hospitals/facilities and gynaecology surgeons, and making information available to support informed participation in the process. SCHI does not accept the NZGA's assertion that there has been an information asymmetry disadvantaging gynaecology surgeons. SCHI has proactively provided detailed information regarding the proposed model and rationale for the transition, and has made repeated efforts to engage directly with gynaecology surgeons to explain the approach and respond to questions. SCHI has been engaging and responding to questions from hospitals/facilities and gynaecology surgeons.

6.2 In summary, that process has involved the following:[66]

(a) In August 2025 SCHI sent initial communications to hospitals/facilities and gynaecology surgeons advising of its intent to begin a project to move gynaecology surgery to being an AP-only service under SCHI policies.[67] Those communications were seven months before SCHI's original (but subsequently deferred) target date of March 2026 for the completion of the project, reflecting an intention from SCHI to allow time for consultation and negotiation.

(b) From September 2025 onwards, SCHI commenced AP negotiations with a number of hospitals/facilities and held multiple face-to-face and online meetings with individual gynaecologists and hospitals/facilities. The process has also included consultation with gynaecologists and RANZCOG in relation to clinical considerations in SCHI developing its code set for the AP programme.

(c) In response to clinical considerations raised by gynaecologists and RANZCOG, SCHI made a number of changes to its originally proposed code set and informed both gynaecologists and RANZCOG of those changes. On 14 November 2025 SCHI provided a detailed 6-page written response to RANZCOG addressing each concern raised (including missing procedures, combined procedures, variation in complexity, and surgical assistants), and explaining the mechanisms built into the code set (including open codes and risk corridors).[68] RANZCOG subsequently acknowledged the improvements made, stating: "We appreciate the careful consideration given to our advice and the improvements made to the code set".[69]

(d) SCHI further responded to RANZCOG on 11 March 2026 in relation to specific concerns about urogynaecology and gynaecological oncology codes, explaining that the "open code" mechanism remains the most appropriate funding approach pending development of further claims data, and confirming that "further refinement of these sub-specialty codes will be enabled as more detailed data becomes available, supporting greater pricing precision".[70]

(e) SCHI agreed to a meeting with the newly formed NZGA in January 2026. SCHI attended that meeting on the understanding it was to discuss clinical considerations that were legitimate to discuss on a sector-wide basis. [ ][71] [ ][72]

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[66] See further, in the form of a chronology, at **Appendix One**.
[67] Except for members covered under SCHI's "UltraCare" (see further at paragraph 7.4 below).
[68] [ ]
[69] [ ]
[70] [ ]
[71] [ ]
[72] [ ]

(f) [ ] SCHI continued to engage with NZGA on clinical matters. On 26 February 2026 (one week after receiving NZGA's letter raising clinical concerns), SCHI provided a substantive written response:

(i) clarifying that pelvic floor procedures are included within the AP programme and funded through open codes;

(ii) amending the photographic evidence requirement for endometriosis procedures so that detailed clinical documentation may be provided in lieu of photographs where consent is not given; and

(iii) inviting NZGA to submit a detailed proposal on clinical documentation standards by 13 March 2026.

SCHI expressly confirmed its commitment to "working constructively with gynaecology surgical providers" and to having "a long term, sustainable and mutually beneficial relationship with providers under the AP Programme".[73]

(g) In February and March 2026 SCHI prepared and distributed:

(i) an "AP Training Guide for Surgeons" and an "AP Training Guide for Facilities" to assist providers with understanding how the codes and agreements were proposed to work in practice; and

(ii) a Provider Matrix showing which AP codes can be claimed together, and a Detailed Pelvic Floor Code Principles guide.

(h) Hospitals/facilities, as lead entities, have also been advising surgeons during their negotiations about how the AP programme works in practice.

(i) During this time [ ][74] Of particular relevance, the pricing being negotiated by SCHI with hospitals/facilities for the relevant gynaecology surgeries[75] reflects a balanced and sustainable approach. [ ]

(i) [ ] and

(ii) [ ] See Figures [13] and [14] below.

[ ] See Figure [15] below. This demonstrates that SCHI's approach therefore does not seek to suppress pricing below sustainable levels, but rather seeks to negotiate prices that better align with efficient/competitive levels without compromising member access or affordability.

Confidential Figure [13] – [ ]

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[73] [ ]

[74] The Application's implied assertion of "association" (paragraph 2.18) or "affiliation" (paragraph 1.7) between SCHI and Southern Cross Healthcare Limited ("**Southern Cross Hospitals**"). Southern Cross Hospitals is a separate independent entity from SCHI, all contract negotiations with Southern Cross Hospitals (as with other hospitals, facilities, and APs) are conducted on an arm's-length basis, and SCHI is committed to treating all hospitals, facilities, and APs on an arm's length commercial basis, taking into account the features of their specific offering (including location, volume, service types, etc). [ ]

[75] Which is for the total "package" – i.e. includes the hospital/facility fee, gynaecology surgeon fee, anaesthetist fee, and other relevant costs.

Confidential Figure [14] – [ ]

Confidential Figure [15] – [ ][76]

6.3 Against that backdrop, the AP transition process reflects a constructive effort by SCHI to provide information, enable engagement, and support hospitals/facilities and gynaecology surgeons to make informed decisions regarding participation, while also maintaining the integrity of a competitive procurement and negotiation process.

6.4 Despite all the steps outlined above, SCHI's experience was that there was unusual resistance from gynaecology surgeons to engaging with hospitals/facilities in relation to the AP programme.[77] Over this period [ ]

6.5 [ ]:

(a) [ ]; and

(b) [ ]

6.6 [ ]:

(a) [ ];

(b) [ ]; and

(c) [ ]

6.7 In the context of the above, SCHI has adopted a measured and flexible approach to the Gynaecology AP Project. The original indicative timeline of approximately seven months was extended by a further two months in response to feedback, and SCHI has subsequently moved away from any fixed implementation date. As at the date of this submission, there is no specified implementation date for the process, with SCHI continuing to engage and negotiate with hospitals/ facilities. [ ].

6.8 This timeline and process contradict NZGA's characterisation of a "compressed timetable". To the contrary, SCHI has allowed for an extended period of engagement, and has demonstrated a willingness to adjust the process in response to feedback. The duration and flexibility of the process reflects an intention to facilitate, rather than constrain, participation. [ ]

6.9 There are also a number of other characterisations in NZGA's Application of the process that are incorrect:

(a) It is not correct to say that SCHI is seeking to implement "uninformed common pricing"[78] for all gynaecology services. Under the AP programme,

[76] [ ]
- [ ]
- [ ]

[77] [ ].

[78] As suggested at paragraph 2.20 of the Application.

hospitals/facilities may agree different pricing with different surgeons for the same procedure. SCHI has not imposed a single fixed gynaecology surgery fee across all hospitals/facilities - pricing forms part of individual negotiations between the relevant hospital/facility and its surgeons, which could include hospitals/facilities agreeing different prices with different gynaecology surgeons.[79] Furthermore, SCHI has been engaging in careful negotiations and consideration (including international benchmarking) as it seeks to reach AP funding arrangements with hospitals/facilities. Therefore, contrary to the Application's assertion, it is not SCHI's AP programme that would remove "price signals" in the sector, but rather it would be the proposed Competitor Coordination that would remove those price signals (by enabling price coordination across ~90% to 100% of gynaecology surgeons).

(b) It is not correct to say that SCHI "initially refused to engage"[80] with gynaecologists or that there has been a "lack of engagement" by SCHI.[81] The evidence shows that SCHI has had significant engagement with individual gynaecologists throughout, including face-to-face meetings with surgeons and facilities from September 2025. Furthermore, following receipt of NZGA's letter of 19 February 2026 raising clinical considerations, SCHI provided a substantive written response on 26 February 2026 addressing each clinical issue, and amending SCHI's position on photographic evidence requirements (accepting clinical documentation in lieu of photographs).[82] [ ]

(c) It is not correct to assert that SCHI has provided "no clarity about the scope of any contracts" under the proposed AP programme. As detailed at paragraph 6.1 above, SCHI has gone to great lengths to provide information to, and consult with, gynaecology surgeons.

(d) It is not correct to assert that SCHI seeking to transition gynaecology surgery to an AP programme is "radical"[83] or is seeking to "invert" the standard contracting model. As outlined at Section 4 above, the transition of gynaecology surgery into the AP programme is consistent with SCHI's well-established model. To the contrary, it is NZGA that is seeking a "radical" contracting model, complaining that SCHI has not wanted to negotiate commercial arrangements with competing gynaecology surgeons on a collective basis,[84] and now seeking to engage in the Competitor Coordination.[85]

(e) It is not correct to say that SCHI's AP programme could "restructure patient relationships",[86] "weaken" patient/clinical relationships,[87] "adversely [impact] the patient/clinician relationship",[88] interfere with "independent clinical decision making",[89] that SCHI's proposed contracting model will "not account for the qualitative aspects of surgery",[90] that the transition to SCHI's AP contracting

[79] The suggestion to the contrary in the Application (for example, at paragraph 1.2) is incorrect.
[80] As suggested at paragraph 1.4 of the Application.
[81] As suggested at paragraph 1.3 of the Application.
[82] [ ]
[83] As suggested at paragraph 2.14 of the Application.
[84] For example, NZGA complains in its Application that: "SCHI has declined to engage on a specialty-wide basis citing competition law concerns" (see paragraph 4.6).
[85] The implied (but vague) assertions of potential "hub and spoke" concerns (at paras 2.14(d), 5.57, and footnote 76) are also incorrect. As noted, SCHI's AP contracting programme is tried and tested, and gynaecology surgeons would negotiate and agree the terms of their own Listed Provider contractual relationship with a hospital/facility. See footnote 35 of this submission.
[86] As suggested at paragraph 2.6 of the Application.
[87] As suggested at paragraph 2.9 of the Application.
[88] As suggested at paragraph 1.2 of the Application.
[89] As suggested at paragraph 2.17 of the Application.
[90] As suggested at paragraph 2.20(a) of the Application.

programme may adversely impact clinical outcomes,[91] or that the Competitor Coordination could result in improved standards of care.[92] Each of the matters raised at paragraph 2.19 of the Application have been carefully considered and consulted on during SCHI's negotiation and consultation process (see above), and SCHI's AP programme has successfully operated to the benefit of SCHI's members and the New Zealand health system across many other specialties since 1997. Further:

(i) The proposed AP Agreement expressly provides[93] that Listed Providers "remain solely responsible for all decisions relating to the medical care of the Member, as well as their treatment" and that "the traditional relationship between the Listed Provider and the Member, and the Listed Provider's obligation to exercise independent medical judgement in providing the Services is not affected in any way by the existence or terms of this agreement."

(ii) The code set for the proposed AP programme would cover all procedures that SCHI currently funds as fee-for-service procedures. That is because irrespective of the funding model used (AP or fee-for-service), SCHI provides the scope of cover to its members as provided for in the relevant member's policy terms and conditions.

(iii) The proposed AP programme would include the implementation of "open codes",[94] “add-on” codes,[95] "risk corridors",[96] and "top up" mechanisms.[97] These are not novel concepts to surgeons and facilities – they are used by SCHI in a number of AP agreements (as well by ACC).[98] SCHI’s claims data demonstrates that these mechanisms are well understood and used regularly across specialties:

(aa) In the last 12 months add-on codes have applied to approximately [ ] of eligible services under the AP Programme for all specialties.

(bb) In the financial year to date (approximately 11 months), SCHI has accepted [ ] top-up claims under the AP programme for all specialities, representing an [ ] acceptance rate of all top-ups requested.

(cc) SCHI has been using “risk corridors” in its AP agreements for [ ] surgery for [ ]. In the last 12 months [ ] instances have been paid using the risk corridors in [ ] surgery AP agreements.

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[91] As suggested at paragraph 2.19 of the Application.
[92] As suggested at paragraph 11.25 of the Application.
[93] SCHI template gynaecology AP Agreement, clause 3.4.
[94] "Open codes" refer to procedures that do not have an agreed fixed contracted price. They are reimbursed on a time and cost basis. These open codes ensure that clinical decision-making is not constrained by coding limitations - surgeons can perform whatever procedure is clinically indicated, and if the procedure is covered by SCHI’s policy terms and conditions, they can claim funding through the open code mechanism.
[95] “Add-on” codes allow access to additional funding.
[96] "Risk corridors" mechanisms are built into AP agreements allowing for additional funding when theatre time exceeds agreed durations.
[97] “Top-up” mechanisms are a mechanism that allows for additional funding to be considered where case complexity falls outside the expected scope of what is already covered under the AP agreement. “Top -Ups” will be reviewed and considered on a case-by-case basis via an application.
[98] Providers can either choose a primary fixed procedure code that covers all applicable procedures included in the service description, or for secondary procedures not covered under a primary fixed procedure code, they can choose either an applicable add-on code, another applicable separate procedure code or an open code.

(iv) Contrary to the assertions in the Application, the gynaecology surgery specialty is not unique compared to other specialties where SCHI's AP programme has been successfully implemented. Many of the factors mentioned in the Application (including differing surgical complexities, medical co-morbidities, high BMI, patient factors, post operative pain and nausea) are common to all specialties. It is SCHI's standard approach to AP contracting to take account of these factors in its proposed pricing, and in the current instance SCHI has included complexity factors in its pricing and benchmarked to surgeries with similar surgical complexity and medical co-morbidities.

(v) The proposed AP programme would not impact on the clinical decision about whether a patient is treated in the private or public system.[99] That decision is not determined by price or the code set, but by whether the surgery and aftercare can be delivered safely in a private setting. It remains a clinical judgement made in the interests of patient safety.

SCHI has explained these points in meetings with hospitals/facilities and to many surgeons. SCHI has also provided detailed written guidance in the Provider Matrix, which outlines which AP codes can be claimed together and was sent to all surgeons, and in the Detailed Pelvic Floor Code Principles guide, which was sent to facilities.[100]

(f) It is not correct to assert that SCHI's proposed AP gynaecology surgery programme may result in insufficient support for other "wrap around services"[101] or that the proposed AP transition gives rise to concerns in relation to "pre and post-operation care by surgeons, nurses and administrative staff".[102] Demonstrating this:

(i) The current AP negotiations are only in relation to gynaecology surgery procedures. Under SCHI's member policies, some of these other "services" are a separate benefit or not included in the individual member's policy. The proposed AP agreements would not stop members being offered additional services, however, they should not be billed within the surgical procedure currently being negotiated, and should be billed separately so that they can be assessed by the member and SCHI against the member's available policy benefits. For example, pre-operative consultations are already covered under a separate consultation AP agreement - they are not part of the surgical episode. In other words, the currently proposed AP transition for gynaecology surgical procedures would not prevent gynaecology surgeons from offering or charging for wrap around services – it is simply the case that they should be billed separately. That is how specialties and health insurance are supposed to operate. [ ]

(ii) SCHI acknowledges within its AP programme that surgical procedures can be complex and may require a second surgeon. In those cases, providers can discuss the circumstances with SCHI before surgery and, if a second surgeon is approved, SCHI will agree with the hospital/facility on an appropriate fee.

[99] As asserted at paragraph 2.19(c) of the Application.
[100] There were also a number of other incorrect clinical-related assertions in the Application, as responded to in **Appendix Two**.
[101] As suggested at paragraph 2.20(b) of the Application.
[102] As suggested at paragraph 2.20(c) of the Application.

(iii) SCHI has also included in the total payment to the facility a portion of that fee that can be used to fund surgical assistants where required. This fee component has been included in all prices for laparoscopic procedures (open surgery does not require a surgical assistant), even though an assistant is not required for every procedure. Where an assistant surgeon is needed, the hospital/facility can use that funding to cover the cost.

(g) It is not correct to assert that SCHI is imposing "imminent time-constraints".[103] SCHI has been being negotiating and consulting over a period exceeding eight months (from August 2025 to now), and (as noted at paragraph 6.7 above) SCHI has not confirmed or specified an AP-only effective date.

[103] As suggested at paragraph 2.8(a) of the Application.

7. NZGA'S APPLICATION OVERSTATES SCHI'S POSITION AS A FUNDER

7.1 The Application significantly overstates SCHI's position as a funder – SCHI does not have "monopsony-like" characteristics,[104] nor is there an imbalance in bargaining power.[105]

7.2 First, SCHI is only one of multiple funders and accounts for only a minority of all gynaecology procedures in New Zealand. Demonstrating this, while SCHI provides health insurance cover to approximately 60% of New Zealanders that have private health insurance, there are a number of other funders of gynaecology surgeries in New Zealand, including Health NZ; ACC; NIB; AIA; UniMed (Accuro); Partners Life; Police Health Plan; and "out-of-pocket" self-funded surgeries. The Application expressly acknowledges that clinicians "practise surgeries across multiple hospitals and across public and private settings."[106] Consistent with this, SCHI understands that approximately [ ] of the [ ] highest-billing gynaecology surgeons practise across both the public and private sectors (meaning that in addition to their billings for private gynaecology work, they also receive a salary for their full time equivalent ("**FTE**") work in the public setting). This demonstrates that gynaecology surgeons operate in a multi-channel funding environment and are not dependent on SCHI (or private insurers) alone.

7.3 Based on published data:

(a) regarding the number of gynaecology procedures that Health NZ funded during FY24; and

(b) by New Zealand Private Surgical Hospital Association Inc ("**NZPSHA**"), which suggests that approximately 20% of surgeries performed in private hospitals in New Zealand are self-funded,[107]

SCHI estimates that across both the private and public health systems it funds only ~[ ] of all gynaecology surgeries in New Zealand. See Figure [16] below.

Figure [16] – Estimates of proportion of total gynaecology surgeries by funder in New Zealand[108]

SCHI	[ ]	[ ]
Other private insurers	[ ]	[ ]
Health NZ	[ ]	[ ]
Self-funded patients ("out of pocket")	[ ]	[ ]
ACC	[ ]	[ ]
TOTAL	**[ ]**	**100%**

[104] As suggested at paragraph 5.30 of the Application.
[105] As suggested at paragraph 11.15 of the Application.
[106] Application at 5.14 (c).
[107] NZPSHA has said that: "Almost half of the patients receiving surgery in private hospitals in the past year were funded through health insurance. 17% were funded by ACC and 13% by Health New Zealand". This suggests that the remaining 20% were self-funded. SCHI does not have specific data on the proportion of gynaecology surgery that is self-funded. It could be lower than this 20% figure given it is anticipated that other surgeries (for example, plastic and orthopaedic surgeries may have a higher proportion of self-funded patients).
See: NZPSHA "Private Surgical Providers Respond to Increasing Demand" (17 September 2025). Retrieved from: https://nzpsha.org.nz/news/media-releases/7/7-Private-surgical-providers-respond-to-increasing-demand
[108] SCHI estimates.

7.4 Further:

(a) even looking just at surgeries performed in private hospitals, it is now estimated that approximately 13% to 15% of all surgeries in private hospitals are funded by Health NZ,[109] and as outlined at paragraph 3.4 above, this proportion is estimated to increase; and

(b) under SCHI's "UltraCare" policies, a member with an "UltraCare" policy can choose to use fee-for-service providers even if that specialty has become an AP-only specialty. UltraCare policies account for [ ]% of all SCHI's female health insurance members,[110] meaning the proportion of gynaecology surgeries that would be funded under the new AP programme would likely be lower than the estimates above.

7.5 Accordingly, SCHI is seeking to negotiate gynaecology surgery AP funding arrangements in circumstances where there are also a number of other funders and options for surgeons.

7.6 Second, the assertion that there is an "overwhelming" bargaining imbalance between individual gynaecology surgeons and SCHI is not correct.[111] As the Commission set out in its NZBA authorisation determination, the "relative bargaining power" of the negotiating parties depends on "several factors", including "the quality of each party's outside options", "the payoffs either party derives from walking away from negotiations", and "the costs suffered by making small concessions to the other party."[112] Applying those factors here, it is apparent that SCHI does not hold the one-sided bargaining power NZGA suggests:

(a) First, as above, gynaecological surgeons have multiple alternative revenue sources (Health NZ (both public and private work), ACC, other private insurers, and self-funded patients).

(b) Second, by contrast, SCHI’s position is constrained by its need to ensure access to care for its approximately [ ] women members across all regions. SCHI is therefore dependent on securing sufficient participation by gynaecological surgeons to provide timely and geographically accessible services. As a member-focused Friendly Society, SCHI is incentivised to agree terms that attract broad gynaecology surgeon participation to cover each region in New Zealand; failure to do so would result in gaps in access to care for members, directly undermining its core purpose. This is inconsistent with the position of a monopsonist capable of imposing “take it or leave it” terms.

(c) Third, reflecting the need for an insurer to offer coverage for each region, the Commission has previously defined regional markets for specific surgical procedures (such as gynaecology surgeries).[113] This further amplifies the countervailing power of the gynaecological surgeons given the concentrated

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[109] NZPSHA has noted the following:

> NZPSHA Chief Executive Chris Roberts says there has been a gradual increase in outsourcing volumes over the last decade, recognising that private hospitals specialise in high quality, planned care.
>
> “Combined, New Zealand’s private hospitals are performing over 20,000 surgical procedures every month. Around 3,000 of these patients each month have been outsourced by Health New Zealand. These patients receive the same high level of care as self-funded patients and those funded by health insurance or ACC.”

See: New Zealand Doctor "Budget 2026: Private Hospitals welcome increase in panned care treatments" (28 May 2026). Retrieved from: https://www.nzdoctor.co.nz/article/undoctored/budget-2026-private-hospitals-welcome-increase-planned-care-treatments.

[110] [ ]

[111] As asserted at paragraph 11.15 of the Application.

[112] *New Zealand Banking Association* [2026] NZCC 14 at [337].

[113] See for example, *Connor Healthcare Limited and Acurity Health Group Limited* [2014] NZCC 39 at [X3].

number of private gynaecological surgeons in regions across New Zealand, as shown in Figure [17] below.

Confidential Figure [17] – [ ]

(d) Fourth, gynaecology surgeons are highly-paid specialists who operate in a concentrated market where demand exceeds supply[114] and where their outside options (of performing services in relation to other funding sources) are realistic and commercially viable.

(e) Fifth, the fact that SCHI does not have monopsony power or a bargaining imbalance is also reflected in the fact that it has engaged in a long-running negotiation and consultation process spanning more than eight months.

(f) Finally, it will not be lost on the Commission that, irrespective of how it is measured, SCHI's share in the funding of gynaecology surgeries is lower than the ~90% plus share of private gynaecology surgeons that NZGA accounts for.

7.7 Collective bargaining is typically reserved only for genuinely vulnerable producers. This is not the situation of individual chicken growers dependent on a single processor.[115] The current situation relates to highly paid specialist surgeons who practise across multiple hospitals/facilities and funding streams, who operate in a concentrated sector, and whose counterparty (far from being a profit-maximising monopsonist) is a member-focused Friendly Society that is itself dependent on securing gynaecology surgeons participation to serve SCHI’s women members. The factual circumstances are not analogous to situations involving vulnerable suppliers and do not support the case for collective bargaining or a collective boycott.

[114] The Application itself estimates that "current wait times for gynaecological surgeries are more than 3 months for private practice and over a year for the public sector". See paragraph 11.4(f)(iii) of the Application.
[115] *New Zealand Tegel Growers Association Incorporated* [2022] NZCC 30.

8. SCHI'S VIEWS ON THE RATIONALE FOR THE AUTHORISATION APPLICATION

8.1 The available evidence strongly suggests that the Application is directed at preserving current fee levels, rather than addressing clinical or patient care considerations. This is reflected in the focus on maintaining existing pricing structures, notwithstanding the evidence of significant price variation, sustained escalation, and a lack of alignment between fees and patient outcomes. Demonstrating this:

(a) SCHI was willing to engage with NZGA on clinical matters (see paragraph 6.1 above). Engagement was only paused when [ ].

(b) SCHI has engaged with RANZCOG, on a sector-wide basis, to obtain and consider feedback from a clinical perspective. As noted paragraph 6.1 above, SCHI has made changes in light of that feedback, which RANZCOG acknowledged.[116]

(c) To the extent the Application is directed at facilitating clinical consultation, authorisation is not required. Clinical quality, standards, and service delivery issues can be addressed through established professional and advisory processes without the need for coordination on commercial terms between competitors.

(d) [ ][117]

(i) [ ]

(ii) [ ]

(iii) [ ]

(e) [ ]

8.2 [ ]

8.3 In this context, the Application is more appropriately understood as an attempt to preserve existing pricing levels and resist competitive negotiation, rather than as a response to clinical, workforce, or patient care concerns.

[116] [ ]
[117] [ ]

9. AUTHORISATION SHOULD BE DECLINED

The onus is on the Applicant given the significant risk of detriments from cartel conduct

9.1 In the context of an authorisation application, the onus is on the applicant to satisfy the Commission that there are sufficient public benefits to outweigh the competitive harm arising from the proposed arrangement – especially, as is the case here, where the proposed arrangement would otherwise amount to cartel conduct.[118]

9.2 This reflects the well-established position that **cartel conduct is inherently and seriously harmful** (akin to "theft or fraud"):[119]

(a) Cartel conduct harms consumers through higher prices, reduced output, and diminished innovation.[120]

(b) International evidence shows that cartels **increase prices by approximately 18 to 20% on average.**[121]

9.3 In the health context specifically, the Commission has emphasised that:

(a) "consumers must be allowed to benefit from competition in the health sector";[122] and

(b) artificially high prices for one service mean less funding for other healthcare services.[123]

9.4 There is, therefore, necessarily a high bar before the Commission can grant authorisation. As the Australian Competition and Consumer Commission ("**ACCC**") has noted in relation to proposed coordination between health specialists:[124]

> generally, agreements between competitors in relation to fees will reduce competition, resulting in increased prices or reduced quality and availability of goods or services. **Outcomes of this nature are associated with significant public detriment**. For the ACCC to consider granting authorisation for such a serious breach of the Competition and Consumer Act 2010, applicants need to show that substantial public benefits are likely to result from the proposed arrangements, as well as the existence of sufficient mitigating factors to limit the resulting detriment. **The onus is on the Applicant to put forward the factual basis to enable the ACCC to be satisfied that public benefits are likely to result, and that those benefits outweigh the likely public detriments**.

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[118] In this respect, and in response to paragraph 33 of the Commission's SOPI, it is clear that the Commission has the jurisdiction to assess the proposed Competitor Coordination given pricing and other commercial coordination, and a collective boycott, across more than ~90% of private gynaecology surgeons would plainly lessen competition, fix prices between competitors, and restrict output between competitors (i.e. would be a cartel arrangement).

[119] In introducing criminal sanctions for cartel conduct, the (then) Ministry of Economic Development stated that "cartels can be viewed as a form of **theft or fraud**, harmful to individuals and society more generally, and can be seen as morally wrong." https://www.mbie.govt.nz/assets/462b7562d4/criminalisation-of-cartels-regulatory-impact-statement.pdf [emphasis added]

[120] Commerce Commission "Cartel conduct now punishable by up to 7 years' jail time (8 April 2021)". Retrieved from: https://www.comcom.govt.nz/news-and-media/news-and-events/2021/cartel-conduct-now-punishable-by-up-to-7-years-jail-time/

[121] Commerce Commission "Cartel Leniency and Immunity FAQ". Retrieved from: https://www.comcom.govt.nz/business/avoiding-anti-competitive-behaviour/what-is-a-cartel/cartel-leniency-faq/

[122] Commerce Commission "Eye surgeons to pay $85,000 for breaching Commerce Act" (28 October 2005). Retrieved from: https://www.comcom.govt.nz/news-and-media/news-and-events/archive/eyes-surgeons-to-pay-85000-for-breaching-commerce-act/.

[123] Commerce Commission "Eye surgeons to pay $85,000 for breaching Commerce Act" (28 October 2005). Retrieved from: https://www.comcom.govt.nz/news-and-media/news-and-events/archive/eyes-surgeons-to-pay-85000-for-breaching-commerce-act/.

[124] *Australian Society of Ophthalmologists* ACCC A91360 at p i.

The anti-competitive detriments significantly outweigh any potential public benefits

9.5 The assertions in the Application that Competitor Coordination covering ~90% to 100%[125] of private gynaecology surgeons would:

(a) "not have, nor be likely to have, the purpose, effect or likely effect of substantially lessening competition";[126] and

(b) "result in little, if any detriment",[127]

are directly contrary to available evidence and standard legal and economic principles.

9.6 The proposed Competitor Coordination would result in clear, direct, and substantial public detriments. There is no credible basis on which any asserted benefits could outweigh these harms:

(a) Competitor Coordination will result in higher gynaecology surgery costs – resulting in higher premiums to members and/or reduced coverage: The inevitable and foreseeable consequence of Competitor Coordination across more than ~90% of private gynaecology surgeons is higher prices.

Collective bargaining between competitors, by its nature, reduces competitive tension and enables pricing outcomes to be set above levels that would otherwise emerge through independent competitive negotiations:

(i) The Application is directed at preserving and stabilising current fee levels, notwithstanding clear evidence of significant fee variability, sustained price escalation, and lack of alignment between cost and patient outcomes.

(ii) Removing competition between gynaecology surgeons will eliminate downward pricing pressure and constrain SCHI's ability to negotiate on a bilateral, competitive basis - directly undermining the operation of normal competitive discipline.

By contrast, the proposed transition to the AP programme is intended to address sustained gynaecology surgery cost increases to help protect affordability and access for our members over the long term. The Commission has previously recognised the AP programme as delivering these consumer benefits (see paragraph 4.15 above). The need for such intervention is underscored by SCHI's evidence that certain gynaecology surgeons are charging prices materially above competitive or efficient levels (see paragraph 5.2 above). Enabling those gynaecology surgeons to coordinate would entrench, rather than correct, those outcomes.

Furthermore, SCHI is a Friendly Society. It cannot absorb non-competitive cost increases:

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[125] The Competitor Coordination could potentially include all (100%) of private gynaecology surgeons in New Zealand given the application is framed to include "current and future" members of NZGA (see footnote 2 of the Application).
[126] As asserted at paragraph 2.23 of the Application.
[127] As asserted at paragraph 2.28 of the Application.

(iii) As noted paragraph 2.3(b) above, in 2025 approximately 94% of premiums were returned in claims [ ], creating a direct pass-through between provider costs and member premiums.

(iv) Absent action to address cost escalation, members will bear the impact. This will manifest in either higher premiums - affecting affordability and retention - or reductions in policy coverage to maintain sustainability. In practical terms, this means members downgrading cover, increasing excess levels, or exiting private health insurance altogether, with corresponding impacts on access to care.

(v) Authorising coordination across more than ~90% of private gynaecology surgeons would therefore directly undermine SCHI's ability to deliver the [ ], and would create a real and immediate risk of further price escalation beyond current levels.

Case Study: Australian Society of Ophthalmologists

The ACCC's approach in *Australian Society of Ophthalmologists* ("**ASO**") is instructive. There, the ACCC denied authorisation for ophthalmologists to collectively set fees, finding that the public detriments of fee-setting by specialists in a market with limited competitive constraints outweighed the claimed benefits.[128] The ACCC expressly noted that there is a material difference between the position of "more generalist professions" (such as general practitioners ("**GPs**") and dentists), which "have a significantly larger number of practices in each region and a substantially higher number of practitioners overall",[129] and the position of medical specialists:[130]

> The ACCC considers that, given the likelihood of relatively small numbers of competitors for the provision of ophthalmic services in many geographic areas, the lack of substitutability for many ophthalmic services and the height of barriers to entry, **the effects of any horizontal agreements between competitors in relation to price would be likely to significantly reduce existing price competition, resulting in higher prices paid by consumers for ophthalmic services and substantial detriment**…

The parallels with the present case are obvious - gynaecology surgeons are highly trained and paid specialists, operating in a concentrated sector.

In addition, it should be noted that there are factors that mean the current Application would result in even more anti-competitive detriments than the ASO application denied by the ACCC:

- the ASO application "only" applied to 60% of specialists, whereas the currently proposed Competitor Coordination would cover more than ~90% of providers;
- the ASO application was at least tied to allowing members "to reach agreements as to the fees to be charged for ophthalmic services provided within a shared practice" (meaning competition would continue between different practices), whereas the currently proposed Application would apply to all gynaecological surgeons irrespective of whether they operate within a shared practice or not (eliminating competition across more than ~90% of providers).

(b) Competitor Coordination would also undermine the other benefits of SCHI's AP programme: As outlined at paragraph 4.14 above (and as recognised by NZGA at paragraph 2.17 of its Application), there are a number of other benefits to providers and members from the AP programme, including facilitating easier prior approvals,

[128] *Australian Society of Ophthalmologists* ACCC A91360.
[129] *Australian Society of Ophthalmologists* ACCC A91360.
[130] *Australian Society of Ophthalmologists* ACCC A91360 at [162]. [Emphasis added]

claims processing, and cost certainty. If the Competitor Coordination prevented a competitive transition to SCHI's AP programme, those other efficiencies and benefits would also be undermined.

(c) Competitor Coordination will affect other funders, not just SCHI: The detriments are not just confined to SCHI and its members – authorisation would also adversely impact Health NZ, ACC, other private insurers, and their patients/customers, as well as hospitals/facilities ability to contract with gynaecology surgeons on competitive terms. That will occur because:

(i) Gynaecology surgeons charge prices to multiple funding sources; and

(ii) Collective bargaining will involve the exchange of competitively sensitive information - including information about their current pricing, cost structures, and approaches to contracting.

Once gynaecology surgeons have established a collectively negotiated "reference price" in relation to SCHI, that price will become an anchor - a floor below which no gynaecology surgeon will be willing to charge any funder. That is of even more concern in this instance given the wide variation in prices (see paragraph 5.2(b)(iii) above), which means that the highest prices will become the price floor (elevating the lower priced gynaecology surgeons up to that level). This will lead to upward price pressure across all funding sources, not just SCHI. The effect will be sector-wide cost inflation, ultimately borne by taxpayers and health insurance customers.

(d) The Competitor Coordination would entrench these collusive outcomes for a decade: The Application seeks authorisation for the Competitor Coordination for 10 years. That is a very long period of time to entrench collusion across more than ~90% (and potentially up to 100%) of gynaecology surgeons and to "lock in" in the significant anti-competitive detriments referred to above. That period would also be significantly longer than SCHI's standard AP agreement, which is usually three years in duration.

(e) [ ]: [ ]

[ ]

[ ]

[ ]

[ ]

(f) The Competitor Coordination will increase the financial pressure on private health insurers: The increased costs from Competitor Coordination will increase the financial pressure on private health insurers. Again, these are not theoretical concerns. As outlined at paragraphs 3.6 to 3.9 above, the Reserve Bank has identified that the health insurance sector has experienced sustained operating losses, with solvency margins reduced by nearly 40% over the past two years. Health insurers have had to implement large premium increases, yet the sector continues to face financial pressures (such as SCHI's $56.9 million reported health insurance deficit in the most recent financial year, and the $99.1 million reported

deficit the year before).[131] SCHI's proposed AP transition for gynaecology is precisely the type of cost-management strategy the Reserve Bank has identified as necessary to ensure sector sustainability. Authorising collective bargaining that would entrench above-market pricing directly undermines this Reserve Bank objective and will increase the financial pressures on the sector (as well increasing the Reserve Bank's costs in overseeing the sector).

(g) <u>The Competitor Coordination will increase the pressure on the public health system</u>: As outlined at paragraphs 3.1 to 3.3 above, it is recognised that private health insurance alleviates pressure on an already under pressure public health system. The Competitor Coordination (by increasing costs to SCHI and other insurers), will not only increase insurance premiums (undermining affordability) but also risks reducing existing policy coverage. That will in turn:

(i) place increased pressure on the publicly funded health system (including specifically in relation to gynaecology healthcare, but also more broadly), as members/customers who can no longer afford private insurance exit and join public surgical waiting lists; and

(ii) over time, create a self-reinforcing cycle of "adverse selection" in private healthcare insurance. As premiums rise, lower-risk members exit private insurance first, worsening the risk pool and increasing average claims costs, further driving premium increases and reducing the pool of privately funded patients (which would exacerbate the effects in paragraph 9.6(g)(i) above).

This would directly undermine the contribution that private health insurance makes to alleviating pressure on the public system.

(h) <u>The Competitor Coordination will result in adverse impacts on the health of New Zealanders</u>: The Authorisation Guidelines set out that "health" benefits can be a relevant category of benefits.[132] As immediately above, the Competitor Coordination will lead to higher insurance premiums, reduced private health insurance coverage (either cancelled policies due to increased premiums, reduced cover within policies, and/or a self-reinforcing "adverse selection" cycle), and increased pressure and wait-lists in the public healthcare system. [ ] The combined effect of the above means that any Competitor Coordination that frustrated a competitive process in transitioning gynaecology surgery to SCHI's AP programme would lead to detrimental health outcomes for New Zealanders. By contrast, there are no health benefits from the Authorisation. As detailed at paragraph 6.9(e) above, SCHI's proposed AP transition will not impact clinical decision making or independence. Other specialties have been transitioned to an AP-programme without any adverse impact on member healthcare. Figure [19] below shows that AP-only specialty surgeries receive more positive patient outcomes than the fee-for-service gynaecology surgery specialty.

(i) <u>It is not correct to assert that SCHI has an ability or incentive to depress prices below competitive levels</u>: As outlined at paragraph 5.2 above, SCHI has evidence that the prices it is currently being charged by certain gynaecology surgeons are significantly above efficient or competitive levels. Furthermore, contrary to the

[131] SCHI " Southern Cross Health Society Group annual results reflect steep increase in demand for private healthcare" (30 September 2024). Retrieved from: https://www.southerncross.co.nz/news/2024/southern-cross-health-society-group-annual-results-reflect-steep-increase-in-demand
[132] Commerce Commission "Authorisation Guidelines" (June 2023) at 75.2. ("**Authorisation Guidelines**").

assertions in the NZGA Application[133] this is not a situation where SCHI has the ability or incentive to depress prices below competitive levels. SCHI is a Friendly Society. The Commission and the Courts have recognised that ownership structure is directly relevant to whether an entity has the incentive or ability to exercise market power – for example, in relation to cooperatives.[134] SCHI is the health insurance equivalent of a consumer-owned cooperative. As a Friendly Society, it is operated for the benefit of its approximately 940,000 members. It has no shareholders, distributes no dividends, and exists solely to serve its members' interests. In theory, a profit-maximising insurer might have an incentive to depress specialist fees below sustainable levels, because the resulting cost savings would accrue as profit to shareholders. However, SCHI has no such incentive.[135] If gynaecological prices were depressed below sustainable levels, the result would be reduced access to services for SCHI's own members - the very people it exists to serve. SCHI, therefore, 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. Furthermore:

(i) There is no evidence that the transition of procedures to SCHI's AP programme results in a reduction of services being performed. To the contrary, the evidence demonstrates that when specialties transition to SCHI's AP programme, volumes of procedures performed continue to increase. See Figure [18] below.

(ii) There is no evidence to suggest that the transition of specialties to SCHI's AP programme negatively impacts patient outcomes. To the contrary, the evidence demonstrates that AP-only specialty surgeries receive more positive patient outcomes than the fee-for-service gynaecology surgery specialty. See Figure [19] below.

(iii) As outlined at paragraph 5.2(b)(ii) above, consistent with international experience, SCHI notes that it can identify no correlation between surgical pricing and quality/outcome metrics. SCHI's quality/outcome survey data shows that despite gynaecology surgery prices being [ ], gynaecology patients [ ].

Confidential Figure [18] – [ ]

Confidential Figure [19] –[ ][136]

(j) Authorisation is not necessary to address a bargaining imbalance – to the extent there has been a delay in reaching AP agreements, [ ]: As outlined at paragraph 7.6 above, it is apparent that SCHI does not hold the one-sided bargaining power that NZGA suggests. To the extent there have been delays in concluding AP agreements in relation to gynaecology surgery to date, [ ]

[133] As suggested in the Application, for example at paragraphs 5.26 and 5.27.
[134] For example, in relation to cooperatives such as Fonterra.
[135] See paragraph 2.2 above.
[136] This reflects the results of SCHI quality/outcome survey programme. [ ] and [ ] are two AP-only surgery specialties. By contrast, gynaecology surgery is predominantly performed under the fee-for-service model.

(k) Application of the "modified total welfare standard" reinforces why authorisation should be declined: In *NZME Ltd v Commerce Commission*,[137] the Court of Appeal confirmed that it is open to the Commission to adopt a "modified total welfare approach" when analysing public benefits, meaning that the Commission "may adjust the weight given to benefits and detriments to reflect their distribution within the community".[138] Reflecting this, the Commission states that:[139]

(i) "we may give less weight to benefits flowing from an agreement, unilateral conduct or merger to a limited number of shareholders through dividends or higher profits"; and

(ii) "Similarly we may give more weight to benefits that are realised by the wider community and sustained over a period of time, or more weight to detriments if the agreement, unilateral conduct or merger would, for example, reduce access to a good or service that is of value to a low income group of consumers."

This is directly relevant to the current Application. Those potentially harmed by the Competitor Coordination would include 940,000 SCHI members (some 18% of New Zealanders), in addition to the harms to other private insurance customers and Health NZ patients referred to above. That wide class of potential victims can be compared to the very narrow group of potential beneficiaries – namely, ~130 highly-paid gynaecology surgeons (less than 0.002% of New Zealanders). [ ][140] [ ][141] [ ].

(l) NZGA has not made any attempt to quantify benefits to justify its Application: The Authorisation Guidelines state that the Commission will "seek to quantify the likely benefits and detriments to the extent practicable"[142] and that "[w]here an applicant considers efficiencies will result from the agreement, unilateral conduct or merger, it should substantiate its claims."[143] However, NZGA has made no any attempt at any quantification or any substantiation - no economic expert evidence accompanies the Application.

(m) The increased healthcare prices that would result from the Competitor Coordination will result in reductions in allocative efficiency: The Authorisation Guidelines state that an increase in prices will cause "a proportion of consumers to switch some or all of their purchases to otherwise inferior or less satisfactory products/services", resulting in "an allocative inefficiency (or a deadweight loss)".[144] That will occur in this case as the Competitor Coordination will result in consumers who can no longer afford insurance and/or reduced coverage by SCHI.

(n) The reduced competition between surgeons that would result from the Competitor Coordination will result in a loss of productive efficiency: The removal of competition between gynaecological surgeons will result in a reduction in productive efficiency as it will remove incentives on gynaecological surgeons to

[137] *NZME Ltd v Commerce Commission* [2018] 3 NZLR 715 (CA) at [75].
[138] Authorisation Guidelines at [85].
[139] Authorisation Guidelines at [86].
[140] [ ]
[141] [ ]
[142] Authorisation Guidelines at [51].
[143] Authorisation Guidelines at [56].
[144] Authorisation Guidelines at [63].

use "the minimum amount of resources to produce a certain volume of output given available technology."[145]

(o) The reduced competition between surgeons that would result from the Competitor Coordination will result in a loss of dynamic efficiency: The Authorisation Guidelines state that:

(i) "competition can be a key driver of innovation";[146] and

(ii) the detrimental impact on dynamic efficiency from coordination will be greater in sectors where innovation is important.[147]

Globally, in recent years there have been significant innovations in gynaecology surgical care,[148] and the Application itself refers to competition between gynaecology surgeons "on innovation (training, new techniques, etc)",[149] and there have been developments in New Zealand in recent years in terms of robotic surgery,[150] demonstrating innovation in this sector is important.[151] In a competitive sector, it would be expected that there would continue to be innovation and dynamism in gynaecological surgery in New Zealand. However, if gynaecology surgeons are permitted to coordinate, the incentive to innovate to achieve cost savings and offer better services will reduce – resulting in a loss of dynamic efficiency. Furthermore, preventing a competitive transition to SCHI's AP programme will undermine SCHI's ability to use the AP programme to spur further innovation in the gynaecology speciality (see paragraph 4.14(a)(ii) above).

(p) Consultation on clinical standards does not require authorisation: NZGA's claimed "clinical governance"[152] objectives do not require authorisation of collective price-setting. SCHI has engaged in significant clinical consultation to date, including making changes to proposed codes in light of clinical feedback received (see paragraph 6.1 above), and therefore, will ultimately be agreeing a code set with hospitals/facilities that has had the benefit of significant clinical input from across the sector. To the extent further consultation on clinical governance matters is considered beneficial, that can be achieved through legitimate advocacy channels, whether bilateral or via industry bodies – indeed, SCHI has engaged with both RANZCOG and NZGA to date in relation to clinical considerations.

(q) No material transaction cost savings or negotiation efficiencies: NZGA claims that collective bargaining will generate transaction cost savings. Any such savings are (at most) modest in the scheme of the potential anti-competitive detriments, such as increased prices and loss of competition on innovation. In particular, NZGA's members are well-resourced professionals capable of retaining their own advisers. The notion that 131 specialist gynaecologists [ ] require the protection of collective bargaining to negotiate contractual terms with hospitals/facilities is unsustainable.

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[145] Authorisation Guidelines at [68].
[146] Authorisation Guidelines at [73].
[147] Authorisation Guidelines at [74.1].
[148] See for example: Raveco Medical "6 Breakthrough Minimally Invasive OB/GYN Procedures Revolutionizing Women's Health" (19 January 2026). Retrieved from: https://www.raveco.com/blog/6-breakthrough-minimally-invasive-ob-gyn-procedures-revolutionizing-women-s-health
[149] Application at paragraph 2.19(d)(i).
[150] SCHI covers gynaecology robotic procedures for hysterectomy (including incidental findings of endometriosis (up to Stage 3) and sacrocolpopexy. SCHI covers surgical approaches such as vaginal natural orifice transluminal endoscopic surgery (vNOTES), and hysteroscopic surgery for uterine conditions. These procedures are mentioned in this article: Raveco Medical "6 Breakthrough Minimally Invasive OB/GYN Procedures Revolutionizing Women's Health" (19 January 2026). Retrieved from: https://www.raveco.com/blog/6-breakthrough-minimally-invasive-ob-gyn-procedures-revolutionizing-women-s-health.
[151] [ ].
[152] Application at paragraph 2.28(a).

In addition, the heterogeneity among gynaecology surgeons (in terms of expertise, experience, and significant variation in prices (see paragraph 5.2(b)(ii) above)), means there will likely be significant internal transaction costs and negotiating inefficiencies within any collective bargaining group. As the Commission has previously noted:[153]

> First, collective negotiations can be more complex than bilateral negotiations if the parties have diverse interests and the contract must cater to the interests of all of those party to the arrangement. Therefore, efficiencies will only be realised if the savings associated with incurring negotiation costs vis à-vis each Digital Platform only once (rather than multiple times for each individual bilateral negotiation) outweigh the costs associated with any increased complexity from negotiating as a collective bargaining group.
>
> Second, if parties in the collective bargaining group are heterogeneous, they may incur costs negotiating amongst themselves due to their diverse needs and interests. Therefore, any transaction cost savings between the collective bargaining group and the counterparty may be offset by internal transaction costs within the collective bargaining group.

Furthermore, SCHI is seeking to engage in the AP transition to achieve transaction cost savings (by negotiating AP agreements with hospitals/facilities) and the ability to negotiate competitive pricing. In the absence of AP agreements with hospitals/facilities, SCHI has no effective means to achieve competitive pricing outcomes. Under the existing fee-for-service model, gynaecology surgeons unilaterally determine their price to patients, with the patient (in the case of SCHI members) then remitting the invoice to SCHI for reimbursement. There is no mechanism for prospective price negotiation and no meaningful competitive constraint on how prices change over time. As a result fee-for-service pricing is not the product of workable competition, but of a model in which the absence of effective competitive negotiation allows fees to escalate without effective scrutiny or constraint.[154] The AP programme addresses these issues by enabling competitive negotiation of procedure-level pricing, which in turn addresses the well-recognised "moral hazard" that can arise in insured healthcare markets. In its recent NZBA authorisation, the Commission recognised that addressing "moral hazard" issues leads to more efficient outcomes.[155] Authorising the Application would undermine SCHI's ability to address these "moral hazard" issues and SCHI's ability to implement ordinary competitive bilateral negotiations – thereby increasing transaction costs and resulting in inefficient outcomes.

(r) <u>There is no evidence of a material risk of "workforce exit" arising from SCHI's AP negotiations</u>: As detailed at paragraph 5.2 above, SCHI has evidence that [ ] and [ ]. In that context, the proposition that aligning pricing towards more sustainable and efficient levels would result in surgeons exiting the workforce is not credible. Gynaecology is a well-remunerated specialty with multiple funding streams, and there is no evidence that surgeons would withdraw from practice or materially

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[153] *News Publishers' Association of New Zealand Incorporated* [2022] NZCC 35 at [97].

[154] These well recognised "moral hazard" issues that can arise (if unaddressed) in insurance sectors undermine NZGA's assertion that "prices are currently set independently by gynaecologists in workably competitive markets" (Application at paragraph 11.5(d)). Currently, in the context of fee-for-service procedures, gynaecology surgeons unilaterally impose their charges on patients with no negotiation, a significant lack of information on the part of the patient as to appropriate competitive prices, and the problem that insured patients do not ultimately bear that cost themselves (and, therefore, have limited incentive to scrutinise or resist the surgeon's fee, or consider pricing in choosing a surgeon, because the patient does not bear the full cost).

[155] *New Zealand Banking Association* [2026] NZCC 14 at [339].

reduce supply as a result of SCHI funding gynaecology surgeries via AP arrangements. Rather, the outcome of the AP transition would be that prices reflect more competitive/efficient levels, while maintaining provider participation and access to care. Accordingly, the claimed risk of workforce exit does not withstand scrutiny and does not provide a credible basis for authorisation. Furthermore:

(i) the alleged workforce exit is supported by only four letters from individual gynaecologists (and a further letter from an anaesthetist). That is a thin (and self-serving) evidentiary basis on which to assert a systemic risk to the supply of gynaecological services, especially in circumstances where prices charged in New Zealand are much higher than other countries; and

(ii) as a member focused Friendly Society, 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. Reflecting this, as outlined at paragraph 9.6(i) above, the evidence demonstrates that procedure volumes continue to grow once a specialty has transitioned to SCHI's AP programme.

(s) Authorisation would undermine [ ]: SCHI paused engagement with NZGA due to [ ]. To rely on SCHI's decision to [ ] as justification for collective bargaining or a collective boycott (as suggested by NZGA's Application)[156] [ ].[157]

9.7 Taken together, the effects of Competitor Coordination are significantly adverse. Those adverse effects include higher-prices that will impact SCHI and its members, and spillover to other funders and their patients/customers, while also risking access to healthcare and health outcomes for New Zealanders. There is no credible basis on which these substantial and widespread detriments could be outweighed by public benefits.

9.8 For completeness, SCHI also records that the significant competitive detriments would not be resolved by the "proposed conditions" suggested at paragraph 6.15 of the Application. In particular:

(a) Reporting to the Commission: Quarterly reporting is a retrospective monitoring mechanism. It does not prevent the competitive harm from occurring; it merely creates a record of it after the fact. By the time the Commission receives and reviews a quarterly report, the anticompetitive conduct (collective price coordination by more than ~90% of private gynaecology surgeons) will already have taken effect. Quarterly reports cannot undo the upward pressure on fees, the information sharing between competitors, or the anchoring of collectively negotiated prices that will have occurred in the intervening period. The Commission would be in the position of observing the consequences of anticompetitive conduct rather than preventing it.

(b) Pre-implementation disclosure: The competitive harm from collective bargaining lies in the process of coordination itself, not merely in the execution of a final agreement. Five days' notice of the final document does not address the damage done by the preceding months (or years) of collective price coordination. Further,

[156] As suggested at paragraph 2.7 of the Application.
[157] [ ]

the Commission has no power under this proposed condition to veto or amend the proposed agreement; notice is not the same as approval.

(c) Legal oversight: The presence of an external legal adviser at meetings does not address the fundamental competitive concern. The competitive detriment from collective bargaining by more than ~90% of gynaecology surgeons is not a compliance failure that a lawyer can prevent; it is the inherent consequence of permitting competitors to collectively negotiate prices. A legal adviser cannot prevent the anticompetitive effects that would flow from the coordinated conduct itself. [ ]

(d) Designated forums: The requirement that all coordinated conduct occur within "specifically designated" forums provides no meaningful constraint. It does not limit the subject matter that can be discussed, the pricing information that can be shared, or the collective positions that can be adopted. It simply requires that the anticompetitive conduct occur in a formal setting rather than informally. Nor does this condition address the contagion risk identified in this submission: information shared in designated forums about pricing, costs, and negotiating strategies will inform how the same surgeons approach negotiations with Health NZ, ACC, and other private insurers outside the forums.

9.9 Finally, SCHI notes that there are a number of incorrect and inconsistent statements in the Application regarding the nature of the authorisation sought:

(a) It is not correct to say that the Competitor Coordination would not "involve entering into contracts, arrangements or understandings regarding services by Participants to their patients".[158] Competitor Coordination that impacts the cost of services to patients and how gynaecology surgeons interact with hospitals/facilities (and ultimately funders) fundamentally "regards" those services. The proposed Competitor Coordination goes to the core of affordability, accessibility, and availability of those services for patients.

(b) It is not correct to say that "Participation is voluntary".[159] The Standstill Deed at Appendix 5 of the Application provides that "any member who does not become a Participant within the timeframe reasonably specified by NZGA is removed as a member of NZGA." The price of non-participation is therefore expulsion from the professional body representing over ~90% of private gynaecologists. This is not genuinely "voluntary" - it is coercion.

(c) Paragraph 2.3(a) of the Application suggests that the Competitor Coordination would solely be in relation to "SCHI-insured patients". However, paragraphs 2.4(d) and 6.2 refer to NZGA (and its members) seeking to collectively negotiate with SCHI and/or hospitals "to the broadest extent necessary to enable effective collective bargaining of the provision of private gynaecological services" and paragraph 6.2 says that the Application is seeking to collective negotiation "in relation to private gynaecology services" with "individual hospitals (or groups of hospitals)". This suggests that authorisation is being sought for the Competitor Coordination to extend beyond just SCHI funded procedures.

(d) There is a lack of clarity in relation to the duration of the authorisation for the proposed collective boycott – namely, the Application (at paragraph 6.5) seeks authorisation "for a period of 10 years" to "engage in a Standstill Agreement for a

[158] As suggested at paragraph 2.4(a) of the Application.
[159] As suggested at paragraph 2.4(b) of the Application.

period of up to 6 months". This indicates that any authorisation could potentially permit multiple six-month Standstill Agreements across a 10-year period.

10. THE "STANDSTILL AGREEMENT" GIVES RISE TO ADDITIONAL CONCERNS

10.1 In addition to the reasons set out at Section 9 above demonstrating why authorisation should not be granted for either collective bargaining or the proposed "Standstill Agreement", it is also necessary to specifically address the additional anti-competitive effects of the proposed "Standstill Agreement".

10.2 Irrespective of the label NZGA seeks to apply, the proposed "Standstill Agreement" would, in substance, amount to a "collective boycott" of SCHI's AP project by over ~90% of private gynaecological surgeons in New Zealand. The practical effect of such coordinated conduct would be to prevent SCHI from progressing competitive negotiations with providers, thereby stalling the introduction of competitive pricing discipline and sustaining unconstrained fee-for-service pricing. In doing so, it would directly undermine competition, entrench higher costs, and ultimately result in increased premiums and/or reduced coverage for members.

10.3 Previous collective bargaining applications to the Commission have consistently and expressly made clear that they are not seeking authorisation for any "collective boycott".[160] That reflects that "collective boycotts" are well-recognised as inflicting significant competitive damage and typically without any redeeming benefits.

10.4 Reflecting this, the Australian Competition Tribunal ("**ACT**") and ACCC has consistently declined to authorise collective boycotts:

(a) In *Re VFF Chicken Meat Growers' Boycott Authorisation* - the ACT found that "Collective boycotts have the capacity to inflict great damage not only on the targets but also on employees, related businesses, consumers and the boycotters themselves",[161] with the ACCC summarising the ACT as saying that "the threat of a boycott — even without it ultimately being engaged in — is likely to come at a high cost to society."[162]

(b) In *Catholic Health Australia*, the ACCC refused to authorise a collective boycott of private health insurers by hospitals, finding it would create "an imbalance in bargaining power in favour of Revenue Negotiation Network members, which may result in higher private health insurance premiums with no commensurate increase in quantity, quality or availability of hospital services."[163]

(c) In *St Vincent's Health*, the ACCC refused to authorise boycotts by the Catholic Health network, finding the public benefits of a collective boycott did not outweigh "the significant public detriments."[164]

10.5 In commenting on the ACT's approach to "collective boycotts" the ACCC has said:[165]

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[160] For example, the Commission noted:
- "There is no proposal, and the NPA is not requesting authorisation, to engage in a collective boycott outside the Proposed Arrangement" in *News Publishers' Association of New Zealand Incorporated* [2022] NZCC 35.
- "The Commission is not authorising any persons to engage in a collective boycott" in *New Zealand Tegel Growers Association Incorporated* [2022] NZCC 30.

[161] *Re VFF Chicken Meat Growers' Boycott Authorisation* [2006] ACompT 9 at [442].

[162] ACCC " Australian Competition Tribunal says no to collective boycott for Victorian chicken growers" (27 April 2006). Retrieved from: https://www.accc.gov.au/media-release/australian-competition-tribunal-says-no-to-collective-boycott-for-victorian-chicken-growers.

[163] *Catholic Health Australia* ACCC AA1000677 (2025).

[164] *St Vincent's Health Australia Limited* ACCC A91099 (2009).

[165] ACCC " Australian Competition Tribunal says no to collective boycott for Victorian chicken growers" (27 April 2006). Retrieved from: https://www.accc.gov.au/media-release/australian-competition-tribunal-says-no-to-collective-boycott-for-victorian-chicken-growers.

> "What this decision means for parties considering seeking authorisation of a collective boycott proposal is that **the benchmark against which it will be measured is high**", Mr Samuel said. "Consistent with this, two recent proposals seeking authorisation of a collective boycott have been opposed by the ACCC as the parties were unable to satisfy it that there was such a benefit to the public that the boycott should be permitted. **It is clear that parties seeking immunity for a proposed collective boycott arrangement bear a heavy onus**".

10.6 In this specific case, the Application's suggestion that "maintaining the status quo" pricing for six months would not have any detrimental effects[166] is demonstrably incorrect. Based on SCHI's modelling that [ ], a six month (collusive) agreement to maintain status quo pricing (which SCHI considers is materially above competitive levels) could, at the very least, have a detrimental impact of increased costs in the order of [ ], and the detrimental impact would likely be much higher given the likelihood that the Competitor Coordination would elevate prices further beyond existing levels and the other anti-competitive detriments outlined at Section 9 above.

10.7 Further enhancing the competitive detriments of the proposed "collective boycott", while the Application states that participation in the Standstill Agreement is "voluntary",[167] as noted at paragraph 9.9(b) above, the Standstill Deed at Appendix 5 of the NZGA Application provides that "any member who does not become a Participant within the timeframe reasonably specified by NZGA is removed as a member of NZGA." Again, this is not genuinely "voluntary" – so this would be a coercive "collective boycott".

10.8 Finally, while NZGA seeks authorisation for both "collective bargaining" and a separate Standstill Agreement under a single application and (presumably, a single filing fee), it is not apparent that it is open to NZGA to seek authorisation for two distinct arrangements under a single application:

(a) Under section 58 a person can seek authorisation to "enter into a contract or arrangement, or arrive at an understanding" or "give effect to a provision of a contract or arrangement or understanding". By contrast, NZGA seeks authorisation for two separate and distinct arrangements under a single application:

(i) The collective bargaining arrangements involve ongoing engagement with SCHI to negotiate terms.

(ii) The Standstill Agreement, by contrast, is a horizontal agreement between competitors not to deal with SCHI at all for six months

(b) The public benefit test requires the Commission to assess the benefits and detriments of the "arrangement" for which authorisation is sought. Combining two arrangements in one application risks conflating the assessment.

(c) While the NZGA Application states that "the Commission may treat the standstill as a standalone request for authorisation which could be varied or subject to conditions separately",[168] that would require a separate authorisation application and a separate filing fee.

[166] As asserted at paragraph 11.27 of the Application.
[167] As suggested at paragraphs 2.4(b) and 6.3(b) of the Application.
[168] As suggested at footnote 4 of the Application.

11. INTERIM AUTHORISATION SHOULD BE DECLINED

11.1 In accordance with the Commission's Authorisation Guidelines and prior decisions, interim authorisation should not be granted. That is for the following reasons:

(a) Interim authorisation will substantially lessen competition: The Commission's Authorisation Guidelines state that the "Commission is unlikely to grant interim authorisation in respect of an agreement or unilateral conduct that has the potential to substantially lessen competition unless there are compelling reasons in the public interest to do so."[169] Plainly a coordination agreement that applies to more than ~90% of providers would have (at the very least) the "potential" to substantially lessen competition. Furthermore, for the reasons outlined at Sections 9 and 10 above, there are no "compelling reasons in the public interest to do so". To the contrary, there are compelling public interest reasons to not grant authorisation or interim authorisation.

(b) Interim authorisation will result in competitive harm: The Commission's Authorisation Guidelines state that in assessing an application for interim authorisation the Commission will consider the "possible harm to other parties (such as customers and competitors) or the public if a request for interim authorisation is granted".[170] For the reasons outlined at Section 9 above, granting interim authorisation would result in significant harm to SCHI, its members, other health insurers and their customers, and Health NZ – including by enabling the exchange of competitively sensitive information that risks permanent damage to the competitive process and higher costs to health insurers, their customers, and other purchasers/funders of gynaecology surgery services. As the Commission set out in its NZBA interim authorisation decision:[171]

> In some cases, information sharing between competitors during collective bargaining would be of significant competition concern, especially if it is likely to facilitate or strengthen cartel behaviour or other forms of collusion that weaken the competitive constraint between parties.

That is particularly the case here, because unlike the NZBA situation, this is not a situation where competing gynaecology surgeons could know each other's competitively sensitive negotiating positions via legitimate means.

(c) There is no emergency. The Commission's Authorisation Guidelines state that in considering an application for interim authorisation the Commission will consider whether "an emergency situation exists and interim authorisation is needed to allow parties to respond".[172] There is no emergency. SCHI's proposed AP contracting programme is a legitimate commercial initiative that is being implemented through ordinary contractual processes, and has been being negotiated/consulted on over a period exceeding eight months (from August 2025 to now). SCHI has no confirmed or specified AP-only effective date. Its original target date of 31 March 2026 was extended to 31 May 2026 following feedback, and has since been further deferred with no currently confirmed date. Individual gynaecologists remain free to contract (or not to contract) with hospitals/provides that propose to participate in the AP programme. In this context, it is not correct for NZGA to assert that its members are "not familiar" with what SCHI is proposing or

[169] Authorisation Guidelines at [177].
[170] Authorisation Guidelines at [178.6].
[171] *New Zealand Banking Association – Interim Authorisation* [2025] NZCC 23 at [50].
[172] Authorisation Guidelines at [178.2.2].

that they "have not had the benefit of seeking legal advice"[173] (indeed, it is apparent that NZGA has engaged two separate law firms in relation to its Application).[174]

(d) There is no risk of permanent change to the market from enabling standard competitive AP negotiations to continue.[175] The Commission's Authorisation Guidelines state that in considering an application for interim authorisation the Commission will consider "the risk that some or all of the benefits of the authorisation may not materialise if interim authorisation is not granted".[176] To the extent there are any possible benefits from the Application (which SCHI refutes, for the reasons outlined at Sections 9 and 10 above), there is no risk of permanent change to the market from enabling standard competitive AP negotiations to continue. Gynaecology surgeons can choose to reach agreements with hospitals/facilities, or not. Furthermore:

(i) any Listed Provider contracts would not be likely be for a long-term, meaning the surgeons could choose to terminate those contracts on notice to the relevant hospital/facility; and

(ii) SCHI's own AP agreements with hospitals/facilities, if agreed, would only typically be for three years.

Reaching short-term contracts that could be terminated or renegotiated does not reflect an irreversible change to the market. By contrast, granting interim authorisation for more than ~90% of gynaecologists to collectively bargain and enter a standstill would result in: substantial lessening of competition; pricing coordination; information exchanges that could result in permanent damage to the competitive process; and higher costs to members. In addition, as above, there has been no confirmed date by which SCHI would introduce an AP-only date. This contradicts NZGA's characterisation of imminent irreversible harm requiring emergency interim authorisation.

(e) There is no risk of "harm to the public". Contrary to the assertion in the Application, there is no risk of "harm to the public"[177] from SCHI negotiating AP agreements with hospitals/facilities in relation to gynaecology surgery. The AP programme is a tried and tested contracting model that the Commission has itself recognised results in a number of pro-competitive and other benefits.

(f) Interim authorisation would not maintain the status quo — it would fundamentally change it. The Commission's Guidelines state that in considering an application for interim authorisation the Commission is:

(i) more likely to grant interim authorisation if it would "maintain the market status quo"[178] or would otherwise not "materially alter the competitive dynamics of the market."[179]

[173] As asserted at paragraph 2.30(b) of the Application.
[174] See Application at paragraph 3.5.
[175] As asserted at paragraph 2.30(b) of the Application.
[176] Authorisation Guidelines at [178.2.1].
[177] As asserted at paragraph 2.30(b) of the Application.
[178] Authorisation Guidelines at [178.4.1].
[179] Authorisation Guidelines at [178.4.2].

(ii) "unlikely to be granted if the relevant agreement or unilateral conduct could significantly alter the competitive dynamics of the market permanently."[180]

These criteria are not met here. The status quo is one in which there is no collective bargaining or collective boycott. The proposed Competitor Collaboration would create a novel collective negotiating structure that has never previously existed, and would enable the exchange of competitively sensitive information that risks permanent damage to the competitive process and higher costs to health insurers, their customers, and other purchasers/funders of gynaecology surgery services.

(g) <u>If the Commission is in "doubt", it must decline interim authorisation</u>. In the NZBA – Interim Authorisation,[181] the Commission emphasised that it "will grant interim authorisation only if satisfied it is appropriate to do so. If it is not satisfied, or remains in doubt, we will not grant interim authorisation" and that "the applicant bears the practical burden of persuasion."[182] For the reasons outlined above (and in sections 9 and 10), the Commission must have "doubt" about whether it is appropriate to grant interim authorisation. Furthermore, as in the NZBA case, here the application makes "little attempt to quantify the benefits that were claimed for the interim authorisation period, and offered limited justifications that the orthodox inefficiencies (detriments) of cartel conduct would not be present in this case" – demonstrating that the application has not met "the practical burden of persuasion".[183]

11.2 For these reasons, interim authorisation would create immediate and potentially irreversible harm to the competitive process without any countervailing urgency or public benefit. Interim authorisation must, therefore, be declined.

[180] Authorisation Guidelines at [179].
[181] *New Zealand Banking Association – Interim Authorisation* [2025] NZCC 23.
[182] *New Zealand Banking Association – Interim Authorisation* [2025] NZCC 23 at [19] and [30].
[183] *New Zealand Banking Association – Interim Authorisation* [2025] NZCC 23 at [30].

12. CONCLUDING COMMENTS

12.1 To conclude, contrary to the assertions in the Application, the matter before the Commission is not about whether clinical engagement should occur, nor about the introduction of a novel or "radical" model. SCHI has been willing to engage on clinical matters, has sought input through appropriate channels, and has adopted a measured and extended process for the proposed transition of gynaecology surgery into the AP programme. The AP programme itself is long-established, operating since 1997 across more than 2,500 providers and more than 30 clinical specialties. It is a proven mechanism for delivering efficient and pro-competitive outcomes that support affordability and access.

12.2 The evidence demonstrates that the proposed Competitor Coordination is directed at preserving existing fee levels in a specialty that to date not been subject to effective competitive constraint - where there is sustained cost escalation, significant price variation, and a lack of alignment between price and member value. The proposed AP transition is a legitimate and competitive response to those issues, aimed at achieving competitive and efficient outcomes.

12.3 By contrast, the proposed Competitor Coordination would displace ordinary competitive processes with (otherwise illegal) coordination across more than ~90% of private gynaecology surgeons. Whether framed as "collective bargaining" or a "Standstill Agreement", the effect is the same: reduced competitive tension, entrenched pricing, and constrained negotiation. The foreseeable consequence is higher costs flowing directly to members through increased premiums and/or reduced coverage. Given SCHI's member-focused Friendly Society model, where the vast majority of premiums are returned in claims, those impacts are immediate and material.

12.4 Authorisation would also create broader public policy risks. It would signal that coordinated conduct is an available strategy to resist competitive cost-containment, [ ], and undermine established procurement and contracting frameworks that support efficient and sustainable healthcare delivery.

12.5 In addition, there is no credible basis for interim authorisation. Interim authorisation would not preserve the status quo, but would instead enable coordination and information exchange among competitors before the Commission has completed its assessment. There is no urgency that justifies such an outcome, particularly given the extensive consultation already undertaken and the absence of any specified implementation date.

12.6 In summary, the proposed Competitor Coordination would undermine competition, increase costs for consumers, and disrupt established pro-competitive models that support affordability and access to care. The Application does not come close to demonstrating countervailing public benefits that could justify otherwise illegal conduct – both the authorisation application and the interim authorisation application must be declined.

12.7 SCHI reiterates that it is committed to supporting a high-quality and sustainable healthcare system, and supporting women to access timely, good value, and high-quality gynaecological surgical care is a priority for SCHI. Those are the very outcomes SCHI is seeking to achieve through its proposed AP transition, and SCHI remains committed to engaging constructively with hospitals/facilities, gynaecology surgeons, and appropriate specialist bodies in accordance with ordinary competitive processes.

12.8 SCHI would welcome the opportunity to assist the Commission further with information or analysis to support its assessment of the Application.

APPENDIX ONE

CHRONOLOGY OF SCHI'S ENGAGEMENT IN RELATION TO ITS AP GYNAECOLOGY PROJECT

APPENDIX TWO

RESPONSE TO SPECIFIC NZGA CLINICAL ASSERTIONS

As noted at footnote 100, there are additional incorrect clinical assertions in NZGA's Application that SCHI wishes to respond to, as follows:

- NZGA's assertion in the Application "that currently SCHI already refuses to exercise 'risk corridor' discretion even when complex surgeries are performed"[184] is not correct. SCHI anticipates that this assertion may be in relation to robotic gynaecology surgical AP agreements, where top-ups have been requested but declined due to the claim being outside SCHI's policy terms and conditions (not because of complexity). For example, top-ups have been requested for robotic gynaecology procedures that are not covered by SCHI's insurance policies and, therefore, are also not contracted for in the relevant AP agreement.

- Contrary to the assertion in the Application, providers would be able to appropriately apply for funding for the example of "a patient with normal pre-operation imaging may have Stage 3 endometriosis requiring ureterolysis, but the need for a vaginal hysterectomy for prolapse repair may not be known until the patient in examined in the operating theatre".[185] For this example, a facility would originally apply for the code "AP 1082 Laparoscopic Endometriosis ASRM Stage 3". However, the facility would then change the claim to code "AP 1210 Vaginal Hysterectomy Complex" (which includes both Stage 3 endometriosis, ureterolysis and vaginal hysterectomy).

- It is very concerning to SCHI that NZGA would imply that gynaecologists would alter treatment ("increase output speed or quantity by doing 'easier' procedures" or subject "women to undergo multiple operations")[186] when there is an appropriate code-set for them to claim under one surgical setting.

- It is not correct to assert that SCHI "had indicated that pelvic floor procedures would remain outside the Affiliated Provider (AP) scheme on a Fee-for-Service basis".[187] SCHI is seeking to implement several pelvic floor procedure codes at agreed prices as part of its AP transition, while also having open pelvic floor procedure codes, which SCHI would fund based on time and costs taken to perform the surgery.

- It is not correct to assert that:

  - "if a patient has stage 3 or 4 endometriosis and also requires hysterectomy the patient may be disadvantaged as full excision of endometriosis would not be covered if carried out with a complex hysterectomy"; or

  - "these codes suggest that when certain pelvic floor procedures are performed together the surgeon (and other providers) will not be able to claim payment if all the procedures that are clinically appropriate are carried out".

  Under code "AP 1208 Laparoscopic Hyserectomy Complex", a complex hysterectomy and a full excision of endometriosis stage 3 is included. If the procedure goes over the applicable risk corridor theatre time, then the extra payments under the risk corridors will apply. If the endometriosis was stage 4 then an additional code can also be claimed, either code "AP 1083

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[184] As asserted at paragraph 2.20(a)(iv) of the Application.
[185] As asserted at paragraph 11.5(a)(i) of the Application.
[186] As suggested at paragraph 2.19(d)(iii) of the Application.
[187] As asserted at paragraph 2.19(b) of the Application.

Lap Endometriosis ASRM Stg4" or "1084 Lap Endo Stg4 + Discoid Resection". When additional pelvic procedures are performed, providers can use the additional pelvic floor code "AP 1478 AP Open Code – Add-On Pelvic Floor Procedure".