AGED RESIDENTIAL CARE

Creating a sustainable future.

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Contents

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Executive summary.

New Zealand's aged residential care sector is being driven by population ageing and longer life expectancy, which is increasing demand for hospital, dementia and specialist care for people with high dependency needs and challenging or disruptive behaviours (psychogeriatric). Providers have opportunities to expand specialist services, improve productivity through technology and scale, and benefit from industry consolidation. However, these opportunities are constrained by a widening funding gap, workforce shortages, increasing resident complexity, rising capital costs, and growing competition from home and community-based care. As a result, ensuring sufficient financial, workforce, and infrastructure capacity to meet growing demand remains the sector's central challenge.

The sector currently comprises approximately 41,500 beds, providing rest home, hospital, dementia and psychogeriatric care, within a nationally regulated system. Despite ongoing consolidation, the sector remains relatively fragmented, with capacity spread across corporates, charitable organisations, regional chains, specialist providers, and independent facilities.

Two provider models exist. Village-linked providers, such as Ryman Healthcare and Summerset, are typically large organisations offering a continuum of care, while standalone providers are more numerous, regionally dispersed, and highly fragmented. Together, they provide complementary coverage through integrated care pathways and regional provision.

Demand is strong, driven by increasing longevity and rising dementia prevalence. While older people remain at home longer, those entering care do so later in life and with more complex needs. As a result, demand growth is concentrated in hospital, dementia, and psychogeriatric care rather than traditional rest-home services.

Financial sustainability is the sector's defining challenge. Aged residential care is funded primarily through government subsidies and resident contributions, but funding growth has not kept pace with rising costs. Consequently, the sector's funding gap has widened from about $170 million in 2014 to around $650 million in 2025.

In response, providers have long called for funding reforms. That's in addition to pursuing operational efficiencies, technology investment, and placing a greater focus on offering premium accommodation and higher-acuity care. While both provider types seek productivity gains, village-linked operators also benefit from retirement village businesses that support occupancy, investment, and additional revenue, whereas standalone providers rely more heavily on operational performance, service specialisation, and local referral networks.

These differences shape competition. Village-linked providers generally compete through facility quality, lifestyle offerings, reputation, and continuum-of-care pathways, while standalone providers compete more through clinical quality, workforce capability, local reputation, and operating efficiency. As resident acuity increases and workforce shortages persist, clinical capability is becoming an increasingly important competitive advantage.

At the same time, competitive pressures are building. Rivalry for residents, staff, and development opportunities is intensifying, while workforce shortages continue to strengthen supplier power. Entry barriers remain high, although home and community-based care is an increasing substitute for lower-acuity services. Competitive pressures are generally greater for standalone providers due to their heavier reliance on care revenue and fewer alternative income streams.

Long-term success will depend on clinical quality, workforce capability, occupancy, financial sustainability, and facility quality. Providers that attract skilled staff, deliver increasingly complex care, maintain occupancy, invest in modern facilities, and generate sustainable returns will be best placed to meet growing demand. Retirement village integration provides an additional advantage for village-linked operators.

The sector's strongest opportunities stem from population ageing, increasing longevity, rising dementia prevalence, and growing demand for higher-acuity care, and opportunities to improve productivity and expand capacity through technology and scale.

However, these opportunities are offset by a widening funding gap, persistent workforce shortages, increasing resident complexity, significant capital requirements, and growing competition from home and community-based care. Together, these factors support strong long-term demand but also continued pressure on financial sustainability and capacity growth.

Table 1: Recommended actions to best maximise opportunities

Opportunity	Village-linked providers	Standalone providers
Population ageing	Expand into high growth urban markets.	Expand into underserved regional markets.
Higher acuity care	Increase hospital, dementia, and psychogeriatric capacity and specialist clinical services.	Develop specialist or niche care offerings.
Alternative revenue streams	Maximise village-to-care pathways, occupancy and property income to support care operations.	Expand premium accommodation and ancillary services where feasible to diversify revenue.
Technology & productivity	Invest in digital technology and centralised support functions to improve scale efficiencies.	Use technology, procurement groups, and shared services to lower operating cost.
Industry consolidation	Acquire or partner with smaller providers to grow market share and capacity.	Consider alliances, mergers, or specialist positioning to strengthen competitiveness.

Table 2: Recommended actions to address key challenges

Challenges	Village-linked providers	Standalone providers
Funding gap	Advocate for funding reforms: Modernise the funding model (to reduce expanding funding gap), support capital investment, minimise regulatory burdens, and create a sustainable model for expanding aged care capacity.	
	In addition, continue to pursue productivity gains.	Focus on cost controls, occupancy, and revenue optimisation.
Workforce shortages	Strengthen recruitment, training, career pathways, and staff retention programmes.	Develop specialist or niche care offerings.
Increasing resident acuity	Build specialist clinical capability and multidisciplinary care teams.	Invest in staff training, clinical governance, and targeted service specialisation.
Capital requirements	Leverage scale and access to capital to prioritise developments in urban locations with strong demand and occupancy prospects.	Focus capital on refurbishments and selective expansion projects with clear returns.
Home care substitution	Strengthen continuum-of-care pathways and focus on higher-acuity care services.	Reposition away from lower-acuity care and specialise in services less easily delivered at home.

In summary, village-linked providers should maximise opportunities and manage key challenges by leveraging their scale, access to capital, and retirement village integration. Standalone providers should remain competitive by focusing on clinical excellence, operational efficiency, service specialisation, and strong local relationships.

Aged residential care defined.

New Zealand's aged residential care (ARC) system provides 24/7 care for older people unable to live independently, with services structured along a continuum that reflects increasing needs as well as clinical complexity.

By order of clinical complexity, ARC covers rest homes, hospital level, dementia and psychogeriatric care. Each of these care levels falls within a broader continuum of healthcare services which all New Zealanders have access to.

Institutional arrangements.

New Zealand's ARC system is structured around a small number of public agencies and a diverse group of private providers.

New Zealand's Ministry of Health sets overall policy, funding parameters, and regulatory standards, while Health NZ operates the system as the single public purchaser, contracting providers, funding services, and administering payments. Care is delivered primarily by private providers under national contracts that specify service, quality, and staffing

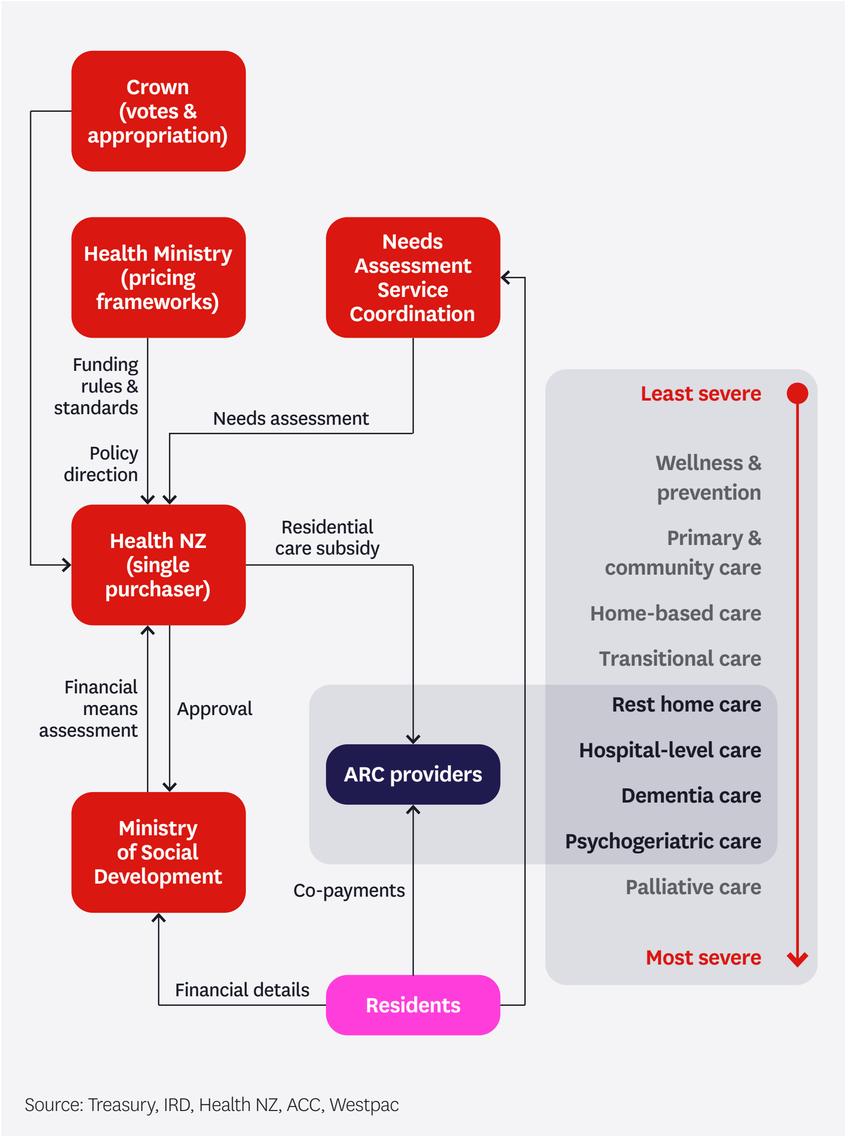
requirements, ensuring a consistent baseline of care across the sector.

Access to ARC begins with a needs assessment, which determines eligibility and the appropriate level of care. A financial means assessment then establishes eligibility for government support. Funding is shared between residents and the government: residents pay up to a regulated maximum for standard care, with the Residential Care Subsidy (RCS) covering the remaining cost and paid directly by Health New Zealand. The system is underpinned by a nationally regulated daily fee covering accommodation, care, and basic living costs.

The ARC system also accommodates differing care needs and resident preferences. Health NZ provides additional funding for higher-acuity residents, particularly those requiring hospital, dementia, or psychogeriatric care. Residents may also purchase premium accommodation and non-clinical services that fall outside the publicly funded package.

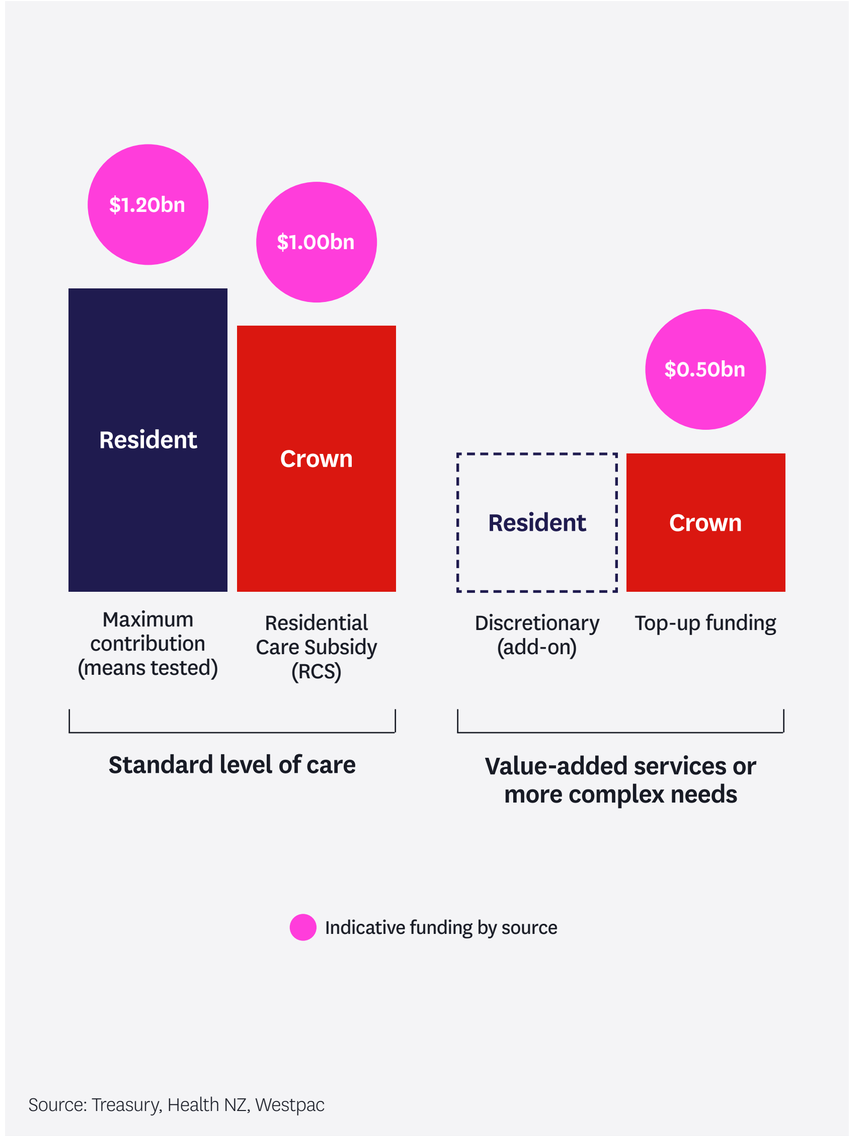
Overall, New Zealand's ARC sector operates as a centrally funded, contract-based system that combines standardised public funding with flexibility for higher care needs and private choice.

Figure 1: High level ARC model



Source: Treasury, IRD, Health NZ, ACC, Westpac

Figure 2: Composition of ARC funding



Source: Treasury, Health NZ, Westpac

Shape of ARC provision.

ARC services are delivered by a diverse mix of providers, including large charitable organisations, national for-profit corporates (listed and privately owned), medium-sized regional operators, and small independent providers (see Appendix A for further detail on provider types, market structure, and how ARC in New Zealand compares to its peer group).

Despite ongoing consolidation, the sector remains fragmented. Large corporate providers have expanded their market share over time but still account for only around half of total ARC bed capacity. Mid-sized and smaller providers remain important, representing about one-third of capacity. Many operate in regional and community-based markets, reflecting the sector's diverse ownership base and its fragmented structure.

ARC delivery in New Zealand remains centred on traditional care models. Around three-quarters of all beds are in rest home and hospital-level care, indicating that these services continue to dominate. This is beginning to change, with capacity having to adjust to increased demand for dementia and psychogeriatric care. Already these levels of care account for more than one-quarter of total capacity, with most services provided by generalist rather than specialist operators.

Table 3: ARC concentration by type of provider

Provider type	Estimated operational beds (number)	Market share (%)*
Listed, large corporates	9,000-9,500	22%-23%
Private, large corporates	9,500-11,500	23%-28%
Large not-for-profit/charitable providers	4,500-6,000	11%-15%
Private, medium-sized chains	7,000-8,500	17%-21%
Small independent/single-site operators	5,500-7,000	13%-17%
High-acuity specialist providers	1,000-1,500	2%-4%
Total (beds)	**41,500**	

Source: Health NZ, Ministry of Health, NZ Aged Care Association, and company disclosures.

* Ranges overlap and should not be summed.

Table 4: ARC concentration by level of care

Care level	Providers (number)	Estimated operational beds (number)*	Market share (%)
Rest home	640	17,000	41%
Hospital	440	13,500	33%
Dementia	260	8,000	19%
Psychogeriatric	90	3,000	7%
Total (beds)		**41,500**	**100%**

Source: Health NZ, Ministry of Health, NZ Aged Care Association, Grant Thornton, BDO, BERL.

* This is a capacity estimate, not occupied beds. Public sources often report "care beds", "care units" or "care beds and suites", not strictly "operational beds".

Business models.

A defining feature of the ARC sector is the coexistence of two distinct business models: village-linked and standalone providers. While both operate within the same regulatory and funding environment, they differ significantly in their revenue sources, profitability, access to capital, and capacity for growth (see Appendix B for further detail).

Village-linked providers.

Village-linked providers are typically larger operators that combine retirement villages with ARC services, often offering a continuum of care across rest home, hospital, dementia, and, in some cases, psychogeriatric services. The integration of retirement villages can provide a pipeline of future care residents while also creating access to a source of capital that is largely unavailable to standalone providers.

The model is built around the Occupation Right Agreement (ORA), under which residents pay an upfront capital sum for the right to occupy a retirement village unit. The value of ORAs is influenced by local housing market conditions, as many residents fund their move into retirement village living through the sale of their home. When residents leave or pass away, operators typically retain a Deferred Management Fee (DMF), normally between 25% to 30% of the original ORA value, with the balance repaid to the resident or their estate.

The village-linked model generates multiple revenue streams, including DMF income, village service fees, development profits, and, where market conditions allow, ORA relicensing gains. Relicensing gains arise when a unit is relicensed to a new resident at a higher ORA value than the previous agreement. Historically, most of these gains have accrued to operators, although some providers now share a portion of the gain with residents or their estates. Examples include Vivid Living and Karaka Pines. Together, these property-related income streams support capital investment and expansion.

Based on listed-provider disclosures and industry estimates, ORA and DMF-related capital can contribute around 50% to 70% of funding for capacity expansion projects, with bank debt typically providing a further 20% to 40%, and the balance sourced from equity and operating cash flow. Strong resident-funded cash flows generally enhance borrowing capacity and support ongoing redevelopment and growth.

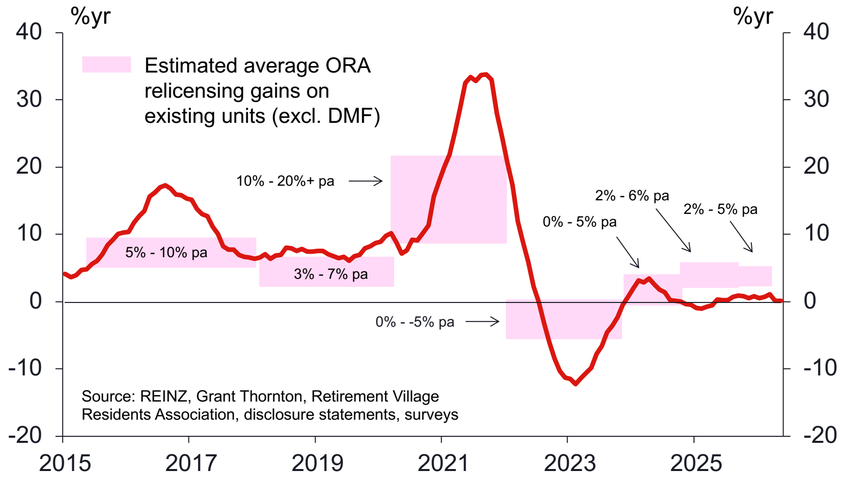
As a result, village-linked providers account for a significant share of new retirement villages and aged care developments built over the past decade.

Table 5: Operators by business model/care level

Care level	Village-linked (number)	Standalone (number)
Rest home	190	450
Hospital	170	270
Dementia	110	150
Psychogeriatric	20	70

Source: Health NZ, Ministry of Health, NZ Aged Care Association, Grant Thornton, BDO, BERL.

Figure 3: House prices and ORA relicensing gains



Standalone providers.

Standalone providers operate a more care-focused model and are generally smaller organisations operating a single facility or regional network. Revenue is derived primarily from government-funded care payments, accommodation supplements and charges, resident contributions, and premium accommodation or service fees.

Unlike village-linked providers, they do not benefit from ORA sales, DMF income, retirement village service fees, or village development profits, making financial performance more dependent on occupancy, workforce management, quality of care, regulatory compliance, and cost control.

The absence of retirement village capital significantly affects the ability of standalone operators to expand capacity. Industry estimates suggest that standalone providers typically rely on bank debt for around 40% to 70% of development funding, supplemented by equity, retained earnings, donations, grants, or asset recycling. With operating margins often tighter and government funding primarily directed towards care delivery rather than capital investment, access to growth capital is generally more constrained.

Expanding development capacity.

In practical terms village-linked providers typically have 2 to 4 times greater development capacity per dollar of equity than their standalone counterparts.

Table 6: Source of funding for capacity expansion

Source	Village-linked (% range)	Standalone (% range)
ORA/DMF	50% to 70%	0%
Bank debt	20% to 40%	40% to 70%
Equity capital	5% to 30%	10% to 30%
Operating cashflow	5% to 15%	10% to 25%
Asset sales/other sources	0% to 10%	0% to 15%

Source: Listed-provider annual reports, financial statements, industry reports (Grant Thornton, JLL, CBRE).

Drivers of demand.

According to Health NZ modelling and industry data, there were approximately 33k to 35k people living in aged residential care in 2023/24. Resident numbers have increased only modestly over the past decade, while they have declined as a share of the population aged 65 years and over. This reflects rapid growth in older age cohorts, later entry into residential care, and expanded home and community support services that enable many older people to remain independent for longer.

Nevertheless, population ageing remains the key driver of ARC demand. Although age-specific utilisation rates have declined and people are entering care at older ages, strong growth in the population aged 85 years and over is more than offsetting these trends, resulting in continued growth in overall demand for residential care.

The nature of demand is also changing. Traditional rest home care has shown little growth over the past decade, while hospital, dementia, and psychogeriatric care have expanded more rapidly. This reflects increasing resident frailty, multiple chronic conditions, cognitive impairment, and greater clinical complexity. Expanded home and community-based support services enable many people to remain at home longer, but those entering care increasingly require higher-acuity services that cannot be safely delivered in the community.

As a result, a growing share of ARC activity is concentrated in higher-acuity settings. Broader pressures across the health system, including the discharge of medically stable older patients who cannot safely return home, are reinforcing demand

Figure 4: ARC residents by level of care

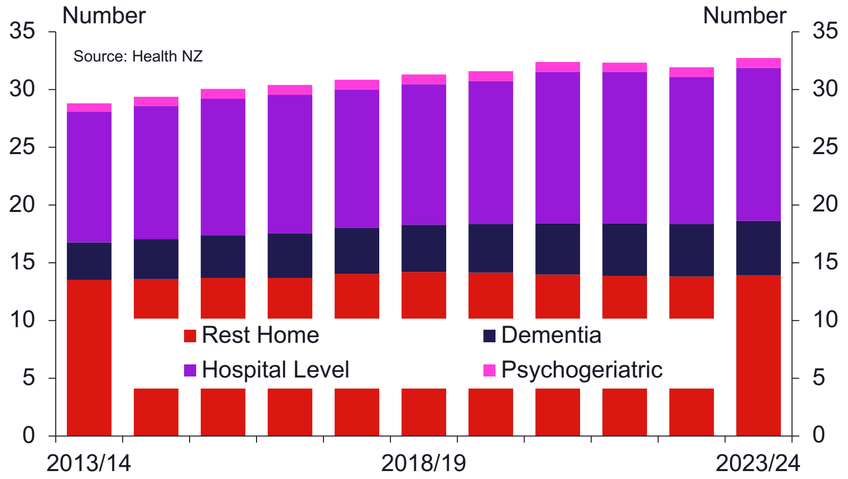


Figure 5: Population demographics

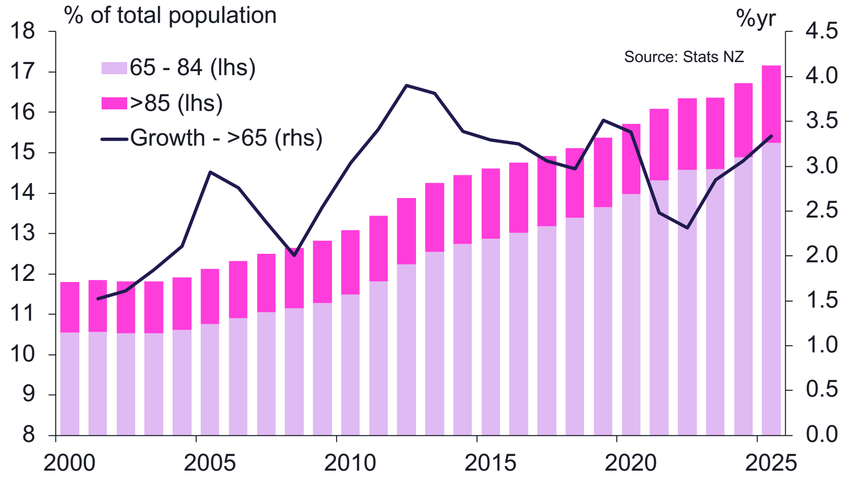
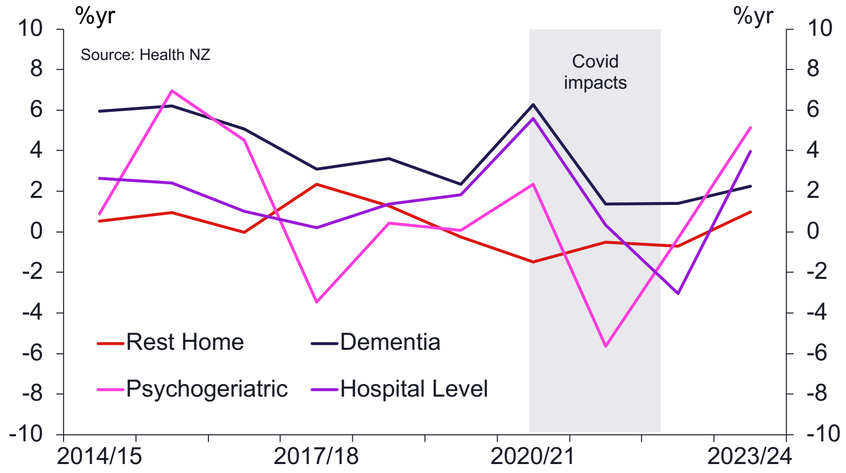


Figure 6: Growth in ARC residents by level of care



for hospital, dementia, and psychogeriatric care, while growth in lower-acuity rest home care remains relatively subdued.

Funding.

Total sector funding rose to just over $2.7bn in 2025, comprising around $1.5bn from RCS and Crown top-ups and $1.2bn from residents. Funding has increased by about 4% annually since 2010, driven by population ageing, resident growth, and increasing care complexity. However, after adjusting for inflation, funding per resident has grown by only around 0.7% per year, indicating much of the increase has been absorbed by rising costs and higher care needs.

In line with demand, funding growth has increasingly been directed toward residents with more complex needs. Crown top-up funding for hospital, dementia, and psychogeriatric care has grown faster than standard RCS payments, reflecting the trend of people entering care later in life with greater frailty, cognitive impairment, and clinical complexity. Resident contributions have also increased steadily, supported by growing demand and greater uptake of premium accommodation and additional services.

Hospital-level care receives the largest share of ARC funding, accounting for just over $1.2bn in 2025, followed by rest home care at around $900m, dementia care at approximately $500m, and psychogeriatric care at about $110m. Between 2014 and 2025, funding for dementia care increased by 134%, hospital care by 94%, psychogeriatric care by 72%, and rest home care by 30%. In real terms,

Figure 7: ARC funding by source (nominal and real)

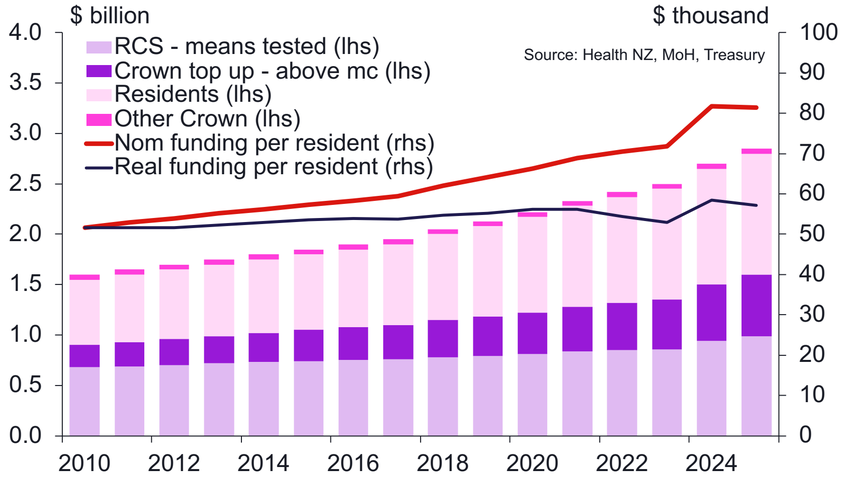


Figure 8: ARC funding by source

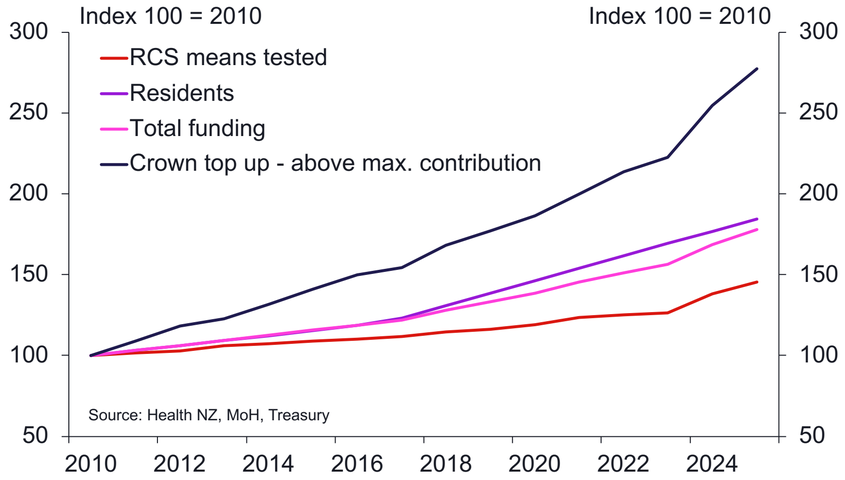
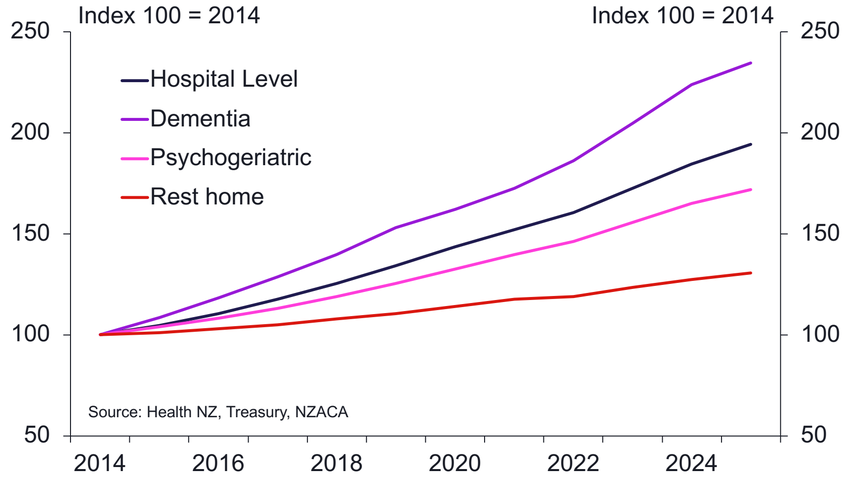


Figure 9: ARC funding by level of care



dementia and hospital care recorded the strongest growth, while rest home funding was broadly flat to slightly lower. These trends highlight the ongoing shift in sector resources toward more specialised and clinically intensive services as resident acuity increases.

Costs of delivery.

The cost of delivering ARC continues to rise and is widely viewed as outpacing available funding. Total sector expenditure was estimated at $3.36bn in 2025, comprising $2.0bn in operating costs and about $1.4bn in capital investment, largely for new developments, refurbishments, and equipment. Since 2014, both operating and capital expenditure have increased by just over 4% annually, reflecting growing demand, higher resident acuity, and ongoing investment in facilities.

Hospital-level care accounted for the largest share of expenditure in 2025 at approximately $1.5bn followed by rest home care ($1.1bn), dementia care ($0.6bn), and psychogeriatric care ($0.1bn). Dementia care recorded the fastest growth, with costs increasing by an estimated 162% between 2014 and 2025, reflecting both rising demand and the resource-intensive nature of dementia services. Hospital-care costs have also increased strongly as residents enter care later in life with more complex clinical needs.

Labour remains the sector's largest cost and has risen substantially due to pay-equity settlements, workforce shortages, reliance on agency staff, rising resident acuity, and Covid-related pressures. Depreciation and clinical costs have also

Figure 10: ARC delivery costs by level of care

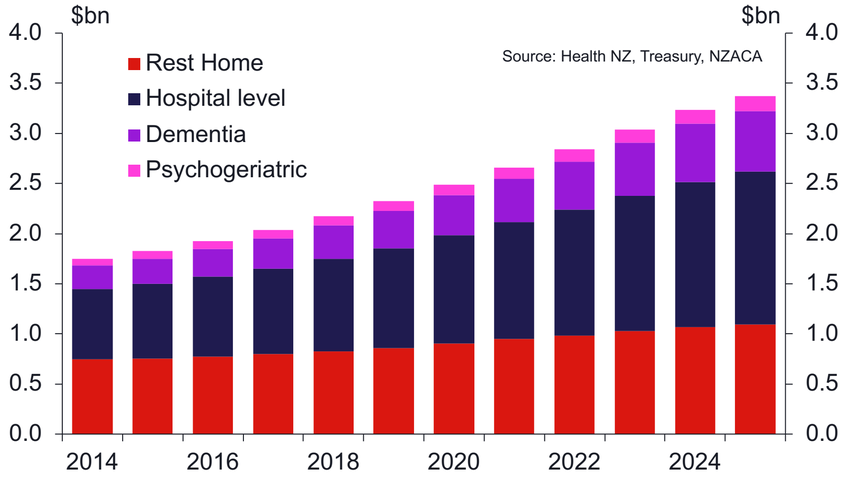


Figure 11: ARC delivery costs by level of care (indexed)

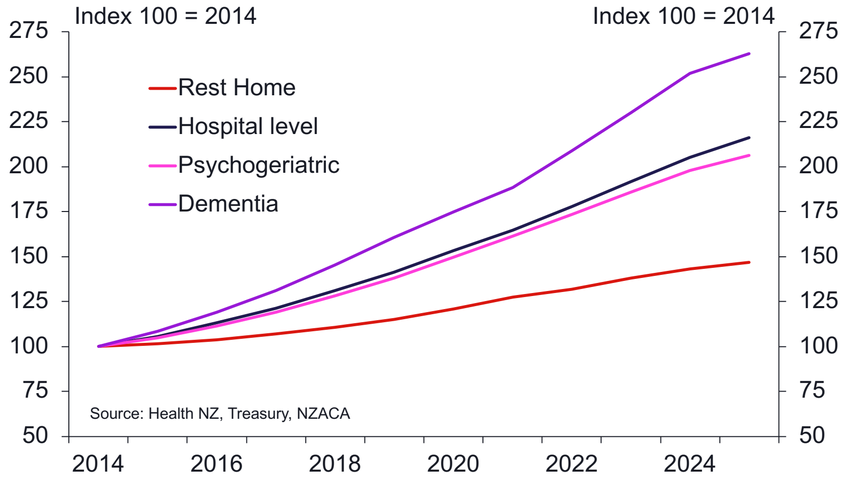
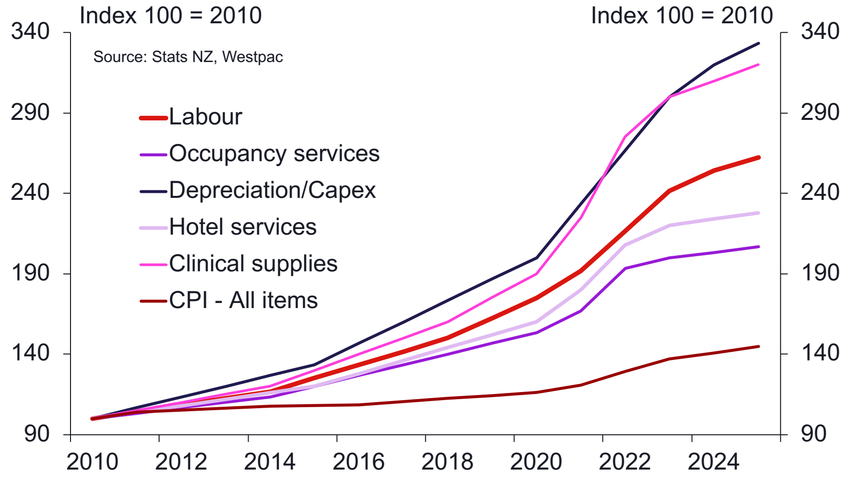


Figure 12: ARC cost price indices



increased, driven by investment in new facilities, refurbishments, compliance requirements, infection control, and more complex care delivery.

Other operating expenses, including utilities, cleaning, laundry, maintenance, food services, and resident amenities, have also risen, easily outstripping headline inflation. Cost pressures were particularly acute during 2021 to 2022 due to inflation, higher energy prices, wage growth, and pandemic-related disruption. Although cost growth has moderated as inflation and labour market pressures have eased, significant structural pressures remain.

Funding gap.

Collectively, these pressures have contributed to an estimated sector funding gap of around $650m in 2025, up from $166m in 2014, highlighting the ongoing challenge of maintaining financial sustainability while meeting increasingly complex care needs. The gap reflects a persistent mismatch between government funding and the actual cost of care, with labour, clinical, compliance, insurance, and capital costs generally rising faster than funding over the past decade.

This funding shortfall spans all levels of care, with estimated deficits of approximately $290m in hospital care, $215m in rest home care, $110m in dementia care, and $35m in psychogeriatric care. Hospital and rest home services account for the largest share of the gap because they represent most sector capacity, while dementia and psychogeriatric services face particularly acute cost pressures, with residents requiring more complex and expensive clinical care as well as higher staffing requirements.

The funding gap has widened substantially over time. We estimate the sector-wide deficit has increased by around 290% since 2014, reflecting a persistent divergence between funding growth and the rising cost of delivering care. While later entry into residential care has concentrated residents with higher and more complex needs, labour, clinical, compliance, insurance, and capital costs have also increased faster than funding. This trend raises concerns about the long-term sustainability of the sector, as a continuing and widening funding gap may reduce providers' ability to reinvest, expand capacity, and meet growing demand.

Having said that, the rate at which this funding gap has grown in recent years has slowed. Wage-linked indexation, targeted funding uplifts, and more responsive price-setting mechanisms have improved funding outcomes, while easing inflationary pressures and labour shortages have tempered cost growth. Even so, the underlying funding imbalance remains unresolved, meaning financial sustainability challenges are likely to persist without further structural changes to funding arrangements.

Figure 13: Gap between ARC funding and costs

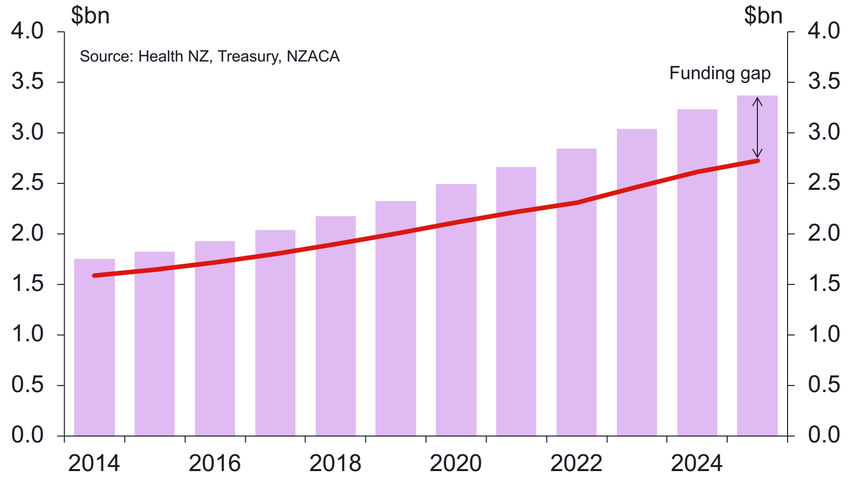
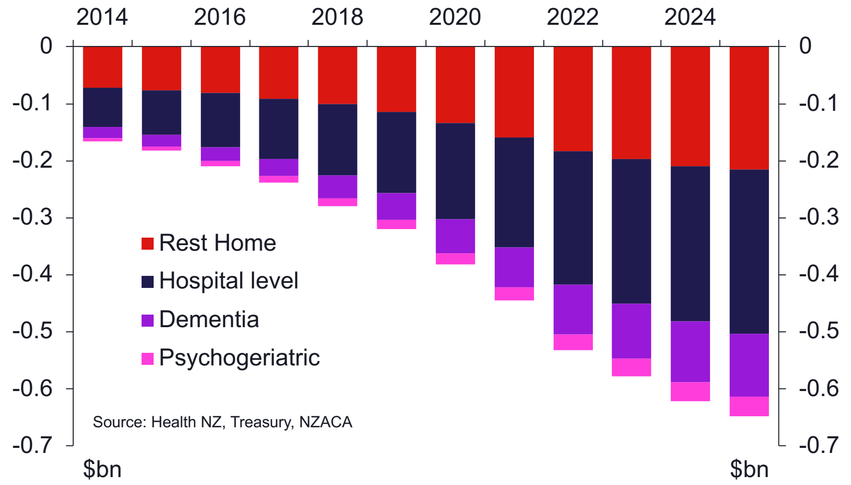


Figure 14: Gap between ARC funding and delivery costs by level of care



Closing the gap.

ARC providers are responding to funding pressures through a combination of revenue diversification, operational efficiencies, and service adaptation. Village-linked providers benefit from retirement village income streams, including DMFs, ORA relicensing gains, and development profits, which support care operations and investment in new facilities. Both village-linked and standalone providers also generate additional revenue through premium accommodation and in the case of the former, care suites.

Some providers are looking to achieve productivity gains through technology, procurement savings, shared services, workforce optimisation, and scale efficiencies. Many are also increasing capacity in hospital, dementia, and psychogeriatric care to meet growing demand from residents with more complex needs. However, funding growth has generally not kept pace with rising labour, clinical, compliance, and capital costs, leading some providers to defer refurbishments, developments, or capacity expansion.

While these measures help improve financial sustainability and adapt services to changing demand, most providers view them as insufficient to fully address the sector's underlying funding gap.

Consequently, the sector continues to advocate for funding arrangements/reforms that better reflect the cost of care delivery and support future capacity growth. Coverage includes the modernising of the funding model, increasing support for capital investment, improving funding transparency, the reviewing of cost sharing arrangements between residents and government, and the changing of regulatory settings to reduce compliance costs.

ORA is big business.

Using public domain information, we estimate that ORA generated from annual unit sales (circa 8,000 at an average price of $600k) is worth about $5bn a year to retirement village operators.

Profitability.

The ongoing challenge of delivering residential care on a financially sustainable basis is shown in table 7. Care-related revenue, including government funding, resident contributions, premium room charges, and ancillary services, is often insufficient to fully cover operating costs, particularly in hospital and psychogeriatric care where clinical, staffing, and compliance requirements are greatest. As a result, care-only margins are frequently negative or only marginally positive.

Financial performance therefore depends heavily on provider business models. Village-linked operators can supplement care revenue through property-related income streams, including DMFs, ORA (new sales and relicensing gains), development profits, and village service fees. These revenue sources can offset care deficits and, for many operators, contribute more to overall profitability than care services themselves. That said, with the funding gap having expanded over time, village-linked operators have become less inclined to divert profits from their village operations, resulting in new villages being designed with a lower proportion of care units than historically has been the case, which means fewer care units available in the future to meet rising demand.

This doesn't apply to standalone providers that are typically more reliant on government funding and accommodation payments, leaving them more exposed to rising costs and funding pressures.

Performance also varies between care types. Hospital and psychogeriatric services generally face the strongest margin pressure because of higher staffing ratios and resident acuity. Dementia care is similarly resource intensive, although specialised service offerings and accommodation charges may partially offset costs. Rest home care tends to have lower clinical intensity and therefore faces less financial pressure than higher-acuity services.

Providers have increasingly relied on accommodation supplements and premium room charges to support viability, with a substantial majority of residents now making some form of accommodation contribution. To that end, transferring a greater share of costs to residents improves provider sustainability.

Overall, the figures reinforce a key sector trend: while aged residential care is fundamentally a care-based service, the financial sustainability of many providers – particularly village-linked operators – depends on access to diversified revenue streams. Property-related income has become increasingly important for funding investment, maintaining service quality, expanding capacity, and bridging the gap between the cost of care and government-funded revenues.

Table 7: Indicative ARC financials by level of care*

Item ($ per bed per day)	Total ARC	Rest home	Hospital	Dementia	Psychogeriatric
Total care funding	100 to 108	78 to 86	88 to 102	82 to 96	78 to 92
Premium/extra services	6 to 10	6 to 10	3 to 7	10 to 8	3 to 7
Respite/ancillary	3 to 5	3 to 5	2 to 5	2 to 5	1 to 4
Operating revenue (care-side only)	109 to 123	87 to 101	93 to 114	94 to 119	82 to 103
Operating costs (care-side attributable)	115 to 129	102 to 116	112 to 130	110 to 128	112 to 132
Care-only profit	-20 to -6	-15 to -1	-22 to -6	-18 to -4	-30 to -10
ORA/DMF income	20 to 28	15 to 22	18 to 28	15 to 24	N/A
Development/resale margin	6 to 12	3 to 8	4 0	4 to 10	N/A
Village fees (net)	6 to 10	6 to 9	6 to 10	6 to 10	N/A
Property + other uplift	22 to 34	23 to 39	20 to 34	24 to 40	N/A
Total operating profit	**2 to 28**	**8 to 38**	**-2 to 28**	**6 to 36**	

Sources: Health New Zealand, Ministry of Health, NZ Aged Care Association, provider disclosures and industry analysis.

* Figures are indicative estimates only and should not be interpreted as actual provider-level results. Financial performance varies materially by occupancy, location, scale, ownership structure, care mix, and retirement village integration. Care-only profitability is often negative, with many village-linked providers relying on retirement village-related income streams to support the overall economics of aged care provision.

Basis of competition.

While village-linked and standalone providers operate within the same funding and regulatory environment, they typically compete in different segments because their business models, revenue sources, and access to capital differ.

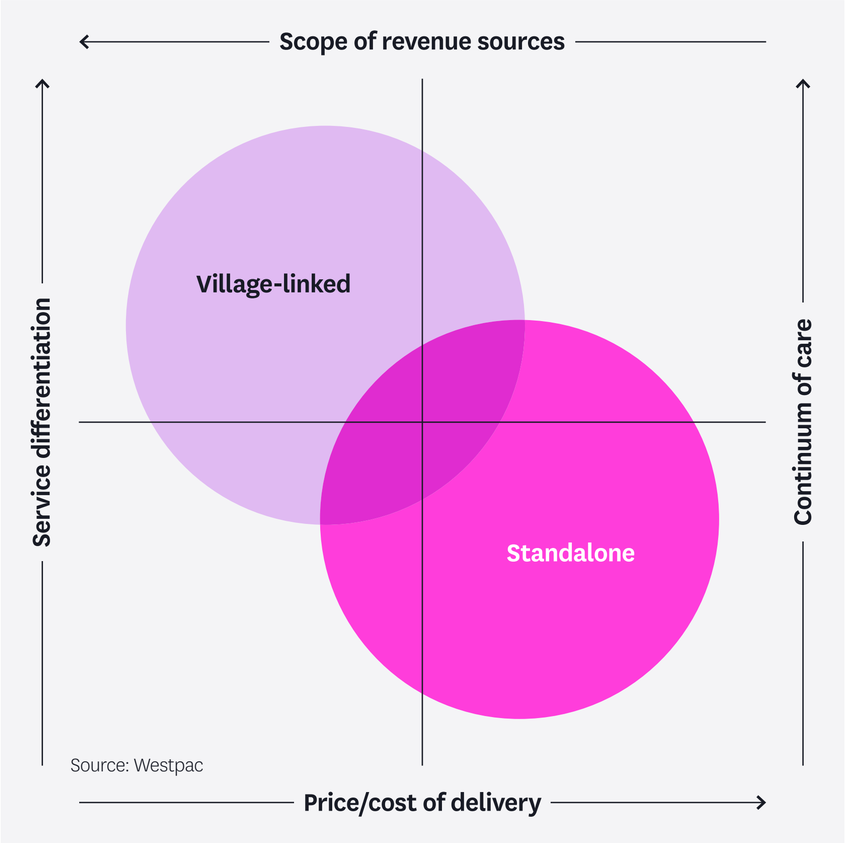
Village-linked providers generally compete through differentiation rather than price. Income from retirement villages, ORAs, DMFs, and care services supports greater investment in facilities, amenities, redevelopment, branding, and service quality. Competition is therefore focused on resident experience, care quality, reputation, modern facilities, and the ability to support residents as their care needs change. Managing costs remain a key focus. The retirement village business model also provides capital that can be reinvested into care services and infrastructure.

Standalone providers face different constraints. Relying primarily on care-related revenue, they generally have less capacity for large-scale capital investment or premium offerings. Competition therefore centres on care quality, occupancy, local relationships, operational efficiency, and cost control. Many also specialise in specific care segments rather than providing a full continuum of care, making competition more localised.

The distinction is not absolute. Some well-capitalised standalone and medium-sized providers with modern facilities compete directly with village-linked operators on quality and service. However, competition remains strongest within each segment, reflecting differences in revenue models, capital resources, and strategic priorities.

For further detail on how village-linked and standalone ARC providers compete, refer to Appendix C.

Figure 15: Basis of competition



Source: Westpac

Competitive pressures.

Competitive pressures are high for village-linked providers and very high for standalone ARC providers, The source, intensity, and direction of competitive pressures also differ.

Industry rivalry is high and increasing for both models. Village-linked providers compete for retirement village residents, premium sites, and development opportunities, with competition centred on lifestyle offerings, facility quality, reputation, and access to a continuum of care. For standalone providers, rivalry is also high and increasing, although competition is more localised and focused on occupancy, care quality, clinical capability, reputation, and operating efficiency.

The threat of new entrants is low and broadly stable for village-linked providers due to high land, capital, development, and regulatory requirements. This threat is moderate and stable for standalone providers. That said, while barriers are lower, workforce shortages, compliance requirements, and relatively low care-sector margins continue to discourage new entry in the standalone sub-segment.

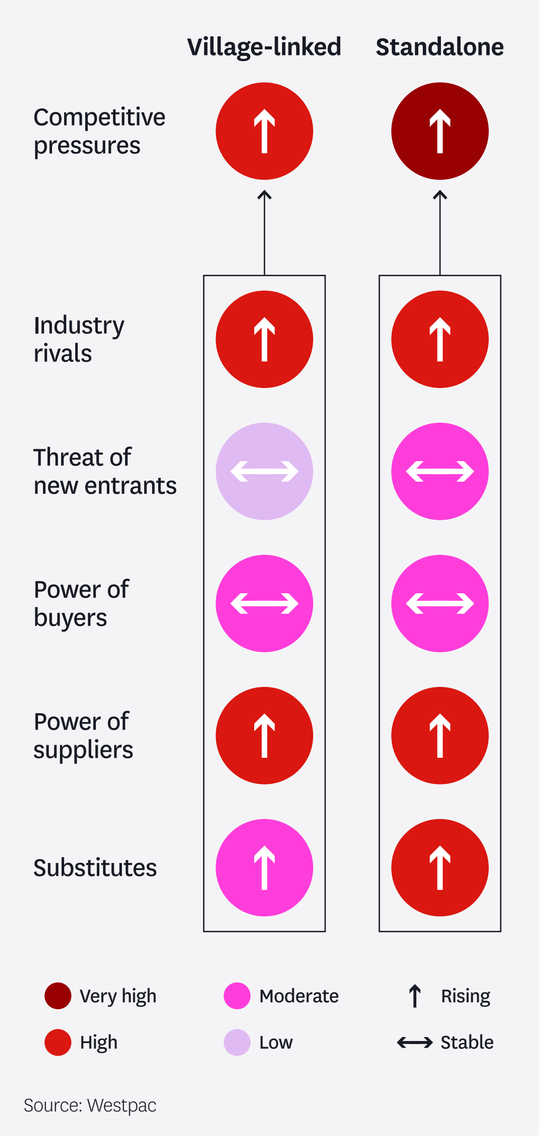
Supplier power is high and rising across the sector because nurses, caregivers, and clinical staff remain in short supply. The impact is greater for standalone providers, which have less scale and fewer opportunities to absorb rising labour costs. Village-linked providers generally benefit from stronger recruitment capability, greater operating scale, and more diversified income streams.

Buyer power is moderate and broadly stable. Residents and families can choose providers based on location, care quality, facilities, and reputation, particularly in larger urban markets. However, demand remains largely needs-based and capacity constraints limit buyer bargaining power. Government also exerts significant influence through funding and pricing arrangements.

The threat of substitutes is moderate to high and increasing, reflecting the expansion of home and community-based services that allow older people to remain at home longer and delay entry into residential care. This pressure is generally greater for standalone providers, particularly those focused on lower-acuity care. Village-linked providers are less exposed because retirement villages can act as an intermediate step between independent living and residential care.

Overall, village-linked providers face their greatest pressures from rising rivalry, housing market exposure, and development risk. While ORA sales, DMFs, relicensing gains, village fees, and development activity provide financial resilience, weaker housing markets, slower sales, higher debt, and elevated construction costs can reduce profitability and growth. Standalone providers face greater pressure from rising supplier power, funding constraints, and substitutes. Their reliance on care-related revenue makes them more exposed to labour cost inflation, workforce shortages, and rising operating costs. Consequently, competitive pressure is assessed as high and increasing for village-linked providers and high to very high and increasing for standalone providers.

Figure 16: Summary of competitive forces



Source: Westpac

Critical success factors.

For both village-linked and standalone ARC providers, long-term success depends on five key factors: clinical quality, workforce capability, occupancy, financial sustainability, and facility quality. While both models generally deliver acceptable care outcomes, village-linked providers tend to perform better overall because retirement villages provide additional revenue streams, stronger referral pathways, and greater scale. As such, the effective integration of the retirement village and aged care business is the most critical success factor for village-linked providers.

Clinical quality is also of critical performance. Most providers meet regulatory standards and achieve acceptable resident outcomes despite increasing care complexity. Village-linked providers generally have a modest advantage due to stronger clinical governance, larger multidisciplinary teams, and greater investment in training, technology, and quality improvement. Standalone providers also perform well, although smaller scale can limit access to specialist expertise and investment.

Workforce attraction, retention, and productivity remain significant challenges. Village-linked providers are generally better positioned because they offer broader career pathways, stronger recruitment capability, and greater staffing flexibility. Standalone providers often face greater recruitment difficulties, particularly in regional and rural areas, and have less capacity to absorb rising labour costs.

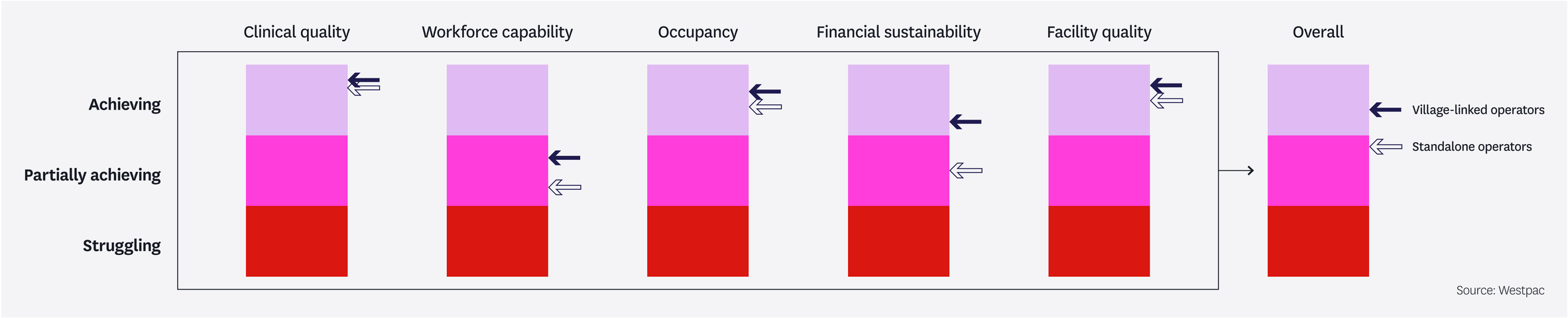
Occupancy and demand management are among the strongest-performing success factors. Village-linked providers benefit from residents transitioning from independent living to care within the same organisation, supporting occupancy and retention. Standalone providers also benefit from strong demographic change but rely more heavily on external referrals and local market conditions.

The largest difference between the models lies in financial sustainability. Village-linked providers benefit from diversified income streams, including DMFs, ORA relicensing gains, development profits, and village service fees, which help offset pressure on care margins. However, they remain exposed to housing market conditions and development risk. Standalone providers rely on government funding, resident fees, and accommodation payments, making them more vulnerable to funding constraints and rising costs.

Facility quality also tends to favour village-linked providers. Larger operators generally have greater access to capital and can invest more consistently in modern accommodation, technology, amenities, and redevelopment. While many standalone providers maintain good-quality facilities, capital constraints can limit refurbishment and expansion.

Overall, village-linked providers generally outperform standalone providers in occupancy, financial sustainability, and facility quality due to the advantages of retirement village integration and diversified revenue streams. Standalone providers often perform comparably on clinical quality but face greater challenges in workforce management, capital investment, and financial resilience. As a result, the integrated village-care model remains the stronger-performing model, although both provider types continue to face workforce shortages, rising costs, and increasing resident acuity.

Figure 17: Sector assessment against critical success factors



Opportunities and challenges.

The sector's strongest opportunities are driven by favourable demographic trends. Population ageing, increasing longevity, rising dementia prevalence, and growing demand for higher-acuity care are expected to support sustained growth in aged residential care demand over coming decades. Additional opportunities exist to improve productivity and expand capacity through greater use of technology, operational efficiencies, and scale.

These opportunities are balanced by several significant challenges. Providers continue to face a widening gap between funding and the cost of care, persistent workforce shortages, increasing resident complexity, rising capital requirements, and growing competition from home and community-based care services. As a result, while long-term demand remains strong, financial sustainability and capacity growth are likely to remain key pressures across the sector.

Recommendations.

To capitalise on these opportunities, village-linked providers should leverage their scale, access to capital, and retirement village integration to expand into high-growth urban markets, increasing hospital, dementia, and psychogeriatric capacity, and strengthening specialist services. They should also maximise village-to-care pathways, occupancy, and property income, while using technology, centralised functions, and selective acquisitions to improve efficiency and expand capacity.

Standalone providers should focus on underserved regional markets, specialist or niche care offerings, and premium accommodation where feasible. Technology, procurement groups, shared services, and strategic alliances can help reduce costs and strengthen competitiveness.

Addressing the sector's challenges will require different strategies. Both village-linked and standalone providers should be advocating for funding reforms. In addition, we think village-linked providers should continue to improve efficiencies, diversify revenue sources, strengthen workforce recruitment and retention, build specialist clinical capability, prioritise developments in high-demand locations, and reinforce continuum-of-care pathways.

Standalone providers should focus on cost control, occupancy, and revenue optimisation. Strong workplace culture, local employment relationships, staff development, and clinical governance will be important to managing workforce pressures and increasing resident acuity. Capital should be directed towards targeted refurbishments and expansion projects, with a greater focus on higher-acuity and specialist services that are less vulnerable to substitution from home-based care.

Appendix A.

Table A1: ARC delivery models in New Zealand

Dimension	Model 1: Listed, large corporates	Model 2: Private, large corporates	Model 3: Large not-for-profit/ charitable providers	Model 4: Private, medium sized providers	Model 5: Small independent/ single-site operators	Model 6: High acuity specialist providers
Providers	Ryman Healthcare, Radius, Summerset, Oceania	Bupa, Heritage, Arvida*, Metlifecare*, Alden	Presbyterian Support and other faith/community trusts	Regional private chains	Single-site private operators	Small number of specialist providers (e.g. dementia/ psychogeriatric)
Characteristics	National coverage	National to multi-regional coverage	Regional to national footprint (often geographically concentrated)	Selected regional coverage	Local	Typically located in larger population centres
	ARC facilities typically co-located with retirement villages	Mix of village-linked and standalone	Mission-driven rather than profit-maximising	Typically not co-located	Limited economies of scale	Narrow specialist service focus
	ARC is one component of a broader property-based business	Mixed care and property exposure	Often long-established with legacy land/buildings	Moderate scale enabling some centralisation	Often ageing infrastructure	High clinical skill and staffing intensity
	Strong balance sheets with access to capital	Moderate to strong access to capital (often shareholder-backed)	Limited access to fresh capital	Generally privately owned and debt funded	Often owner-operated or family businesses	Heavily reliant on public funding and service contracts
Economics	ARC delivers lower returns and supports overall village profitability	Low-margin but commercially sustainable at a portfolio level	ARC typically operates around breakeven or loss, supported by donations and asset recycling	Thin margins	ARC delivers thin margins	Margins typically very thin due to high clinical cost base
	Viability supported by cross-subsidisation (village margins, fees, ORAs)	Limited internal cross-subsidy	Limited ability to offset losses beyond asset sales, cost control and external funding	Occupancy and acuity critical	Structurally challenged under the current funding model, highly occupancy dependent	Viability depends on subsidies and cross-support from related services
Strategic behaviour	Willing to expand into higher-acuity care despite lower margins	Disciplined expansion; portfolio optimisation	Continue providing services despite financial pressure	Cautious expansion into higher acuity	May exit market (sell or close facilities)	Capacity constrained due to specialist workforce requirements
	Continue investing to support village value and resident proposition	Selective capex, refurbishments and acquisitions	Under pressure to rationalise capacity and older facilities	Limited new builds; portfolio churn	Often reduces service scope to manage costs	Highly sensitive to staffing availability and funding changes

Source: NZ Retirement Commission (sector and international scans), OECD long-term care framework, Australian Department of Health (AN-ACC), company disclosures.

* Arvida and Metlifecare operate similar to Ryan and Summerset on the “Economics” dimension.

Table A2: ARC New Zealand peer comparisons

Feature	New Zealand	Australia	United Kingdom	Canada
System type	Publicly funded, price-regulated, privately delivered	Public subsidies and user contributions, privately delivered	Social care, means-tested, largely privately delivered	Publicly funded health plus mixed long-term care, user-paid accommodation
Access trigger	Needs assessment (NASC)	Needs assessment	Local authority needs and means assessment	Provincial needs assessment
Means testing	Yes: determines subsidy and contributions	Yes: determines care and accommodation contributions	Yes: strict means testing	Yes: varies by province
Who pays for care	Govt pays if eligible, others self fund up to a maximum contribution. Govt funds balance for higher levels of care.	Govt majority via AN-ACC, resident co-pay	State pays if eligible, others self-fund	Provinces fund medical/nursing care
Who pays for accommodation	User-paid (means-tested, capped)	User-paid	User-paid	User-paid (often capped)
Price setting	National regulated prices	AN-ACC funding model	No national prices, locally set	Provincial budgets and fees
Care differentiation	4 care levels	Case-mix (AN-ACC)	Residential/nursing/dementia	Varies by province
Provider ownership	Mostly private for-profit	Mixed (for-profit and not-for-profit)	Mixed, mainly private	Mixed (public, non-profit, private)
Capital funding model	Provider-funded (debt/equity)	User and provider capital	User-funded/developer-led	Mixed, often publicly supported
Financial risk – providers	High	Moderate	High	Mixed
Equity of access	High once eligible	Moderate-high	Low-moderate	High for care, mixed for accommodation

Source: NZ Retirement Commission (international scan), Australian Dept. of Health (AN-ACC), OECD long-term care framework, National Institute on Ageing (Canada), country funding frameworks.

Appendix B.

Table B1: Value proposition of ARC business models

Aspects	Village-linked ARC providers	Standalone ARC providers
Core value proposition	Lifestyle and care continuum. From a provider's view, care is supplementary to its lifestyle offering.	Care only service – no lifestyle offering.
Target customers	Wealthier residents and existing village residents transitioning into care.	Rest of the population, which means a heavy reliance on RCS.
Quality and amenities	Competes on having modern facilities, premium rooms, lifestyle offering. Village cashflows fund ongoing upgrades and redevelopment.	Competes on basic care quality and reputation. Facilities tend to older and with more basic facilities, that offer less amenity differentiation.
Pricing/revenue flexibility	Can offer premium rooms and extras (supported by village brand and positioning), allowing for premium pricing.	Limited pricing power; relies more on standard funding and small top-ups to complex care needs.
Demand pipeline	Internal pipeline-village residents transition through stages of care.	Must compete for external referrals only (GPs, hospitals, NASC).
Location strategy	Often in premium/high-demand locations linked to villages.	More mixed, often local/community-based.
Service offering (continuum of care)	More likely to offer fuller continuum of care i.e., rest home, hospital and dementia care as needs rise. Psychogeriatric care is a very small offering.	Often more limited care mix – typically rest home and some hospital care Most psychogeriatric care is provided by standalone operators.
Brand and reputation	Competes on strong national brands and integrated retirement lifestyle proposition.	Competes on local reputation and relationships.
Occupancy management	More stable as residents move through continuum of care plus brand pull.	More volatile; relies on local demand conditions.
Staffing capability	Better ability to attract staff because of scale, pay and better career prospects.	Competes on culture and flexibility, but face recruitment challenges.
Cost efficiency	Benefits from scale economies (larger sites with more beds, centralised procurement, systems).	Smaller scale implies lack of economies of scale and higher unit costs of delivery.
Capital investment	Competes through continuous reinvestment in facilities (funded by village model). New builds are common.	Limited ability to invest/re-invest facilities often older/slower to upgrade.
Business resilience	Competes with diversified income (property and care).	Compete purely on care performance and cost control.

Source: New Zealand Retirement Commission, New Zealand Aged Care Association, Grant Thornton, EY, IBISWorld, company disclosures.

Appendix C.

Table C1: How village-linked providers compete

Driver	How they compete	What “winning” looks like
Location strategy	· Target high-growth, high-income areas. · Co-locate villages and care facilities.	Sites in desirable locations with strong demand and pricing power.
Village offering (entry funnel)	· Attract residents into retirement villages earlier. · Offer strong lifestyle proposition.	Large resident base feeding into care pipeline.
Facility quality and design	· Continuous upgrades, premium rooms (larger, ensuite, care suites) and hotel-style amenities.	“Best-in-class” facilities that justify premium fees and attract high-income residents.
Brand and reputation	· Invest in national brand recognition. · Market lifestyle and continuum of care.	Strong brand that drives demand and trust.
Continuum of care	· Provide full range of care level services.	Ability to retain residents as care needs escalate.
Customer experience	· Focus on lifestyle, wellbeing, and service quality. · Differentiate on non-clinical aspects.	High resident satisfaction and referrals.
Pricing/premium positioning	· Offer differentiated accommodation and extras. · Segment rooms by price/quality.	Ability to capture higher fees above regulated funding.
Occupancy optimisation	· Use internal pipeline from village residents. · Manage mix of residents and care levels.	High and stable occupancy across care levels.
Product mix strategy	· Shift toward premium rooms/care suites. · Adjust mix toward higher-acuity care.	Better revenue yield per bed.
Development pipeline	· Build new villages to expand care capacity. · Villages are looking to limit care options to existing residents.	Ongoing growth and asset recycling.
Capital access and deployment	· Use ORA inflows/balance sheet strength to fund expansion.	Ability to invest ahead of competitors.
Scale and efficiency	· Operate large sites (100–300 beds) for efficiency. · Centralise operations (procurement, systems).	Lower unit costs and higher margins.
Staffing attractiveness	· Offer career pathways, scale, and better conditions.	More stable workforce and care quality.

Source: NZ Retirement Commission, OECD, PWC, BDO, IBISWorld, company disclosures.

Table C2: How standalone providers compete

Driver	How they compete	What 'winning' looks like
Occupancy and vacancy management	· Operators compete on speed and certainty of admission, and on minimising empty-bed days. · Operators have to be able to respond quickly to referrals, streamline admissions, manage waitlists and bed flow.	Sustained high occupancy with low churn and minimal empty-bed days.
Workforce stability and agency dependence	· Providers compete on improved rosters, retention, supervision, and reduced agency use.	Tight rostering, a focus on staff retention, recruitment pipelines, flexible shifts, float/backfill where possible.
Unit-cost control (labour and overhead)	· Providers focus on optimising the skills mix, improve procurement efficiencies, reduce non-care overhead layers, and standardise consumables	Cost per resident per day (unit cost) is lower than peers without triggering quality failures.
Referral network strength (NASC/hospital/GP)	· Preferred-provider status drives steady inflow. · Build trusted relationships, be ‘easy to place’, fast clinical info and paperwork.	Repeat referrals and stable inflow even when capacity tight.
Quality and compliance performance	· Internal audits, documentation discipline, training compliance, rapid corrective action to ensure quality standards are met. · Avoidance of negative signals to regulator/referrers.	Clean/low-severity audit findings every cycle, fast closure of actions and low compliance burden.
Clinical risk management	· Falls/infection control, meds management, escalation protocols, care planning discipline. · Providers compete by reducing hidden costs (labour spikes, transfers, claims).	Lower adverse events relative to acuity mid, fewer 'cost shocks’, and less complaints.
Case-mix/acuity fit (right resident for capability)	· Manage care level mix, align staffing/skills with acuity, avoid wrong-fit placements.	Better revenue mix without Registered Nurse/clinical cost blowout.
Reputation and family experience (local market trust)	· Strong communication, transparency, consistent experience, culturally aligned care. · Better reputation increases referrals/occupancy and reduces marketing effort.	Word-of-mouth momentum and strong conversion, fewer complaints.
Asset utilisation and configuration	· Minimise idle wings, reconfigure rooms where possible, targeted refurb for appeal. · No idle capacity and rooms match demand.	Improves revenue without major capex, raises return on existing assets.
Capital discipline and maintenance backlog control	· Prioritise safety/compliance capex, stage refurb, avoid capex cliffs. · Compete on surviving without overinvesting.	Cashflow resilience with manageable backlog.

Source: Health New Zealand, Ministry of Health, NZ Aged Care Association, OECD, BDO, PWC, BERL, IBISWorld.

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